Contra Costa Health Plan (CCHP)

Basic Healthcare (BHC) Formulary

Last Updated: June 1, 2026

Note: The CCHP Formulary is subject to change, and all previous versions are no longer in effect.

- To access the electronic version of the CCHP formulary on the health plan's website, please go to the following web address: https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/pharmacy-services
- To access the CCHP interactive formulary search tool, please go to the following web address: https://client.formularynavigator.com/Search.aspx?siteCode=5927423023
- To access plan-specific coverage information including cost sharing information, member handbook, and other important materials such as your Evidence of Coverage (EOC) documents, please go to the following web address:

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Frequently Asked Questions

What is the CCHP formulary?

The CCHP formulary (also known as the CCHP preferred drug list, or PDL) includes drugs used to treat common diseases or health problems. This formulary applies only to outpatient drugs and self-administered drugs – it does not apply to medications used in the inpatient setting or in medical offices.

The formulary is a continually reviewed and revised list of preferred medications based on safety, efficacy, and cost-effectiveness. It is updated monthly and is effective the first of every month. Updates are based on input from a team of doctors and pharmacists that meet regularly to decide which drugs should be included. These updates may include but are not limited to the following: (i) removal or addition of drugs and/or dosage forms. (ii) changes in tier placement of a drug (iii) changes to utilization management restrictions (such as quantity limits, step therapy, etc.). Updated documents are available online at: https://www.cchealth.org

How do I use the CCHP formulary?

The list of formulary drugs begins on Page 1. To locate a drug on the formulary, simply look for the name of the drug in the index at the end of this booklet - the index lists all the drugs on the formulary, including brand name and generic name. Once you have located the name of the drug in the index, you will see the page number where you can find more information about your drug listed next to it.

Instead of using the index, the formulary can also be searched by using ctrl+F to find a specific medication by brand name, generic name, or therapeutic class.

A mobile-enabled version of the CCHP formulary is also available using the ePocrates application. After you have downloaded the application to your mobile device, simply choose the “Contra Costa Health Plan-Commercial” formulary to display the formulary status of drugs within the application. If you have any questions about the installation or use of the Epocrates application, please contact Epocrates Customer Support at (800)230-2150 or goldsupport@epocrates.com.

The presence of a prescription drug on the CCHP formulary does not guarantee that a member will be prescribed that medication by his or her prescribing provider for a particular medical condition. The absence of a drug on the CCHP means that the drug

is not on the formulary, and will require prior authorization to be covered (specific information about the CCHP prior authorization process is located below in the section titled "What if the drug that I need isn't listed on the CCHP formulary?")

How are drugs listed on the formulary?

Drugs are listed alphabetically by brand and generic name within the therapeutic category and class to which they belong. Brand name drugs will appear in all CAPITAL letters, with the generic name listed in parentheses after the brand name in all ***bold and italicized lowercase letters***. If a generic drug is available, it will be listed separately from the brand name drug and will always be listed in ***bold and italicized lowercase letters***. If a generic equivalent of a brand name drug is not available, then the generic drug will not be listed separately from the brand name drug. In situations where an FDA approved generic equivalent is available, brand names are listed for reference purposes only, and do not denote coverage for the brand, unless specifically noted.

An example listing from the CCHP formulary is below:

Therapeutic Class ⇩ **Drug Tier** ⇩

Insulins - Drugs For Diabetes		
LANTUS SOLOSTAR U-100 INSULIN (***insulin glargine***)	T2	QL (30mL per 30 days)

⇧ **Brand Name** ⇧ **Generic Name** ⇧ **Coverage Limits**

What if the drug that I need isn't listed on the CCHP formulary?

If your drug isn't listed on the CCHP formulary you can ask your doctor if there is a different drug on the formulary that will work the same way. If your doctor decides that you need a drug that is not on the formulary, they can ask CCHP to make an exception through the prior authorization process. All prior authorization requests will be evaluated by a health plan clinician (pharmacist or medical doctor) based upon CCHP prior authorization criteria that is approved by the CCHP Pharmacy and Therapeutics (P&T) committee. In instances where specific criteria do not exist, FDA indications, peer reviewed literature, other plan criteria, national treatment guidelines (such as IDSA, NCCN, AACE, etc.), and other medical compendia will be used for evaluation. Exceptions can be made for a variety of different reasons:

- Your doctor can ask CCHP to cover a drug that is listed on the formulary as requiring a prior authorization (PA): these drugs require approval prior to being dispensed at a network pharmacy. Each request will be reviewed by a health plan clinician, and if the

request does not meet the guidelines established by the plan it will not be approved, and alternative therapy may be recommended.

- Your doctor can ask CCHP to cover a drug that isn't listed on the formulary: any drug not found on this list is considered non-formulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists and if there isn't an alternate agent on the formulary.
- Your doctor can ask CCHP to make an exception to limits on a drug. For example, if a drug has a limit of 1 tablet per day, your doctor can ask us to cover more. If quantities exceeding the limit are necessary, an exception to coverage may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists without compromising safety.
- Your doctor can ask CCHP to make an exception to Step Therapy (ST) requirements: these drugs require one or more first step drugs to be tried before progressing to the second step drug (for example, if Drug A and Drug B both treat your health condition, CCHP may not cover Drug B unless you try Drug A first). If there is a medical need to use a second step drug without trying a first step drug, an exception to coverage may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists. If you have already tried and failed the preferred drug(s), or if you are already taking a drug that is subject to step therapy when you switch to CCHP, you will not have to try the preferred drugs again. Your doctor can simply request approval through the plan for continuation of therapy.

How is the CCHP prior authorization process initiated?

To start the CCHP prior authorization process or to ask for an exception, your doctor must fax a prior authorization request to CCHP at **1-866-428-7369** for urgent requests, or **1-866-205-8014** for standard requests. Your doctor may also be able to submit the request electronically to CCHP using the electronic medical record. If the request is approved, you will be able to get your medication filled at a pharmacy that works with CCHP. If we deny the request, we will send you and your doctor a letter and will tell you how to file an appeal or a grievance. An "appeal" is when you want a decision to be reviewed again by the health plan (usually with additional information), and a "grievance" is a complaint or concern regarding the health plan.

CCHP will decide to deny or approve all prior authorization and exception requests within 24 hours of receiving the request. If CCHP fails to respond to a prior authorization or step therapy request within 72 hours of receiving a non-urgent request or 24 hours of receiving a request based on exigent circumstances, the request shall be deemed approved.

CCHP will provide coverage pursuant to a non-urgent request for the duration of the prescription, including refills. CCHP will provide coverage, including refills, pursuant to a request based on exigent circumstances for the duration of the exigency.

If you would like to download the CCHP Medication Prior Authorization Request (PA) form, it is available at: https://www.cchealth.org/health-insurance/information-for-providers/preferred-drug-list

What if I need my medication urgently – do pharmacies have the ability to fill emergency supplies of medication?

Yes. To ensure that CCHP members have access to a sufficient supply of medications in emergency situations, CCHP has established an Emergency Supply Policy that allows pharmacists to use their clinical judgement to override claims that deny at the point of sale. When a pharmacist determines that a medication is medically necessary, they may enter an authorization code that allows them to fill a 5-day emergency supply of medication for any CCHP member. CCHP promotes the use of the Emergency Supply Policy through point-of-sale messaging.

Instead of using the 5-day Emergency Supply Policy, pharmacies may also choose to call the PerformRx provider call center at 877-234-4269 – representatives are available 24 hours per day, 365 days per year. Staff at the call center have the ability to override prescriptions based on guidance provided by CCHP.

What if I am a new CCHP member?

If you are a new CCHP member you may be taking drugs that are not on our formulary, or you may be taking drugs that are on our formulary but have limits. If possible, you should talk to your doctor to see if you can change to a preferred drug on the CCHP formulary. If you cannot switch to a preferred drug, then your doctor will need to ask CCHP for an exception to cover a drug you have been taking (known as continuation of therapy). See the section above titled "What if the drug that I need isn't listed on the CCHP formulary?" for more information.

Does CCHP cover generic and brand name medications?

CCHP covers brand and generic drugs, but when a generic drug is available CCHP requires that it be used. All drugs that become available generically are subject to review by the CCHP Pharmacy & Therapeutics committee.

A prescriber may request a brand name product in lieu of an approved generic if the prescriber determines that there is a documented medical need for the brand equivalent. This type of

request for coverage may be made through the CCHP prior authorization process described above in the section titled "What if the drug that I need isn't listed on the CCHP formulary."

Are there drugs that are excluded from coverage?

For the CCHP Basic Healthcare pharmacy benefit, there are no prescription medications that are excluded for coverage. Your doctor can ask CCHP to cover a drug that isn't listed on the formulary: any drug not found on this list is considered nonformulary. Coverage for non-formulary agents may be requested by the prescriber. Each request will be reviewed by a health plan clinician, and approval will be given if a documented medical need exists and if there isn't an alternate agent on the formulary.

If CCHP's coverage is amended to exclude a drug that we have been covering and providing to you under your current coverage, we will continue to provide the drug if a plan physician continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

Can I go to any pharmacy for my medication?

No, members must use a pharmacy that is in the CCHP network. To find a network pharmacy, visit the CCHP website or call the health plan directly to have one of our member services or pharmacy staff help you locate a pharmacy near you (see section below titled "How do I find a pharmacy?").

How do I find a pharmacy?

To find a pharmacy near you, visit the CCHP website at https://secure.healthx.com/ccproviderdirectory. Once you have navigated to the CCHP website, follow the directions below:

(1) Click on the "Facility" tab, and choose "Pharmacy" as the facility type

(2) Choose how you want to search (by zip code, distance, etc.)

(3) Click "Find a Facility" - results will immediately show up (as a map and a list)

Be sure to show your CCHP Member ID card when you fill your prescriptions at the pharmacy.

Note: some medications are subject to limited distribution by the U.S. Food and Drug Administration. These types of drugs are called "specialty medications" because they require special handling, provider coordination, or special education that may not be provided at your local pharmacy. CCHP has a contract with Walgreens to provide these types of medications. If

you have specific questions about these types of drugs, please contact the CCHP pharmacy unit directly.

What drugs are covered by CCHP?

You can get the following drugs and other items when they are prescribed by your doctor and are medically necessary:

- Prescription drugs listed on the CCHP formulary
- Non-prescription drugs or over-the-counter drugs (such as cough/cold syrups, cough
- drops or aspirin) listed on the CCHP formulary
- Formulary diabetic supplies: insulin, insulin syringes, glucose test strips, lancets and
- lancet puncture devices, pen delivery systems, and blood glucose monitors
- FDA-approved birth control and contraceptives listed on the CCHP formulary
- Emergency contraception
- Epi-Pens, peak flow meters and spacers

Are intravenous (IV) and injectable drugs covered by CCHP?

Yes, the CCHP formulary lists certain injectable products that are covered as a pharmacy benefit. CCHP also covers most other intravenous medications through the medical benefit. Medications that are generally covered through the medical benefit are those that are given in a doctor's office, clinic, or hospital setting. Requests for coverage of a medication through the medical benefit should be directed to the CCHP Utilization Management Department by downloading the medical referral form at https://cchealth.org/healthplan/providers/ and faxing to (925) 313-6058 for routine requests or (925) 313-6458 for urgent requests.

Coverage of intravenous and injectable drugs through the pharmacy benefit are outlined below:

- Simple intravenous solutions: simple intravenous solutions are typically used for hydration therapy. Included are commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10% in Water) and Lactated Ringer's Solution; commercially prepared solutions of potassium chloride in such solutions are also included in this definition. Simple intravenous solutions should be billed using the product's National Drug Code (NDC) number.
- Parenteral nutrition solutions (TPN or hyperalimentation): restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when (IV) therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this 10-day period. (Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that typically are

suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin &/or mineral supplements and trace elements.) Adjuncts to parenteral nutrition are other drugs which are physically mixed into a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.

- Separately administered intravenous lipids: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when (IV) therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this10-day period. Intravenous lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, are not physically mixed into the parenteral nutrition solution container) should be billed using the product's NDC number.
- Intravenous solutions of unlisted antibiotics: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when IV therapy with the same antibiotic was started before discharge. There is a maximum of 10 days supply per dispensing within the 10-day period. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.
- Intravenous solutions of other unlisted drugs: restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when IV therapy with the same drug was started before discharge. There is a maximum of 10 days supply per dispensing within the10-day period. **Note:** Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim.

How much will I pay for my drugs?

For all CCHP BHC members, you do not have to pay for covered services; medications are available with no copay.

Can providers make suggestions to CCHP to improve the formulary?

Absolutely. The formulary is a tool to promote cost-effective prescription drug use. CCHP has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. CCHP welcomes the participation of physicians, pharmacists, and ancillary medical providers in this dynamic process. Physicians and pharmacists are highly encouraged to direct any suggestions or comments to CCHP via e-mail at: cchp_pharmacy_director@hsd.cccounty.us.

What if I need more information?

For more information about your pharmacy benefits, please review your Evidence of Coverage documents or call CCHP directly to discuss it. CCHP member services department and pharmacy department staff are available to answer questions Monday through Friday from 8:00am to 5:00pm Pacific Time at the phone numbers listed below:

CCHP Member Services Department: **(877) 661-6230 x2**

CCHP Pharmacy Department: **(877) 661-6230 x3**

Definitions & Abbreviations

Definitions

There are several terms that are used in this document that Contra Costa Health Plan wants to make sure that you understand. Below are some definitions and abbreviations:

“Brand name drug” is a drug that is marketed under a proprietary, trademark protected name. The brand name drug is listed in all CAPITAL letters.

“Coinsurance” is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“Copayment” is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

“Deductible” is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

“Drug Tier” is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

“Enrollee” is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

“Exception request” is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing healthcare provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

“Exigent circumstances” are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

“Formulary” is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.

"Generic drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in bold and italicized lowercase letters.

"Nonformulary drug" is a prescription drug that is not listed on the health plan's formulary.

"Out-of-pocket cost" are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

"Prescribing provider" is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

"Prescription" is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

"Prescription drug" is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

"Prior Authorization" is a health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant prior authorization when it is medically necessary for the enrollee to obtain the drug.

"Step therapy" is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee's medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee's prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

"Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

Abbreviations

Additional abbreviations and terms used on the CCHP formulary document are explained below:

Abbreviation	Term	Definition
AL	Age Limit	Some drugs are only covered for certain ages.
NF	Non-Formulary	These drugs are not covered on the Drug List. If your doctor feels you need a drug that is not covered, he or she can ask us to make an exception.
PA	Prior Authorization	Your doctor must ask for approval from CCHP before some drugs will be covered.
QL	Quantity Limit	Some drugs are only covered for a certain amount.
SCO	State Carve-Out	These drugs are carved out by the Department of Health Care Services. This means these drugs are covered by the Medi-Cal Fee-for-Service program and must be billed to the State by the pharmacy.
ST	Step Therapy	In some cases, you must first try certain drugs before CalViva Health covers another drug for your medical condition. For example, if Drug A and Drug B both treat your health condition, CCHP may not cover Drug B unless you try Drug A first.

The CCHP formulary uses a 3 tier structure – the tiers are explained below:

Abbreviation	Term	Definition
T1	Tier 1	Tier 1 medications are preferred on the CCHP formulary and are available without restriction or prior authorization.
T2	Tier 2	Tier 2 medications are preferred on the CCHP formulary and are available without prior authorization, BUT may have certain restrictions such as quantity limits, step therapy, etc. (the specific restrictions are listed on the CCHP formulary).
T3	Tier 3	Tier 3 medications are non-preferred. These medications require prior authorization.

Plan de Salud de Contra Costa (CCHP) Organización de Administración de Salud "Basic Healthcare" (BHC) Formulario

Última actualización: 1 de junio de 2026

Nota: El formulario del CCHP está sujeto a cambios, y todas las versiones anteriores ya no están vigentes.

- Para acceder a la versión electrónica del formulario del CCHP en el sitio web del plan de salud, visite la siguiente dirección web: https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/pharmacy-services
- Para acceder a la herramienta de búsqueda del formulario interactivo del CCHP, visite la siguiente dirección web: https://client.formularynavigator.com/Search.aspx?siteCode=5927423023
- Para acceder a la información de cobertura específica del plan que incluye información de costos compartidos, manual para miembros y otros materiales importantes como los documentos de su Evidencia de cobertura (EOC), visite la siguiente dirección web:

Preguntas frecuentes

¿Qué es el formulario del CCHP?

El formulario del CCHP (también conocido como la lista de medicamentos preferidos del CCHP, o PDL) incluye medicamentos utilizados para tratar enfermedades o problemas de salud comunes. Este formulario aplica solo a los medicamentos para pacientes en consulta externa y medicamentos autoadministrados, no aplica a medicamentos utilizados en el entorno de pacientes internados o en consultorios médicos.

El formulario es una lista de medicamentos preferidos examinada y revisada continuamente en función de la seguridad, eficacia y rentabilidad. Se actualiza mensualmente y es efectiva el primer día de cada mes. Las actualizaciones se basan en comentarios de un grupo de médicos y farmacéuticos que se reúnen regularmente para decidir qué medicamentos deben incluirse. Estas actualizaciones pueden incluir, entre otros, lo siguiente: (i) eliminación o adición de medicamentos o formas farmacéuticas, (ii) cambios en la colocación de nivel de un medicamento, (iii) cambios en las restricciones de administración de utilización (como límites de cantidad, tratamiento escalonado, etc.). Los documentos actualizados están disponibles en línea en: https://www.cchealth.org

¿Cómo uso el formulario del CCHP?

La lista de medicamentos de formulario comienza en la Página 1. Para ubicar un medicamento en el formulario, simplemente busque el nombre del medicamento en el índice al final de este folleto. El índice enumera todos los medicamentos en el formulario, incluidos los medicamentos de marca y los medicamentos genéricos. Una vez que haya ubicado el nombre del medicamento en el índice, verá el número de página en donde puede encontrar más información sobre el medicamento indicado junto a este.

En lugar de usar el índice, también se puede buscar en el formulario usando ctrl+F para encontrar un medicamento específico por marca, nombre genérico o clase terapéutica.

Una versión para teléfonos celulares del formulario del CCHP también está disponible usando la aplicación ePocrates. Después de que haya descargado la aplicación a su dispositivo móvil, simplemente elija el formulario “Plan de Salud de Contra Costa MediCal” para mostrar el estado de formulario de los medicamentos en la aplicación. Si tiene alguna pregunta sobre la instalación o uso de la aplicación Epocrates, comuníquese con atención al cliente de Epocrates al (800)230-2150 or goldsupport@epocrates.com.

La presencia de un medicamento que requiere receta en el formulario del CCHP no garantiza que el proveedor que emite recetas le recete a un miembro ese medicamento para una afección médica particular.

Si un medicamento no está en el formulario del CCHP, requerirá una autorización previa para que esté cubierto (la información específica sobre el proceso de autorización previa del CCHP se encuentra a continuación en la sección titulada “¿Qué sucede si el medicamento que necesito no está en el formulario del CCHP?”)

¿Cómo se indican los medicamentos en el formulario?

Los medicamentos están indicados alfabéticamente por marca y nombre genérico en la categoría terapéutica y clase a la que pertenecen. Los medicamentos de marca aparecerán en MAYÚSCULAS, con el nombre genérico indicado en paréntesis después de la marca todo escrito en ***letra minúscula negrita y cursiva***. Si el medicamento genérico está disponible, se indicará de forma separada del medicamento de marca y siempre se indicará en ***letra minúscula negrita y cursiva***. Si un genérico equivalente de un medicamento de marca no está disponible, el medicamento genérico no estará indicado de forma separada del medicamento de marca. En situaciones en las que un equivalente genérico aprobado por la Administración de Alimentos y Medicamentos (Food & Drug Administration, FDA) está disponible, las marcas se indican con fines de referencia únicamente, y no denotan cobertura para la marca, a menos que se indique específicamente.

Una lista de ejemplo del formulario del CCHP se encuentra a continuación:

Clase terapeutica ⇩ **Nivel de medicamento** ⇩

Insulins - Drugs For Diabetes		
LANTUS SOLOSTAR U-100 INSULIN (***insulin glargine***)	T2	QL (30mL per 30 days)

⇧ **Marca** ⇧ **Nombre generico** ⇧ **Limites de cobertura**

¿Qué sucede si el medicamento que necesito no está indicado en el formulario del CCHP?

Si su medicamento no figura en el formulario del CCHP, puede preguntarle a su médico si hay un medicamento diferente en el formulario que funcione de la misma manera. Si su médico decide que necesita un medicamento que no está en el formulario, puede pedirle al CCHP que haga

una excepción a través del proceso de autorización previa. Todas las solicitudes de autorización previa serán evaluadas por un médico del plan de salud (farmacéutico o médico) según los criterios de autorización previa del CCHP aprobados por el comité de Farmacia y Terapéutica (P&T) del CCHP. En los casos en que no existan criterios específicos, se utilizarán para la evaluación indicaciones de la FDA, literatura revisada por pares, otros criterios del plan, pautas nacionales de tratamiento (como IDSA, NCCN, AACE, etc.) y otros compendios médicos. Se pueden hacer excepciones por una variedad de motivos diferentes:

- Su médico puede pedirle al CCHP que cubra un medicamento que figura en el formulario que requiere una autorización previa (PA): estos medicamentos requieren aprobación antes de ser despachados en una farmacia de la red. Cada solicitud será revisada por un médico del plan de salud, y si la solicitud no cumple con las pautas establecidas por el plan, no será aprobada, y se puede recomendar una terapia alternativa.
- Su médico puede pedirle al CCHP que cubra un medicamento que no figura en el formulario: cualquier medicamento que no se encuentre en esta lista se considera no incluido en el formulario. La persona que emite la receta puede solicitar cobertura para agentes que no figuran en el formulario. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada y si no hay un agente alternativo en el formulario.
- Su médico puede pedirle al CCHP que haga una excepción a los límites de un medicamento. Por ejemplo, si un medicamento tiene un límite de 1 tableta por día, su médico puede pedirnos que cubramos más. Si se necesitan cantidades que exceden el límite, la persona que emite la receta puede solicitar una excepción a la cobertura. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada sin comprometer la seguridad.
- Su médico puede pedirle al CCHP que haga una excepción a los requisitos de tratamiento escalonado (ST): estos medicamentos requieren que se prueben uno o más medicamentos de primer paso antes de pasar al medicamento de segundo paso (por ejemplo, si el medicamento A y el medicamento B tratan su afección de salud, el CCHP puede no cubrir el medicamento B a menos que primero pruebe el medicamento A). Si existe una necesidad médica de usar un medicamento de segundo paso sin probar un medicamento de primer paso, la persona que emite la receta puede solicitar una excepción a la cobertura. Cada solicitud será revisada por un médico del plan de salud y se aprobará si existe una necesidad médica documentada. Si ya probó el medicamento preferido y este falló, o si ya está tomando un medicamento sujeto a tratamiento escalonado cuando se cambia al CCHP, no tendrá que probar los medicamentos preferidos nuevamente. Su médico simplemente puede solicitar una aprobación a través del plan para la continuación del tratamiento.

¿Cómo se inicia el proceso de autorización previa de CCHP?

Para comenzar el proceso de autorización previa del CCHP o para solicitar una excepción, su médico debe enviar por fax una solicitud de autorización previa al CCHP al **1-866-428-7369** para solicitudes urgentes, o **1-866-205-8014** para solicitudes estándar. Su médico también puede enviar la solicitud electrónicamente al CCHP utilizando la historia clínica electrónica. Si se aprueba la solicitud, podrá surtir su medicamento en una farmacia que trabaje con el CCHP. Si denegamos la solicitud, le enviaremos una carta a usted y a su médico y le diremos cómo presentar una apelación o una queja formal. Una "apelación" es cuando desea que el plan de salud revise nuevamente una decisión (generalmente con información adicional), y una "queja formal" es una queja o inquietud relacionada con el plan de salud.

El CCHP tomará la decisión de denegar o aprobar todas las solicitudes de autorización previa y de excepción dentro de las 24 horas posteriores a la recepción de la solicitud. Si el CCHP no responde a una autorización previa o solicitud de tratamiento escalonado dentro de las 72 horas de haber recibido una solicitud no urgente o 24 horas después de recibir una solicitud basada en circunstancias exigentes, la solicitud se considerará aprobada.

El CCHP proporcionará cobertura de conformidad con una solicitud no urgente por la duración de la receta, incluidos los resurtidos. El CCHP proporcionará cobertura, incluidos los resurtidos, de conformidad con una solicitud basada en circunstancias exigentes por la duración de la exigencia.

Si desea descargar el formulario de autorización previa del CCHP, está disponible en: https://www.cchealth.org/health-insurance/information-for-providers/preferred-drug-list

¿Qué sucede si necesito mi medicamento con urgencia? ¿Las farmacias tienen la capacidad de surtir suministros de medicamentos de emergencia?

Sí. Para garantizar que los miembros del CCHP tengan acceso a un suministro suficiente de medicamentos en situaciones de emergencia, el CCHP ha establecido una Política de suministros de emergencia que permite a los farmacéuticos utilizar su criterio clínico para anular los reclamos que rechazan en el punto de venta. Cuando un farmacéutico determina que un medicamento es médicamente necesario, puede ingresar un código de autorización que le permita surtir un suministro de medicamentos de emergencia para 5 días para cualquier miembro del CCHP. El CCHP promueve el uso de la Política de suministros de emergencia a través de mensajes en el punto de venta.

En lugar de utilizar la Política de suministros de emergencia para 5 días, las farmacias también pueden optar por llamar al centro de llamadas del proveedor de PerformRx al 877-234-4269; los representantes están disponibles las 24 horas del día, los 365 días del año. El personal del centro de llamadas tiene la capacidad de anular las recetas en función de la orientación proporcionada por el CCHP.

¿Qué sucede si soy un miembro nuevo del CCHP?

Si es un miembro nuevo del CCHP, puede estar tomando medicamentos que no están en nuestro formulario, o puede estar tomando medicamentos que están en nuestro formulario, pero que tienen límites. Si es posible, debe hablar con su médico para ver si puede cambiar a un medicamento preferido en el formulario del CCHP. Si no puede cambiarse a un medicamento preferido, entonces su médico deberá solicitarle al CCHP una excepción para cubrir un medicamento que ha estado tomando (conocido como continuación del tratamiento). Consulte la sección anterior titulada "¿Qué sucede si el medicamento que necesito no figura en el formulario del CCHP?" para obtener más información.

¿El CCHP cubre medicamentos genéricos y de marca?

El CCHP cubre medicamentos de marca y genéricos, pero cuando hay un medicamento genérico disponible, el CCHP requiere que se use. Todos los medicamentos que están disponibles genéricamente están sujetos a revisión por parte del comité de Farmacia y Terapéutica del CCHP.

Una persona que emite una receta puede solicitar un producto de marca en lugar de un genérico aprobado si determina que existe una necesidad médica documentada del equivalente de marca. Este tipo de solicitud de cobertura se puede realizar a través del proceso de autorización previa del CCHP descrito anteriormente en la sección titulada "¿Qué sucede si el medicamento que necesito no está indicado en el formulario del CCHP?"

¿Hay medicamentos que están excluidos de la cobertura?

Para el beneficio de farmacia de CCHP Basic Healthcare, no existen medicamentos recetados que estén excluidos de la cobertura. Su médico puede solicitar al CCHP la cobertura de un medicamento que no esté incluido en el formulario; cualquier medicamento que no aparezca en esta lista se considera un medicamento que no figura en el formulario. El proveedor que emite la receta puede solicitar cobertura para medicamentos que no figuran en el formulario. Cada solicitud será revisada por un clínico del plan de salud y se aprobará si existe una necesidad médica documentada y si no existe un agente alternativo en el formulario.

Si la cobertura del CCHP se modifica para excluir un medicamento que hemos estado cubriendo y proporcionándole bajo su cobertura actual, continuaremos proporcionándole el medicamento si un médico del plan continúa recetándolo para la misma afección y para un uso aprobado por la Administración de Alimentos y Medicamentos (FDA).

¿Puedo ir a cualquier farmacia por mi medicamento?

No, los miembros deben usar una farmacia que esté en la red del CCHP. Para encontrar una farmacia de la red, visite el sitio web del CCHP o llame al plan de salud directamente para que uno de los miembros del personal de servicios para miembros o de farmacia le ayuden a ubicar una farmacia cercana (consulte la sección a continuación titulada “¿Cómo encuentro una farmacia?”).

¿Cómo encuentro una farmacia?

Para encontrar una farmacia cercana, visite el sitio web del CCHP en https://secure.healthx.com/ccproviderdirectory. Una vez que haya navegado al sitio web del CCHP, siga las instrucciones a continuación:

(1) Haga clic en la pestaña "Instalaciones" (Facility) y elija "Farmacia" (Pharmacy) como

tipo de instalación

(2) Elija cómo desea buscar (por código postal, distancia, etc.)

(3) Haga clic en "Buscar una instalación" (Find a Facility): los resultados aparecerán

inmediatamente (como un mapa y una lista)

Asegúrese de mostrar su tarjeta de identificación de miembro del CCHP cuando surta sus recetas en la farmacia.

Nota: algunos medicamentos están sujetos a una distribución limitada por parte de la Administración de Alimentos y Medicamentos de EE. UU. Estos tipos de medicamentos se denominan "medicamentos de especialidad" porque requieren un manejo especial, coordinación de proveedores o instrucciones especiales que es posible que su farmacia local no le proporcione. El CCHP tiene un contrato con Walgreens para proporcionar este tipo de medicamentos. Si tiene preguntas específicas sobre este tipo de medicamentos, comuníquese directamente con la unidad de farmacia del CCHP.

¿Qué medicamentos están cubiertos por el CCHP?

Usted puede obtener los siguientes medicamentos y otros artículos cuando los haya recetado su médico y sean médicamente necesarios:

- Medicamentos recetados que figuran en el formulario del CCHP
- Medicamentos sin receta o medicamentos de venta libre (como jarabes para la tos/resfrío, pastillas para la tos o aspirina) mencionados en el formulario del CCHP
- Suministros para diabéticos del formulario: insulina, jeringas de insulina, tiras reactivas de glucosa, lancetas y dispositivos de punción de lancetas, sistemas de administración de plumas y monitores de glucosa en sangre
- Anticonceptivos aprobados por la FDA que figuran en el formulario del CCHP
- Anticoncepción de emergencia
- Epipens, medidores de flujo máximo y espaciadores

¿Los medicamentos intravenosos (IV) e inyectables están cubiertos por el CCHP?

Sí, el formulario del CCHP enumera ciertos productos inyectables que están cubiertos como un beneficio de farmacia. El CCHP también cubre la mayoría de los demás medicamentos intravenosos a través del beneficio médico. Los medicamentos que generalmente están cubiertos a través del beneficio médico son aquellos que se administran en el consultorio de un médico, clínica u hospital. Las solicitudes de cobertura de un medicamento a través del beneficio médico deben dirigirse al Departamento de Administración de Utilización del CCHP descargando el formulario de referencia médica en https://cchealth.org/healthplan/providers/ y enviando un fax al (925) 313-6058 para solicitudes de rutina o (925) 313-6458 para solicitudes urgentes.

La cobertura de medicamentos intravenosos e inyectables a través del beneficio de farmacia se detalla a continuación:

- Soluciones intravenosas simples: las soluciones intravenosas simples normalmente se usan para la terapia de hidratación. Se incluyen soluciones comercialmente disponibles (no compuestas) como solución salina normal, dextrosa (hasta 10% en agua) y solución de ringer lactato; las soluciones de cloruro de potasio preparadas comercialmente en tales soluciones también se incluyen en esta definición. Las soluciones intravenosas simples se deben facturar utilizando el número del Código Nacional de Medicamentos (National Drug Code, NDC) del producto.
- Soluciones de nutrición parenteral (TPN o hiperalimentación): restringidas para dispensar dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando se inició la terapia (IV) con el mismo producto antes del alta. Hay un suministro máximo para 10 días por dispensación dentro de este período de 10 días. (Las soluciones de nutrición parenteral son productos nutricionales administrados por vía intravenosa o intraarterial que suelen ser suspensiones o soluciones de

aminoácidos o proteínas, dextrosa, lípidos, electrolitos, suplementos vitamínicos y/o minerales y oligoelementos). Los complementos a la nutrición parenteral son otros medicamentos que se mezclan físicamente con una solución de nutrición parenteral en cualquier momento antes de la administración. Facture estos productos como parte de la facturación de nutrición parenteral. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.

- Lípidos intravenosos administrados por separado: restringidos para ser dispensados dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia (IV) con el mismo producto se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro de este período de 10 días. Las soluciones o suspensiones de lípidos intravenosos que se administran por separado de las soluciones de nutrición parenteral (es decir, no se mezclan físicamente en el recipiente de la solución de nutrición parenteral) deben facturarse utilizando el número NDC del producto.
- Soluciones intravenosas de antibióticos no incluidos en la lista: restringidas para ser dispensadas dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia IV con el mismo antibiótico se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro del período de 10 días. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.
- Soluciones intravenosas de otros medicamentos no indicados en la lista: restringidas para ser dispensadas dentro de los 10 días posteriores al alta hospitalaria de un hospital de cuidados agudos, cuando la terapia IV con el mismo medicamento se haya iniciado antes del alta. Hay un suministro máximo para 10 días por dispensación dentro del período de 10 días. **Nota:** Los productos no compuestos deben facturarse utilizando el número NDC del producto. Las soluciones compuestas deben facturarse como un reclamo compuesto.

¿Cuánto pagaré por mis medicamentos?

Los miembros de Medi-Cal del CCHP no tienen que pagar los servicios cubiertos; los medicamentos están disponibles sin copago.

Los miembros comerciales del CCHP (con planes como el plan comercial A, el plan B, IHSS, etc.) pueden tener que pagar pequeños copagos por sus medicamentos. Consulte los materiales de su plan para determinar si tiene un copago.

¿Los proveedores pueden hacer sugerencias al CCHP para mejorar el formulario?

Por supuesto que sí. El formulario es una herramienta para promover el uso rentable de medicamentos recetados. El CCHP ha hecho todo lo posible para crear un documento que satisfaga todas las necesidades terapéuticas; sin embargo, el arte de la medicina hace que esta sea una tarea formidable. El CCHP agradece la participación de médicos, farmacéuticos y proveedores de servicios médicos auxiliares en este proceso dinámico. Se alienta a los médicos y farmacéuticos a dirigir cualquier sugerencia o comentario al CCHP por correo electrónico a: cchp_pharmacy_director@hsd.cccounty.us.

¿Qué puedo hacer si necesito más información?

Para obtener más información sobre sus beneficios de farmacia, revise los documentos de su Evidencia de cobertura o llame al CCHP directamente para hablar sobre ellos. El departamento de servicios para miembros del CCHP y el personal del departamento de farmacia están disponibles para responder preguntas de lunes a viernes de 8 a.m. a 5 p.m., hora del Pacífico, en los números de teléfono que se detallan a continuación:

Departamento de Servicios a Miembros del CCHP: **(877) 661-6230 x2**

Departamento de Farmacia del CCHP: **(877) 661-6230 x3**

Definiciones y abreviaturas

Definiciones

En este documento, se usan varios términos que el Plan de Salud Contra Costa quiere asegurarse de que usted entienda. A continuación se presentan algunas definiciones y abreviaturas:

“**Medicamento de marca”** es un medicamento que se comercializa bajo un nombre patentado y protegido por marca registrada. El medicamento de marca aparece en todas las letras en MAYÚSCULAS.

“Coseguro” es un porcentaje del costo de un beneficio de atención médica cubierto que un afiliado paga después de que haya pagado el deducible, si se aplica un deducible al beneficio de atención médica, como el beneficio de medicamentos recetados.

“Copago” es un monto fijo en dólares que un afiliado paga por un beneficio de atención médica cubierto después de que haya pagado el deducible, si se aplica un deducible al beneficio de atención médica, como el beneficio de medicamentos recetados.

“Deducible” es el monto que un afiliado paga por los beneficios de atención médica cubiertos antes de que el plan de salud del afiliado comience a pagar la totalidad o parte del costo del beneficio de atención médica según los términos de la póliza.

“Nivel de medicamento” es un grupo de medicamentos recetados que corresponde a un nivel de costo compartido especificado en la cobertura de medicamentos recetados del plan de salud. El nivel en el que se coloca un medicamento recetado determina la parte del costo del medicamento para el afiliado.

“Afiliado” es una persona inscrita en un plan de salud que tiene derecho a recibir servicios del plan. Todas las referencias a los afiliados en esta plantilla del formulario también incluirán suscriptores como se define en esta sección a continuación.

“Solicitud de excepción” es una solicitud de cobertura de un medicamento recetado. Si un afiliado, su persona designada o el proveedor de atención médica que emite la receta presenta una solicitud de excepción para la cobertura de un medicamento recetado, el plan de salud debe cubrir el medicamento recetado cuando se determina que el medicamento es médicamente necesario para tratar la afección del afiliado.

“Circunstancias exigentes” se producen cuando un afiliado sufre una afección de salud que puede poner en grave peligro la vida, la salud o la capacidad del afiliado de recuperar su función

máxima, o cuando un afiliado se somete a un tratamiento actual con un medicamento que no figura en el formulario.

“Formulario” es la lista completa de medicamentos preferidos para su uso y elegibles para la cobertura de un producto del plan de salud, e incluye todos los medicamentos cubiertos bajo el beneficio de medicamentos recetados para pacientes ambulatorios del producto del plan de salud. El formulario también se conoce como una lista de medicamentos recetados.

“Medicamento genérico” es el mismo medicamento que su equivalente de marca en dosis, seguridad, concentración, cómo se toma, calidad, rendimiento y uso previsto. Un medicamento genérico aparece en ***letra minúscula negrita y*** cursiva.

“Medicamento que no figura en el formulario” es un medicamento recetado que no figura en el formulario del plan de salud.

“Costo de bolsillo” son copagos, coseguros y el deducible aplicable, más todos los costos por servicios de atención médica que no están cubiertos por el plan de salud.

“Proveedor que emite la receta” es un proveedor de atención médica autorizado para emitir una receta médica para tratar una afección médica de un afiliado al plan de salud.

“Receta” es una orden oral, escrita o electrónica de un proveedor que emite recetas para un afiliado específico que contiene el nombre del medicamento recetado, la cantidad del medicamento recetado, la fecha de emisión, el nombre y la información de contacto del proveedor que receta, la firma del proveedor que emite recetas si la receta es por escrito, y si la persona inscrita lo solicita, la afección médica o el propósito para el cual se receta el medicamento.

“Medicamento recetado” es un medicamento recetado por el proveedor del afiliado que emite recetas y requiere una receta en virtud de la ley aplicable.

“Autorización previa” es un requisito del plan de salud de que el afiliado o el proveedor del afiliado que emite recetas obtenga la autorización del plan de salud para un medicamento recetado antes de que el plan de salud cubra el medicamento. El plan de salud otorgará una autorización previa cuando sea médicamente necesario que el afiliado obtenga el medicamento.

“Tratamiento escalonado” es un proceso que especifica la secuencia en la que se recetan diferentes medicamentos recetados para una afección médica determinada y médicamente apropiados para un paciente en particular. El plan de salud puede requerir que el afiliado pruebe uno o más medicamentos para tratar la afección médica del afiliado antes de que el plan de salud cubra un medicamento en particular para la afección de conformidad con una solicitud de tratamiento escalonado. Si el proveedor que emite recetas al afiliado presenta una solicitud

de excepción de tratamiento escalonado, los planes de salud harán excepciones al tratamiento escalonado cuando se cumplan los criterios.

“Suscriptor” es la persona responsable del pago de un plan o cuyo empleo u otra circunstancia, excepto la dependencia familiar, es la base para la elegibilidad para la membresía en el plan.

Abreviaturas

A continuación se explican abreviaturas y términos adicionales utilizados en el documento del formulario del CCHP:

Abreviatura	Término	Qué significa
AL	Límite de edad	Algunos medicamentos solo están cubiertospara ciertas edades.
NF	No figura en elformulario	Estos medicamentos no están cubiertos en laLista de medicamentos. Si su médicoconsidera que necesita un medicamento queno está cubierto, puede solicitarnos quehagamos una excepción.
PA	Autorización previa	Su médico debe solicitar la aprobación delCCHP antes de que se cubran algunosmedicamentos.
QL	Límite de cantidad	Algunos medicamentos solo están cubiertospara ciertas cantidades.
SCO	Exclusión estatal	Estos medicamentos están excluidos por elDepartamento de Servicios de AtenciónMédica. Esto significa que estos medicamentosestán cubiertos por el programa de tarifa porservicio de Medi-Cal y deben ser facturados alestado por la farmacia.
ST	Tratamientoescalonado	En algunos casos, primero debe probar ciertos medicamentos antes de que CalViva Health cubra otro medicamento para su afección médica.Por ejemplo, si el Medicamento A y el Medicamento B tratan su afección de salud, es posible que el CCHP no cubra el Medicamento B a menos que pruebe el Medicamento A primero.

El formulario del CCHP utiliza una estructura de 3 niveles; los niveles se explican a continuación:

Abreviatura	Término	Qué significa
T1	Tier 1	Los medicamentos de nivel 1 se prefieren en el formulario del CCHP y están disponibles sin restricción o autorización previa.
T2	Tier 2	Los medicamentos de nivel 2 se prefieren enel formulario del CCHP y están disponibles sinautorización previa, PERO pueden tenerciertas restricciones, como límites de cantidad,tratamiento escalonado, etc. (las restriccionesespecíficas se enumeran en el formulario delCCHP).
T3	Tier 3	Los medicamentos de nivel 3 no sonpreferidos. Estos medicamentos requierenautorización previa.

Contra Costa Health Plan Formulary

Antidote Therapeutics 1
Antihistamine Drugs 3
Anti-Infective Agents 7
Antineoplastic Agents 19
Antitoxins,Immune Glob,Toxoids,Vaccines 22
Autonomic Drugs 26
Blood Formation, Coagulation, Thrombosis 36
Cardiovascular Drugs 44
Central Nervous System Agents 67
Dental Agents 96
Devices 97
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Electrolytic, Caloric, And Water Balance 103
Enzymes 110
Eye, Ear, Nose And Throat (Eent) Preps. 111
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	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidote Therapeutics		
Acetaminophen Antidote		
Acetylcysteine Inhalation	T1	
Alcohol Deterrents (91:02)		
Acamprosate Calcium	T1	
Disulfiram Oral	T1	
Naltrexone HCl Oral	T1	
VIVITROL (***Naltrexone***)	T1	
Antidote Therapeutics		
Atropine Sulfate Ophthalmic Solution 1 %	T1	
BAQSIMI ONE PACK (***Glucagon***)	T1	
BAQSIMI TWO PACK (***Glucagon***)	T1	
CHEMET (***Succimer***)	T1	
Deferoxamine Mesylate	T1	PA
Glucagon Emergency Injection Solution Reconstituted	T1	
GNP Naloxone HCl	T1	
Hyoscyamine Sulfate ER Oral Tablet Extended Release 12 Hour	T1	
Hyoscyamine Sulfate Oral	T1	
Hyoscyamine Sulfate Sublingual	T1	
Hyosyne	T1	
Iodine Strong Oral	T1	
KLOXXADO (***Naloxone HCl***)	T1	QL (4 EA per 180 days)
Magnesium Sulfate Injection Solution 50 %	T1	
Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML	T1	
Naloxone HCl Injection Solution Cartridge	T1	

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bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**Coverage Requirements and Limits** **AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML	T1	
Naloxone HCl Nasal	T1	
NULEV (***Hyoscyamine Sulfate***)	T1	
Oscimin Oral Tablet	T1	
Oscimin Sublingual	T1	
penicillAMINE Oral	T1	PA
Phytonadione Injection Solution 1 MG/0.5ML, 10 MG/ML	T1	
Phytonadione Oral	T1	
REXTOVY (***Naloxone HCl***)	T1	QL (4 EA per 180 days)
RIVIVE (***Naloxone HCl***)	T1	QL (4 EA per 180 days)
Vitamin K1 Injection Solution 1 MG/0.5ML, 10 MG/ML	T1	
Antidotes (91:04)		
Atropine Sulfate Injection Solution 8 MG/20ML	T1	
Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML	T1	
Magnesium Sulfate Injection Solution 50 %	T1	
Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML	T1	
Naloxone HCl Injection Solution Cartridge	T1	
Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML	T1	
Naltrexone HCl Oral	T1	
Sevelamer Carbonate Oral Tablet	T1	
Sevelamer HCl	T1	PA
VIVITROL (***Naltrexone***)	T1	
Chemotherapy Antidotes/Protectants		
LEDERLE LEUCOVORIN (***Leucovorin Calcium***)	T1	
Leucovorin Calcium Oral Tablet 5 MG	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cyanide Antidotes		
EXODERM EXTERNAL LOTION (***Sod Thiosulfate-Salicylic Acd***)	T1	
Antihistamine Drugs		
Antihistamine Drugs		
Promethazine HCl Oral Tablet 25 MG	T1	
Ethanolamine Derivatives		
Carbinoxamine Maleate Oral Solution	T1	
Carbinoxamine Maleate Oral Tablet 4 MG	T1	
Clemastine Fumarate Oral Syrup	T1	
Clemastine Fumarate Oral Tablet 2.68 MG	T1	
CVS Itch Relief External Gel	T1	
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
First Gen. Antihist. Derivatives, Misc.		
Cyproheptadine HCl Oral	T1	
First Generation Antihistamines		
Carbinoxamine Maleate Oral Solution	T1	
Carbinoxamine Maleate Oral Tablet 4 MG	T1	
Clemastine Fumarate Oral Syrup	T1	
Clemastine Fumarate Oral Tablet 2.68 MG	T1	
CVS Itch Relief External Gel	T1	
Cyproheptadine HCl Oral	T1	
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
Hydrocod Poli-Chlorphe Poli ER	T1	QL (240 ML per 30 days); AL (Min 18 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrOXYzine HCl Oral Syrup 10 MG/5ML	T1	
hydrOXYzine HCl Oral Tablet	T1	
hydrOXYzine Pamoate Oral	T1	
Meclizine HCl Oral Tablet 12.5 MG, 25 MG	T1	
Meclizine HCl Oral Tablet Chewable	T1	
Promethazine HCl Oral Solution 6.25 MG/5ML	T1	
Promethazine HCl Oral Tablet	T1	
Promethazine HCl Rectal Suppository 12.5 MG, 25 MG	T1	
Promethazine-Codeine	T1	QL (240 ML per 30 days); AL (Min 18 Years)
Promethazine-DM Oral Syrup 6.25-15 MG/5ML	T1	
Promethazine HCl (Promethegan)	T1	
Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML	T1	PA
Other Antihistamines		
Cimetidine Oral	T1	
Famotidine Oral Suspension Reconstituted	T1	
Famotidine Oral Tablet 20 MG, 40 MG	T1	
hydrOXYzine HCl Oral Syrup 10 MG/5ML	T1	
hydrOXYzine HCl Oral Tablet	T1	
hydrOXYzine Pamoate Oral	T1	
Olopatadine HCl Ophthalmic	T1	
Phenothiazine Derivatives		
Promethazine HCl Oral Solution 6.25 MG/5ML	T1	
Promethazine HCl Oral Tablet	T1	
Promethazine HCl Rectal Suppository 12.5 MG, 25 MG	T1	
Promethazine-Codeine	T1	QL (240 ML per 30 days); AL (Min 18 Years)
Promethazine-DM Oral Syrup 6.25-15 MG/5ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Promethazine HCl (Promethegan)	T1	
Piperazine Derivatives		
hydrOXYzine HCl Oral Syrup 10 MG/5ML	T1	
hydrOXYzine HCl Oral Tablet	T1	
hydrOXYzine Pamoate Oral	T1	
Meclizine HCl Oral Tablet 12.5 MG, 25 MG	T1	
Meclizine HCl Oral Tablet Chewable	T1	
Propylamine Derivatives		
Hydrocod Poli-Chlorphe Poli ER	T1	QL (240 ML per 30 days); AL (Min 18 Years)
Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML	T1	PA
Second Generation Antihistamines		
All Day Allergy Childrens Oral Solution 5 MG/5ML	T1	
All-Day Allergy Childrens	T1	
Allergy Childrens Oral Solution	T1	
Allergy Childrens Oral Suspension	T1	ST
Allergy Rel Child (Loratadine)	T1	
Allergy Relief Childrens Oral Solution 1 MG/ML	T1	
Allergy Relief Oral Tablet 5 MG	T1	
Cetirizine HCl Allergy Child	T1	
Cetirizine HCl Childrens Alrgy Oral Solution	T1	
Cetirizine HCl Oral Solution 1 MG/ML	T1	
Cetirizine HCl Oral Tablet Chewable	T1	
Childrens 24 Hour Allergy	T1	
Childrens Loratadine Oral Solution	T1	
CVS Allergy Childrens Oral Solution	T1	
CVS Allergy Relief Childrens Oral Solution	T1	
CVS Allergy Relief Childrens Oral Suspension	T1	ST

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CVS Allergy Relief Oral Tablet 5 MG	T1	
CVS Allergy Relief Oral Tablet Dispersible 5 MG	T1	
CVS Allergy Relief(Cetirizine)	T1	
Desloratadine Oral Tablet	T1	PA
Desloratadine Oral Tablet Dispersible 5 MG	T1	PA
Epinastine HCl	T1	PA
EQ Allerg Relief Child (Cetir)	T1	
EQ Allerg Relief Child (Lorat)	T1	
EQ Allergy Childrens Oral Solution	T1	
EQ Allergy Relief (Cetirizine) Oral Solution	T1	
EQ Cetirizine HCl Oral Solution	T1	
EQL All Day Allergy Childrens	T1	
GNP All Day Allergy Childrens Oral Solution	T1	
GNP Allergy Relief 24 HR	T1	
GNP Loratadine Childrens Oral Solution	T1	
GNP Loratadine Oral Solution	T1	
GoodSense All Day Allergy Oral Solution	T1	
KLS ALLER-TEC CHILDRENS ORAL SOLUTION 5 MG/5ML (***Cetirizine HCl***)	T1	
Levocetirizine Dihydrochloride Oral Tablet	T1	
Loratadine Childrens Oral Solution	T1	
Loratadine Oral Solution	T1	
QC All Day Allergy	T1	
WAL-ITIN CHILDRENS (***Loratadine***)	T1	
WAL-ITIN ORAL SOLUTION (***Loratadine***)	T1	
WAL-ZYR ALL DAY ALLERGY CHILD (***Cetirizine HCl***)	T1	
WAL-ZYR ALLERGY CHILDRENS (***Cetirizine HCl***)	T1	
WAL-ZYR CHILDRENS ORAL SOLUTION (***Cetirizine HCl***)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAL-ZYR CHILDRENS ORAL TABLET CHEWABLE 10 MG (***Cetirizine HCl***)	T1	
Anti-Infective Agents		
1St Generation Cephalosporin Antibiotics		
Cefadroxil	T1	
Cephalexin Oral Capsule 250 MG, 500 MG	T1	
Cephalexin Oral Suspension Reconstituted	T1	
Cephalexin Oral Tablet	T1	PA
2Nd Generation Cephalosporin Antibiotics		
Cefaclor ER	T1	PA
Cefaclor Oral Capsule	T1	
Cefaclor Oral Suspension Reconstituted 250 MG/5ML	T1	
Cefprozil	T1	
Cefuroxime Axetil Oral Tablet	T1	
3Rd Generation Cephalosporin Antibiotics		
Cefdinir Oral Capsule	T1	QL (60 EA per 30 days)
Cefdinir Oral Suspension Reconstituted 125 MG/5ML	T1	QL (9000 ML per 30 days)
Cefdinir Oral Suspension Reconstituted 250 MG/5ML	T1	QL (6000 ML per 30 days)
Cefixime Oral Capsule	T1	QL (2 EA per 30 days)
Cefpodoxime Proxetil Oral Suspension Reconstituted	T1	
Cefpodoxime Proxetil Oral Tablet	T1	QL (112 EA per 180 days)
CefTAZidime (Tazicef Intravenous Solution Reconstituted 2 Gm)	T1	
Adamantane Antivirals		
Amantadine HCl Oral Capsule	T1	
Amantadine HCl Oral Solution 50 MG/5ML	T1	
Amantadine HCl Oral Tablet	T1	
riMANTAdine HCl	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Allylamine Antifungals		
Athletes Foot (Terbinafine)	T1	
CVS Athletes Foot External Cream	T1	
CVS Jock Itch	T1	
EQ Athletes Foot (Terbinafine)	T1	
GNP Terbinafine Hydrochloride	T1	
LAMISIL AT ATHLETES FOOT (***Terbinafine HCl***)	T1	
Terbinafine HCl External	T1	
Terbinafine HCl Oral	T1	
Amebicides		
Chlorhexidine Gluconate Mouth/Throat	T1	
Hydrocortisone-Iodoquinol External Cream 1-1 %	T1	
metroNIDAZOLE External Cream	T1	QL (45 GM per 30 days)
metroNIDAZOLE External Gel 0.75 %	T1	QL (45 GM per 30 days)
metroNIDAZOLE External Gel 1 %	T1	QL (60 GM per 30 days)
metroNIDAZOLE Oral Capsule	T1	
metroNIDAZOLE Oral Tablet 250 MG, 500 MG	T1	
metroNIDAZOLE Vaginal	T1	
NORITATE (***MetroNIDAZOLE***)	T1	PA
Chlorhexidine Gluconate (Periogard)	T1	
Aminoglycoside Antibiotics		
Gentamicin Sulfate External	T1	
Gentamicin Sulfate Ophthalmic Solution	T1	
Neomycin Sulfate Oral	T1	
Streptomycin Sulfate Intramuscular	T1	QL (1 EA per 30 days)
TOBRADEX OPHTHALMIC OINTMENT (***Tobramycin-Dexamethasone***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tobramycin Inhalation Nebulization Solution 300 MG/5ML	T1	PA
Tobramycin Ophthalmic	T1	
Tobramycin-Dexamethasone	T1	
TOBREX OPHTHALMIC OINTMENT (***Tobramycin***)	T1	
Aminopenicillin Antibiotics		
Amoxicill-Clarithro-Lansopraz Oral Therapy Pack	T1	PA
Amoxicillin Oral Capsule	T1	
Amoxicillin Oral Suspension Reconstituted	T1	
Amoxicillin Oral Tablet	T1	
Amoxicillin Oral Tablet Chewable 125 MG, 250 MG	T1	
Amoxicillin-Pot Clavulanate ER	T1	
Amoxicillin-Pot Clavulanate Oral Suspension Reconstituted	T1	
Amoxicillin-Pot Clavulanate Oral Tablet	T1	
Ampicillin Oral Capsule 500 MG	T1	
Ampicillin Sodium Injection Solution Reconstituted 1 GM, 2 GM, 500 MG	T1	
Ampicillin-Sulbactam Sodium Injection Solution Reconstituted 1.5 (1-0.5) GM, 3 (2-1) GM	T1	
Anthelmintics		
Albendazole Oral	T1	PA
EMVERM (***Mebendazole***)	T1	QL (60 EA per 30 days)
Ivermectin Oral Tablet 3 MG	T1	QL (30 EA per 365 days)
Praziquantel Oral	T1	PA
Antifungals, Miscellaneous		
Griseofulvin Microsize Oral	T1	
Griseofulvin Ultramicrosize Oral Tablet 125 MG, 250 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Iodine Strong Oral	T1	
Antileprosy Agents		
Dapsone Oral	T1	
Antimalarials		
Atovaquone-Proguanil HCl Oral Tablet 250-100 MG	T1	QL (180 EA per 365 days)
Atovaquone-Proguanil HCl Oral Tablet 62.5-25 MG	T1	QL (540 EA per 365 days)
Avidoxy	T1	
Chloroquine Phosphate Oral	T1	
Doxycycline Hyclate (Doxy 100)	T1	
Doxycycline Hyclate Oral Capsule	T1	
Doxycycline Hyclate Oral Tablet 100 MG	T1	
Doxycycline Hyclate Oral Tablet 20 MG	T1	PA
Doxycycline Monohydrate Oral Capsule 100 MG, 50 MG	T1	
Doxycycline Monohydrate Oral Suspension Reconstituted	T1	
Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG	T1	
Hydroxychloroquine Sulfate Oral Tablet 200 MG	T1	
Mefloquine HCl	T1	
Minocycline HCl Oral Capsule 100 MG	T1	QL (60 EA per 30 days)
Minocycline HCl Oral Capsule 50 MG	T1	
Doxycycline Monohydrate (Mondoxyne Nl Oral Capsule 100 Mg)	T1	
Primaquine Phosphate Oral Tablet 26.3 (15 Base) MG	T1	
Pyrimethamine Oral	T1	
quiNIDine Gluconate ER	T1	
quiNIDine Sulfate Oral	T1	
QuiNINE Sulfate Oral	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tetracycline HCl Oral Capsule	T1	
Antimycobacterials, Miscellaneous		
Dapsone Oral	T1	
Antiprotozoals, Cryptosporidiosis		
Nitazoxanide Oral	T1	
Antiprotozoals, Miscellaneous		
Atovaquone Oral	T1	PA
Dapsone Oral	T1	
metroNIDAZOLE Oral Capsule	T1	
metroNIDAZOLE Oral Tablet 250 MG, 500 MG	T1	
Nitazoxanide Oral	T1	
Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML	T1	
Sulfamethoxazole-Trimethoprim Oral Tablet	T1	
Tinidazole Oral	T1	
Antiprotozoals,Nitroimidazole-Derivative		
Tinidazole Oral	T1	
Antituberculosis Agents		
Ciprofloxacin HCl Oral Tablet 250 MG, 500 MG, 750 MG	T1	
Clarithromycin ER	T1	PA
Clarithromycin Oral Suspension Reconstituted	T1	PA
Clarithromycin Oral Tablet	T1	
cycloSERINE Oral	T1	
Ethambutol HCl Oral	T1	
Isoniazid Oral	T1	
levoFLOXacin Oral Solution	T1	
levoFLOXacin Oral Tablet	T1	QL (30 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Moxifloxacin HCl Oral	T1	QL (21 EA per 21 days)
PRIFTIN (***Rifapentine***)	T1	
Pyrazinamide Oral	T1	
Rifabutin	T1	
rifAMPin Oral	T1	
Streptomycin Sulfate Intramuscular	T1	QL (1 EA per 30 days)
Antivirals, Miscellaneous		
PAXLOVID (150/100) (***Nirmatrelvir-Ritonavir***)	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100 & 150/100) (***Nirmatrelvir-Ritonavir***)	T1	QL (11 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) (***Nirmatrelvir-Ritonavir***)	T1	QL (30 EA per 180 days); AL (Min 12 Years)
Azole Antifungals		
Fluconazole Oral	T1	
Itraconazole Oral	T1	PA
Ketoconazole External Cream	T1	
Ketoconazole External Shampoo 2 %	T1	
Posaconazole Oral Tablet Delayed Release	T1	PA
Voriconazole Intravenous	T1	PA
Voriconazole Oral	T1	PA
Bacitracin Antibiotics		
Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM	T1	
Bacitra-Neomycin-Polymyxin-HC	T1	
EQL Bacitracin Zinc	T1	
Coronavirus (Covid-19)		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAXLOVID (150/100) (***Nirmatrelvir-Ritonavir***)	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100 & 150/100) (***Nirmatrelvir-Ritonavir***)	T1	QL (11 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) (***Nirmatrelvir-Ritonavir***)	T1	QL (30 EA per 180 days); AL (Min 12 Years)
Erythromycin Antibiotics		
Ery	T1	
Erythromycin Base Oral	T1	
Erythromycin Ethylsuccinate Oral	T1	
Erythromycin External Gel	T1	
Erythromycin External Solution	T1	
Erythromycin Oral	T1	
Glycopeptide Antibiotics		
Vancomycin HCl Oral	T1	
Hcv Polymerase Inhibitor Antivirals		
Sofosbuvir-Velpatasvir	T1	PA
Hcv Protease Inhibitor Antivirals		
MAVYRET (***Glecaprevir-Pibrentasvir***)	T1	PA
ZEPATIER (***Elbasvir-Grazoprevir***)	T1	PA
Hcv Replication Complex Inhibitors		
MAVYRET (***Glecaprevir-Pibrentasvir***)	T1	PA
Sofosbuvir-Velpatasvir	T1	PA
ZEPATIER (***Elbasvir-Grazoprevir***)	T1	PA
Hiv Nonnucleoside Rev.Transcrip. Inhib.		
Methocarbamol Oral Tablet 500 MG	T1	
Hiv Nucleoside, Nucleotide Rt Inhibitors		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lamiVUDine Oral Tablet 100 MG	T1	PA
Tenofovir Disoproxil Fumarate	T1	
VIREAD ORAL POWDER (***Tenofovir Disoproxil Fumarate***)	T1	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (***Tenofovir Disoproxil Fumarate***)	T1	
Interferon Antivirals		
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Peginterferon alfa-2a***)	T1	PA
Lincomycin Antibiotics		
CLEOCIN VAGINAL SUPPOSITORY (***Clindamycin Phosphate***)	T1	ST
Clindamycin Phosphate (Clindacin Etz External Swab)	T1	
Clindamycin Phosphate (Clindacin-P)	T1	
Clindamycin HCl Oral	T1	
Clindamycin Phos (Once-Daily)	T1	
Clindamycin Phos (Twice-Daily)	T1	
Clindamycin Phos-Benzoyl Perox External Gel 1-5 %	T1	PA
Clindamycin Phosphate External Lotion	T1	
Clindamycin Phosphate External Solution	T1	
Clindamycin Phosphate External Swab	T1	
Clindamycin Phosphate Vaginal	T1	
Macrolide Antibiotics		
Erythromycin Base Oral	T1	
Erythromycin Ethylsuccinate Oral	T1	
Erythromycin Oral	T1	
Natural Penicillin Antibiotics		
BICILLIN C-R (***Penicillin G Benzathine & Proc***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BICILLIN C-R 900/300 (***Penicillin G Benzathine & Proc***)	T1	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Penicillin G Benzathine***)	T1	
Penicillin G Potassium	T1	
Penicillin G Sodium	T1	
Penicillin V Potassium	T1	
Penicillin G Potassium (Pfizerpen)	T1	
Neuraminidase Inhibitor Antivirals		
Oseltamivir Phosphate Oral Capsule	T1	QL (10 EA per 180 days)
Oseltamivir Phosphate Oral Suspension Reconstituted	T1	QL (120 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (***Zanamivir***)	T1	QL (20 EA per 180 days)
Nitroimidazole Derivatives, Misc		
metroNIDAZOLE External Cream	T1	QL (45 GM per 30 days)
metroNIDAZOLE External Gel 0.75 %	T1	QL (45 GM per 30 days)
metroNIDAZOLE External Gel 1 %	T1	QL (60 GM per 30 days)
metroNIDAZOLE Oral Capsule	T1	
metroNIDAZOLE Oral Tablet 250 MG, 500 MG	T1	
metroNIDAZOLE Vaginal	T1	
NORITATE (***MetroNIDAZOLE***)	T1	PA
Nucleoside And Nucleotide Antivirals		
Acyclovir External	T1	PA
Acyclovir Oral Capsule	T1	
Acyclovir Oral Suspension 200 MG/5ML	T1	
Acyclovir Oral Tablet	T1	
Adefovir Dipivoxil	T1	PA
Entecavir	T1	
Famciclovir Oral	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAGEVRIO (***Molnupiravir***)	T1	QL (40 EA per 180 days); AL (Min 18 Years)
Ribavirin Inhalation	T1	PA
valACYclovir HCl Oral	T1	
valGANciclovir HCl Oral Tablet	T1	PA
VEMLIDY (***Tenofovir Alafenamide Fumarate***)	T1	PA
Other Macrolide Antibiotics		
Amoxicill-Clarithro-Lansopraz Oral Therapy Pack	T1	PA
Azithromycin Oral Suspension Reconstituted	T1	
Azithromycin Oral Tablet 250 MG, 500 MG, 600 MG	T1	
Clarithromycin ER	T1	PA
Clarithromycin Oral Suspension Reconstituted	T1	PA
Clarithromycin Oral Tablet	T1	
Other Macrolides (8:12.12.92)		
Amoxicill-Clarithro-Lansopraz Oral Therapy Pack	T1	PA
Azithromycin Oral Suspension Reconstituted	T1	
Azithromycin Oral Tablet 250 MG, 500 MG, 600 MG	T1	
Clarithromycin ER	T1	PA
Clarithromycin Oral Suspension Reconstituted	T1	PA
Clarithromycin Oral Tablet	T1	
Oxazolidinone Antibiotics		
Linezolid Oral	T1	PA
Penicillinase-Resistant Penicillins		
Dicloxacillin Sodium	T1	
Nafcillin Sodium Injection Solution Reconstituted 1 GM	T1	
Oxacillin Sodium Injection Solution Reconstituted 2 GM	T1	
Polyene Antifungals		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nystatin External	T1	
Nystatin Mouth/Throat	T1	
Nystatin Oral Tablet	T1	
Nystatin-Triamcinolone	T1	
Nystatin (Nystop)	T1	
Polymyxin Antibiotics		
Polymyxin B-Trimethoprim	T1	
Quinolone Antibiotics		
Ciprofloxacin HCl Oral Tablet 250 MG, 500 MG, 750 MG	T1	
levoFLOXacin Oral Solution	T1	
levoFLOXacin Oral Tablet	T1	QL (30 EA per 30 days)
Moxifloxacin HCl (2X Day)	T1	PA
Moxifloxacin HCl Ophthalmic Solution	T1	
Moxifloxacin HCl Oral	T1	QL (21 EA per 21 days)
Ofloxacin Ophthalmic	T1	
Ofloxacin Oral Tablet 300 MG, 400 MG	T1	PA
Ofloxacin Otic	T1	
Rifamycin Antibiotics		
PRIFTIN (***Rifapentine***)	T1	
Rifabutin	T1	
rifAMPin Oral	T1	
XIFAXAN ORAL TABLET 200 MG (***Rifaximin***)	T1	PA
Sulfonamide Antibiotics (Systemic)		
sulfADIAZINE Oral	T1	
Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML	T1	
Sulfamethoxazole-Trimethoprim Oral Tablet	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sulfaSALAzine Oral	T1	
Tetracycline Antibiotics		
Avidoxy	T1	
Demeclocycline HCl Oral	T1	PA
Doxycycline Hyclate (Doxy 100)	T1	
Doxycycline Hyclate Oral Capsule	T1	
Doxycycline Hyclate Oral Tablet 100 MG	T1	
Doxycycline Hyclate Oral Tablet 20 MG	T1	PA
Doxycycline Monohydrate Oral Capsule 100 MG, 50 MG	T1	
Doxycycline Monohydrate Oral Suspension Reconstituted	T1	
Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG	T1	
Minocycline HCl Oral Capsule 100 MG	T1	QL (60 EA per 30 days)
Minocycline HCl Oral Capsule 50 MG	T1	
Doxycycline Monohydrate (Mondoxyne Nl Oral Capsule 100 Mg)	T1	
Tetracycline HCl Oral Capsule	T1	
Urinary Anti-Infectives		
Fosfomycin Tromethamine	T1	
Methenamine Hippurate	T1	
Methenamine Mandelate Oral Tablet	T1	
Nitrofurantoin Macrocrystal Oral	T1	
Nitrofurantoin Monohyd Macro	T1	
Nitrofurantoin Oral Suspension 25 MG/5ML	T1	
Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML	T1	
Sulfamethoxazole-Trimethoprim Oral Tablet	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Trimethoprim Oral	T1	
Antineoplastic Agents		
Antineoplastic Agents		
ALECENSA (***Alectinib HCl***)	T1	PA
Anastrozole Oral	T1	QL (30 EA per 30 days)
Bexarotene Oral	T1	PA
Bicalutamide	T1	
CABOMETYX (***Cabozantinib S-Malate***)	T1	PA
Capecitabine	T1	PA
COTELLIC (***Cobimetinib Fumarate***)	T1	PA
Cyclophosphamide Oral Tablet 50 MG	T1	
Dasatinib Oral Tablet 100 MG, 20 MG, 50 MG, 70 MG	T1	PA
DROXIA (***Hydroxyurea***)	T1	
ELIGARD (***Leuprolide Acetate (3 Month)***)	T1	
Erlotinib HCl	T1	PA
Etoposide Oral	T1	
Exemestane	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***Degarelix Acetate***)	T1	QL (1 EA per 30 days)
Fluorouracil External Cream 5 %	T1	
Fluorouracil External Solution	T1	
Gefitinib	T1	PA
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (***Lomustine***)	T1	
Hydroxyurea Oral	T1	
IBRANCE (***Palbociclib***)	T1	PA
ICLUSIG (***PONATinib HCl***)	T1	PA
Imatinib Mesylate Oral	T1	PA

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JAKAFI (***Ruxolitinib Phosphate***)	T1	PA
Lapatinib Ditosylate	T1	PA
Lenalidomide	T1	PA
Letrozole Oral	T1	QL (30 EA per 30 days)
LEUKERAN (***Chlorambucil***)	T1	
LUPRON DEPOT (1-MONTH) (***Leuprolide Acetate***)	T1	PA
LUPRON DEPOT (3-MONTH) (***Leuprolide Acetate (3 Month)***)	T1	PA
LUPRON DEPOT (4-MONTH) (***Leuprolide Acetate (4 Month)***)	T1	PA
LUPRON DEPOT-PED (1-MONTH) (***Leuprolide Acetate***)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (***Leuprolide Acetate (3 Month)***)	T1	PA
LYSODREN (***Mitotane***)	T1	
MATULANE (***Procarbazine HCl***)	T1	
Megestrol Acetate Oral Suspension 40 MG/ML	T1	
Megestrol Acetate Oral Tablet	T1	
Mercaptopurine Oral Tablet	T1	
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Oral	T1	
MYLERAN (***Busulfan***)	T1	
Nilutamide	T1	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Peginterferon alfa-2a***)	T1	PA
Pomalidomide	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG (***Lenalidomide***)	T1	PA
SIKLOS (***Hydroxyurea***)	T1	PA
SORAfenib Tosylate	T1	PA
SUNItinib Malate Oral Capsule 12.5 MG, 25 MG, 50 MG	T1	PA
TABLOID (***Thioguanine***)	T1	
TALZENNA (***Talazoparib Tosylate***)	T1	PA
Tamoxifen Citrate Oral	T1	
TASIGNA ORAL CAPSULE 200 MG (***Nilotinib HCl***)	T1	PA
Temozolomide	T1	PA
THALOMID ORAL CAPSULE 100 MG, 50 MG (***Thalidomide***)	T1	PA
TICE BCG (***BCG Live***)	T1	
Toremifene Citrate	T1	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (***Triptorelin Pamoate***)	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (***Triptorelin Pamoate***)	T1	
Tretinoin External Cream	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin External Gel 0.01 %, 0.025 %	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin Microsphere External Gel 0.04 %, 0.1 %	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin Microsphere Pump External Gel 0.04 %, 0.1 %	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin Oral	T1	PA
VERZENIO (***Abemaciclib***)	T1	PA
XALKORI ORAL CAPSULE (***Crizotinib***)	T1	PA
XTANDI (***Enzalutamide***)	T1	PA

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZELBORAF (***Vemurafenib***)	T1	PA
ZOLADEX (***Goserelin Acetate***)	T1	
ZOLINZA (***Vorinostat***)	T1	PA
Antitoxins,Immune Glob,Toxoids,Vaccines		
Antitoxins And Immune Globulins		
HYPERRHO (***Rho D Immune Globulin***)	T1	
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (***Rho D Immune Globulin***)	T1	
Toxoids		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***Tetanus-Diphth-Acell Pertussis***)	T1	QL (0.5 ML per 1 FILL)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Tetanus-Diphth-Acell Pertussis***)	T1	QL (0.5 ML per 1 FILL)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Tetanus-Diphth-Acell Pertussis***)	T1	QL (0.5 ML per 1 FILL)
TENIVAC INTRAMUSCULAR SUSPENSION (***Tetanus-Diphtheria Toxoids Td***)	T1	QL (0.5 ML per 1 FILL)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***DTaP-IPV-Hib-Hepatitis B Recmb***)	T1	QL (0.5 ML per 1 Fill)
Vaccines		
ABRYSVO (***RSV Pre-Fusion F A&B Vac Rcmb***)	T1	QL (1 Vial per 1 Dose)
ACTHIB (***Haemophilus B Polysac Conj Vac***)	T1	QL (1 ML per 1 Fill)
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (***Tetanus-Diphth-Acell Pertussis***)	T1	QL (0.5 ML per 1 FILL)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Tetanus-Diphth-Acell Pertussis***)	T1	QL (0.5 ML per 1 FILL)
AFLURIA (***Influenza Virus Vaccine Split***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Influenza Virus Vacc Split PF***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
AREXVY (***RSVPreF3 Vac Recomb Adjuvanted***)	T1	QL (1 Vial per 1 Dose); AL (Min 18 Years)
BCG Vaccine Injection Solution Reconstituted	T1	PA
BEXSERO (***Meningococcal B Recomb OMV Adj***)	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Tetanus-Diphth-Acell Pertussis***)	T1	QL (0.5 ML per 1 FILL)
CAPVAXIVE (***Pneumococcal 21-Valent Conjuga***)	T1	QL (0.5 lifetime per 1 day); AL (Min 18 Years)
COMIRNATY 5-11 YEARS (***COVID-19 mRNA Virus Vaccine***)	T1	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***COVID-19 mRNA Virus Vaccine***)	T1	
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (***Hepatitis B Vac Recombinant***)	T1	QL (2 ML per 1 Fill)
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE (***Hepatitis B Vac Recombinant***)	T1	QL (2 ML per 1 Fill)
FLUAD (***Influenza Vac A&B Surf Ant Adj***)	T1	QL (1 ML per 270 days); AL (Min 65 Years)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Influenza Virus Vacc Split PF***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (***Influenza Vac Recombinant HA***)	T1	QL (1 ML per 270 days); AL (Min 9 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION (***Influenza Vac Tiss-Cult Subunt***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Influenza Vac Tiss-Cult Subunt***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Influenza Virus Vacc Split PF***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUMIST (***Influenza Virus Vaccine Live***)	T1	QL (1 EA per 270 days); AL (Min 3 Years and Max 49 Years)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Influenza Vac Split High-Dose***)	T1	QL (1 ML per 270 days); AL (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION (***Influenza Virus Vaccine Split***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Influenza Virus Vacc Split PF***)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
GARDASIL 9 (***HPV 9-Valent Recomb Vaccine***)	T1	QL (0.5 ML per 1 Fill); AL (Max 45 Years)
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Hepatitis A Vaccine***)	T1	QL (1 ML per 1 Fill)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (***Hepatitis B Vac Recomb Adj***)	T1	QL (0.5 ML per 1 Fill); AL (Min 18 Years)
HIBERIX INJECTION (***Haemophilus B Polysac Conj Vac***)	T1	QL (1 ML per 1 Fill)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED (***Rabies Virus Vaccine, HDC***)	T1	QL (1 ML per 1 Fill)
IPOL INJECTION SUSPENSION (***Poliovirus Vaccine Inactivated***)	T1	QL (0.5 ML per 1 Fill)
MENQUADFI INTRAMUSCULAR SOLUTION (***Mening ACY&W-135 Tetanus Conj***)	T1	QL (0.5 ML per 1 Fill)
MENVEO INTRAMUSCULAR SOLUTION (***Meningococcal A C Y&W-135 Olig***)	T1	QL (0.5 ML per 1 Fill); AL (Max 55 Years)
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (***Meningococcal A C Y&W-135 Olig***)	T1	QL (1 ml per 1 Fill); AL (Max 55 Years)
M-M-R II INJECTION (***Measles, Mumps & Rubella Vac***)	T1	QL (1 EA per 1 Fill)
MNEXSPIKE (***COVID-19 mRNA Virus Vaccine***)	T1	
MRESVIA (***RSV mRNA Pre-F Virus Vaccine***)	T1	QL (0.5 ML per 1 lifetime); AL (Min 18 Years)
Nuvaxovid COVID-19 Vaccine	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION (***Haemophilus B Polysac Conj Vac***)	T1	QL (0.5 ML per 1 Fill)
PENBRAYA (***Mening ACYW(Tet Conj)-B(Rcmb)***)	T1	QL (1 vial per 1 Fill); AL (Max 25 Years)
Penmenvy	T1	QL (1 vial per 1 Fill); AL (Min 10 Years and Max 25 Years)
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE (***Pneumococcal Vac Polyvalent***)	T1	QL (0.5 ML per 1 Dose)
PREVNAR 20 (***Pneumococcal 20-Val Conj Vacc***)	T1	QL (0.5 ML per 1 Fill)
PRIORIX (***Measles, Mumps & Rubella Vac***)	T1	QL (1 EA per 1 Fill)
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (***Measles-Mumps-Rubella-Varicell***)	T1	QL (1 EA per 1 Fill)
RABAVERT (***Rabies Vaccine, PCEC***)	T1	
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (***Hepatitis B Vac Recombinant***)	T1	QL (1 ML per 1 Fill)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE (***Hepatitis B Vac Recombinant***)	T1	QL (1 ML per 1 Fill)
SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Zoster Vac Recomb Adjuvanted***)	T1	QL (1 syringe per 1 Fill); AL (Min 18 Years)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (***Zoster Vac Recomb Adjuvanted***)	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)
SPIKEVAX 6M-11Y (***COVID-19 mRNA Virus Vaccine***)	T1	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***COVID-19 mRNA Virus Vaccine***)	T1	
TICE BCG (***BCG Live***)	T1	
TRUMENBA (***Meningococcal B Vac (Recomb)***)	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***Hepatitis A-Hep B Recomb Vac***)	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE (***Typhoid Vl Polysaccharide Vacc***)	T1	QL (0.5 ML per 270 days)
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML (***Hepatitis A Vaccine***)	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION 50 UNIT/ML (***Hepatitis A Vaccine***)	T1	QL (1 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML (***Hepatitis A Vaccine***)	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 UNIT/ML (***Hepatitis A Vaccine***)	T1	QL (1 ML per 1 Fill)
VARIVAX INJECTION (***Varicella Virus Vaccine Live***)	T1	QL (1 EA per 1 Dose)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (***DTaP-IPV-Hib-Hepatitis B Recmb***)	T1	QL (0.5 ML per 1 Fill)
VAXNEUVANCE (***Pneumococcal 15-Val Conj Vacc***)	T1	QL (0.5 ML per 1 Fill)
VIVOTIF (***Typhoid Vaccine***)	T1	QL (4 EA per 5 yearss)
Autonomic Drugs		
Alpha- And Beta-Adrenergic Agonists		
Bupivacaine-Epinephrine (PF) Injection Solution 0.25% -1:200000, 0.5% -1:200000	T1	
BUPivacaine-EPINEPHrine Injection Solution 0.25% -1:200000, 0.5% -1:200000	T1	
EPINEPHrine Injection Solution 1 MG/ML	T1	
EPINEPHrine Injection Solution Auto-Injector 0.15 MG/0.3ML, 0.3 MG/0.3ML	T1	QL (4 EA per 180 days)
EPINEPHrine PF Injection Solution	T1	
Lidocaine-EPINEPHrine Injection Solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000	T1	
Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML	T1	PA
Bupivacaine-Epinephrine (Sensorcaine/Epinephrine)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bupivacaine-Epinephrine (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (***Bupivacaine-Epinephrine***)	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 (***Lidocaine-Epinephrine***)	T1	
Alpha-Adrenergic Agonists (12:12)		
cloNIDine	T1	
cloNIDine HCl Oral Tablet 0.1 MG, 0.2 MG, 0.3 MG	T1	
Methyldopa Oral	T1	
Midodrine HCl	T1	
Antimuscarinics/Antispasmodics		
Atropine Sulfate Injection Solution 8 MG/20ML	T1	
Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML	T1	
Atropine Sulfate Ophthalmic Solution 1 %	T1	
ATROVENT HFA (***Ipratropium Bromide HFA***)	T1	
BREZTRI AEROSPHERE (***Budeson-Glycopyrrol-Formoterol***)	T1	PA
chlordiazePOXIDE-Clidinium	T1	
COMBIVENT RESPIMAT (***Ipratropium-Albuterol***)	T1	
Dicyclomine HCl Intramuscular	T1	PA
Dicyclomine HCl Oral Capsule	T1	
Dicyclomine HCl Oral Tablet 20 MG	T1	
Diphenoxylate-Atropine Oral Liquid	T1	
Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG	T1	
Glycopyrrolate Oral Tablet 1 MG, 2 MG	T1	
HYDROcodone Bit-Homatrop MBr	T1	QL (45 ML per 30 days); AL (Min 18 Years)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hyoscyamine Sulfate ER Oral Tablet Extended Release 12 Hour	T1	
Hyoscyamine Sulfate Oral	T1	
Hyoscyamine Sulfate Sublingual	T1	
Hyosyne	T1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (***Umeclidinium Bromide***)	T1	QL (30 EA per 30 days)
Ipratropium Bromide Inhalation	T1	
Ipratropium Bromide Nasal	T1	
Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML	T1	
Methscopolamine Bromide Oral Tablet 2.5 MG	T1	PA
MOTOFEN (***Difenoxin-Atropine***)	T1	
NULEV (***Hyoscyamine Sulfate***)	T1	
Oscimin Oral Tablet	T1	
Oscimin Sublingual	T1	
PB-Hyoscy-Atropine-Scopolamine	T1	
PHENobarbital-Belladonna Alk Oral Elixir	T1	
PHENOHYTRO ORAL TABLET (***PB-Hyoscy-Atropine-Scopolamine***)	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (***Tiotropium Bromide***)	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***Tiotropium Bromide-Olodaterol***)	T1	
Tiotropium Bromide	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***Fluticasone-Umeclidin-Vilant***)	T1	PA
Umeclidinium-Vilanterol	T1	

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	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiparkinsonian Agents		
Benztropine Mesylate Oral	T1	QL (120 EA per 30 days)
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
Trihexyphenidyl HCl	T1	
Autonomic Drugs, Miscellaneous		
CVS Nicotine Mouth/Throat Gum	T1	QL (340 EA per 30 days)
CVS Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
CVS Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
CVS Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
CVS Nicotine Transdermal	T1	QL (30 EA per 30 days)
EQ Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
EQ Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
EQ Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
EQ Nicotine Step 3	T1	QL (30 EA per 30 days)
EQ Nicotine Transdermal Patch 24 Hour 14 MG/24HR, 21 MG/24HR	T1	QL (30 EA per 30 days)
GNP Nicotine Mini	T1	QL (324 EA per 30 days)
GNP Nicotine Mouth/Throat Gum 4 MG	T1	QL (340 EA per 30 days)
GNP Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
GNP Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
GNP Nicotine Transdermal	T1	QL (30 EA per 30 days)
GoodSense Nicotine Mouth/Throat Gum	T1	QL (340 EA per 30 days)
GoodSense Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
KLS QUIT2 MOUTH/THROAT LOZENGE (***Nicotine Polacrilex***)	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE (***Nicotine Polacrilex***)	T1	QL (324 EA per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nicotine Mini	T1	QL (324 EA per 30 days)
Nicotine Polacrilex Mini	T1	QL (324 EA per 30 days)
Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
Nicotine Step 1	T1	QL (30 EA per 30 days)
Nicotine Step 2	T1	QL (30 EA per 30 days)
Nicotine Step 3	T1	QL (30 EA per 30 days)
Nicotine Transdermal Patch 24 Hour	T1	QL (30 EA per 30 days)
NICOTROL NS (***Nicotine***)	T1	PA
QC Nicotine Transdermal System	T1	QL (30 EA per 30 days)
SM Nicotine Mouth/Throat Gum	T1	QL (340 EA per 30 days)
SM Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
SM Nicotine Polacrilex Mouth/Throat Lozenge 4 MG	T1	QL (324 EA per 30 days)
Varenicline Tartrate (Starter)	T1	QL (180 EA per 365 days)
Varenicline Tartrate Oral Tablet 0.5 MG, 1 MG	T1	QL (180 EA per 365 days)
Botulinum Toxins		
DYSPORT (***AbobotulinumtoxinA***)	T1	PA
XEOMIN (***IncobotulinumtoxinA***)	T1	PA
Centrally Acting Skeletal Muscle Relaxnt		
Chlorzoxazone Oral Tablet 250 MG, 500 MG	T1	
Cyclobenzaprine HCl Oral Tablet 10 MG, 5 MG	T1	
Metaxalone Oral Tablet 800 MG	T1	PA
Methocarbamol Oral Tablet 500 MG, 750 MG	T1	
tiZANidine HCl Oral Capsule 2 MG, 4 MG, 6 MG	T1	PA
tiZANidine HCl Oral Tablet 2 MG	T1	QL (540 EA per 30 days)
tiZANidine HCl Oral Tablet 4 MG	T1	QL (270 EA per 30 days)
Direct-Acting Skeletal Muscle Relaxants		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dantrolene Sodium Oral	T1	
Gaba-Derivative Skeletal Muscle Relaxant		
Baclofen Oral Tablet 10 MG, 20 MG	T1	
Baclofen Oral Tablet 5 MG	T1	QL (90 EA per 30 days)
Indirect-Acting Skeletal Muscle Relaxant		
Norgesic Forte	T1	
Orphenadrine Citrate Injection	T1	
Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (***Orphenadrine-Aspirin-Caffeine***)	T1	
Non-Sel. Beta-Adrenergic Blocking Agents		
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***Timolol Hemihydrate***)	T1	
Carvedilol	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	
Labetalol HCl Oral	T1	
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Pindolol	T1	PA
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Timolol Maleate (Once-Daily)	T1	
Timolol Maleate (Timolol Maleate Ocudose)	T1	
Timolol Maleate Ophthalmic	T1	
Timolol Maleate Oral	T1	PA
Timolol Maleate PF	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Non-Sel.Alpha-1-Adrenergic Blocking Agts		
Doxazosin Mesylate Oral	T1	
Prazosin HCl Oral	T1	
Terazosin HCl Oral	T1	
Non-Sel.Alpha-Adrenergic Blocking Agents		
Dihydroergotamine Mesylate Injection	T1	PA
Ergotamine-Caffeine	T1	
MIGERGOT (***Ergotamine-Caffeine***)	T1	
Phenoxybenzamine HCl Oral	T1	
Parasympathomimetic (Cholinergic Agents)		
Bethanechol Chloride Oral Tablet 10 MG, 25 MG, 5 MG	T1	
Bethanechol Chloride Oral Tablet 50 MG	T1	PA
Cevimeline HCl	T1	
Donepezil HCl Oral Tablet 10 MG, 5 MG	T1	
Donepezil HCl Oral Tablet 23 MG	T1	PA
Donepezil HCl Oral Tablet Dispersible	T1	
Neostigmine Methylsulfate Intravenous Solution Prefilled Syringe 3 MG/3ML	T1	PA
Pilocarpine HCl Ophthalmic Solution 1 %, 2 %, 4 %	T1	
Pilocarpine HCl Oral Tablet 5 MG	T1	
Pilocarpine HCl Oral Tablet 7.5 MG	T1	PA
Pyridostigmine Bromide ER Oral Tablet Extended Release	T1	
pyRIDostigmine Bromide Oral Tablet 60 MG	T1	
Rivastigmine Tartrate	T1	
Selective Alpha-1-Adrenergic Block.Agent		
Alfuzosin HCl ER	T1	
Carvedilol	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Labetalol HCl Oral	T1	
Tamsulosin HCl	T1	
Selective Beta-2-Adrenergic Agonists		
Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT	T1	QL (36 GM per 30 days)
Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, (5 MG/ML) 0.5%, 2.5 MG/0.5ML	T1	
Albuterol Sulfate Inhalation Nebulization Solution 0.63 MG/3ML, 1.25 MG/3ML	T1	PA
Albuterol Sulfate Oral Syrup 2 MG/5ML	T1	
Albuterol Sulfate Oral Tablet	T1	
BREZTRI AEROSPHERE (***Budeson-Glycopyrrol-Formoterol***)	T1	PA
Budesonide-Formoterol Fumarate	T1	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT (***Ipratropium-Albuterol***)	T1	
DULERA (***Mometasone Furo-Formoterol Fum***)	T1	
Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT	T1	
Fluticasone-Salmeterol Inhalation Aerosol	T1	PA
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT	T1	
Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML	T1	
Levalbuterol HCl Inhalation Nebulization Solution 0.31 MG/3ML, 0.63 MG/3ML, 1.25 MG/0.5ML, 1.25 MG/3ML	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***Salmeterol Xinafoate***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***Tiotropium Bromide-Olodaterol***)	T1	
Terbutaline Sulfate Oral	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***Fluticasone-Umeclidin-Vilant***)	T1	PA
Umeclidinium-Vilanterol	T1	
Fluticasone-Salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Selective Beta-Adrenergic Blocking Agent		
Acebutolol HCl Oral	T1	
Atenolol Oral	T1	
Atenolol-Chlorthalidone	T1	
Betaxolol HCl	T1	PA
BETOPTIC-S (***Betaxolol HCl***)	T1	PA
Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Metoprolol Succinate ER	T1	
Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Skeletal Muscle Relaxants, Miscellaneous		
DYSPORT (***AbobotulinumtoxinA***)	T1	PA
Norgesic Forte	T1	
Orphenadrine Citrate Injection	T1	
Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (***Orphenadrine-Aspirin-Caffeine***)	T1	
XEOMIN (***IncobotulinumtoxinA***)	T1	PA
Smoking Cessation Agents		
buPROPion HCl ER (Smoking Det)	T1	QL (60 EA per 30 days)
CVS Nicotine Mouth/Throat Gum	T1	QL (340 EA per 30 days)
CVS Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
CVS Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
CVS Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
CVS Nicotine Transdermal	T1	QL (30 EA per 30 days)
EQ Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
EQ Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
EQ Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
EQ Nicotine Step 3	T1	QL (30 EA per 30 days)
EQ Nicotine Transdermal Patch 24 Hour 14 MG/24HR, 21 MG/24HR	T1	QL (30 EA per 30 days)
GNP Nicotine Mini	T1	QL (324 EA per 30 days)
GNP Nicotine Mouth/Throat Gum 4 MG	T1	QL (340 EA per 30 days)
GNP Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
GNP Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
GNP Nicotine Transdermal	T1	QL (30 EA per 30 days)
GoodSense Nicotine Mouth/Throat Gum	T1	QL (340 EA per 30 days)
GoodSense Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
KLS QUIT2 MOUTH/THROAT LOZENGE (***Nicotine Polacrilex***)	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE (***Nicotine Polacrilex***)	T1	QL (324 EA per 30 days)
Naltrexone HCl Oral	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nicotine Mini	T1	QL (324 EA per 30 days)
Nicotine Polacrilex Mini	T1	QL (324 EA per 30 days)
Nicotine Polacrilex Mouth/Throat Gum	T1	QL (340 EA per 30 days)
Nicotine Polacrilex Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
Nicotine Step 1	T1	QL (30 EA per 30 days)
Nicotine Step 2	T1	QL (30 EA per 30 days)
Nicotine Step 3	T1	QL (30 EA per 30 days)
Nicotine Transdermal Patch 24 Hour	T1	QL (30 EA per 30 days)
NICOTROL NS (***Nicotine***)	T1	PA
QC Nicotine Transdermal System	T1	QL (30 EA per 30 days)
SM Nicotine Mouth/Throat Gum	T1	QL (340 EA per 30 days)
SM Nicotine Mouth/Throat Lozenge	T1	QL (324 EA per 30 days)
SM Nicotine Polacrilex Mouth/Throat Lozenge 4 MG	T1	QL (324 EA per 30 days)
TYRVAYA (***Varenicline Tartrate***)	T1	PA
Varenicline Tartrate (Starter)	T1	QL (180 EA per 365 days)
Varenicline Tartrate Oral Tablet 0.5 MG, 1 MG	T1	QL (180 EA per 365 days)
VIVITROL (***Naltrexone***)	T1	
Blood Formation, Coagulation, Thrombosis		
Antianemia Drugs		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***Epoetin Alfa***)	T1	PA
PROCRIT (***Epoetin Alfa***)	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (***Epoetin Alfa-epbx***)	T1	PA
Anticoagulants, Miscellaneous		
ACD-A NOCLOT-50 (***Anticoagulant Cit Dext Soln A***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fondaparinux Sodium	T1	
Antithrombotic Agents, Miscellaneous		
LODOCO (***Colchicine***)	T1	PA
Coumarin Derivatives		
Warfarin Sodium Oral	T1	
Direct Factor Xa Inhibitors		
ELIQUIS (1.5 MG PACK) (***Apixaban***)	T1	
ELIQUIS (2 MG PACK) (***Apixaban***)	T1	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK (***Apixaban***)	T1	QL (74 EA per 30 days)
ELIQUIS ORAL CAPSULE SPRINKLE (***Apixaban***)	T1	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET (***Apixaban***)	T1	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET SOLUBLE (***Apixaban***)	T1	
Fondaparinux Sodium	T1	
XARELTO ORAL SUSPENSION RECONSTITUTED (***Rivaroxaban***)	T1	QL (600 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG (***Rivaroxaban***)	T1	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG (***Rivaroxaban***)	T1	QL (42 EA per 21 days)
XARELTO ORAL TABLET 2.5 MG (***Rivaroxaban***)	T1	QL (60 EA per 30 days)
XARELTO STARTER PACK (***Rivaroxaban***)	T1	QL (51 EA per 30 days)
Direct Thrombin Inhibitors		
Dabigatran Etexilate Mesylate	T1	QL (60 EA per 30 days)
Hematopoietic Agents		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (***Epoetin Alfa***)	T1	PA
FULPHILA (***Pegfilgrastim-jmdb***)	T1	PA
FYLNETRA (***Pegfilgrastim-pbbk***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Tbo-Filgrastim***)	T1	PA
NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML (***Pegfilgrastim***)	T1	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Pegfilgrastim***)	T1	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (***Filgrastim***)	T1	PA
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE (***Filgrastim***)	T1	PA
NIVESTYM (***Filgrastim-aafi***)	T1	PA
NYPOZI (***Filgrastim-txid***)	T1	PA
NYVEPRIA (***Pegfilgrastim-apgf***)	T1	PA
PROCRIT (***Epoetin Alfa***)	T1	PA
Releuko Subcutaneous	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (***Epoetin Alfa-epbx***)	T1	PA
STIMUFEND (***Pegfilgrastim-fpgk***)	T1	PA
UDENYCA (***Pegfilgrastim-cbqv***)	T1	PA
UDENYCA ONBODY (***Pegfilgrastim-cbqv***)	T1	PA
ZARXIO (***Filgrastim-sndz***)	T1	PA
ZIEXTENZO (***Pegfilgrastim-bmez***)	T1	PA
Hemorrheologic Agents		
Pentoxifylline ER	T1	
Hemostatics		
Aminocaproic Acid Oral Solution	T1	PA
Aminocaproic Acid Oral Tablet 1000 MG	T1	
Aminocaproic Acid Oral Tablet 500 MG	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Desmopressin Ace Spray Refrig	T1	PA
Desmopressin Acetate Injection	T1	PA
Desmopressin Acetate Nasal	T1	PA
Desmopressin Acetate Oral	T1	
Desmopressin Acetate PF	T1	PA
Desmopressin Acetate Spray	T1	PA
GELFILM OPHTHALMIC (***Gelatin Adsorbable***)	T1	PA
Heparins		
Enoxaparin Sodium Injection Solution 300 MG/3ML	T1	
Enoxaparin Sodium Injection Solution Prefilled Syringe 100 MG/ML, 150 MG/ML	T1	QL (40 ML per 180 days)
Enoxaparin Sodium Injection Solution Prefilled Syringe 120 MG/0.8ML, 80 MG/0.8ML	T1	QL (32 ML per 180 days)
Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3ML	T1	QL (12 ML per 180 days)
Enoxaparin Sodium Injection Solution Prefilled Syringe 40 MG/0.4ML	T1	QL (16 ML per 180 days)
Enoxaparin Sodium Injection Solution Prefilled Syringe 60 MG/0.6ML	T1	QL (24 ML per 180 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (***Dalteparin Sodium***)	T1	
Heparin Na (Pork) Lock Flsh PF Intravenous Solution 10 UNIT/ML	T1	
Heparin Sod (Pork) Lock Flush Intravenous Solution 10 UNIT/ML, 100 UNIT/ML	T1	
Heparin Sodium (Porcine) Injection Solution 1000 UNIT/ML, 10000 UNIT/ML, 20000 UNIT/ML, 5000 UNIT/ML	T1	
Heparin Sodium (Porcine) PF Injection Solution 1000 UNIT/ML	T1	
Indirect Factor Xa Inhibitors		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fondaparinux Sodium	T1	
Iron Preparations		
Classic Prenatal	T1	
Complete Natal DHA Oral 29-1-200 & 200 MG	T1	
ELITE-OB (***Prenatal Vit-Iron Carbonyl-FA***)	T1	
EQL Prenatal Formula	T1	
GERITOL ENERGY SUPPORT (***Iron-Vitamins***)	T1	
GERITOL TONIC (***Iron-Vitamins***)	T1	
GNP PreNatal	T1	
Hematinic Plus Vit/Minerals	T1	
Hematinic/Folic Acid	T1	
HEMATOGEN FA (***Fe Fum-Vit C-Vit B12-FA***)	T1	
INFED (***Iron Dextran***)	T1	
M-Natal Plus	T1	
Multiple Vitamins-Iron Oral Tablet Chewable	T1	
Multivitamin Adult Oral Tablet	T1	
Multivitamin Oral Tablet	T1	
NUTRIVIT (***B Complex-Lysine-Min-Fe-FA***)	T1	
Poly-Iron 150 Forte	T1	
PRENATAL MULTIVITAMIN + DHA (***Prenatal MV-Min-Fe Fum-FA-DHA***)	T1	
Prenatal One Daily	T1	
Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG	T1	
Prenatal Plus	T1	
Prenatal Vitamin and Mineral	T1	
Prenatal Vitamins Oral Tablet 28-0.8 MG	T1	
Prenatal/Iron	T1	
QC Prenatal	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Thrivite Rx	T1	
Trigels-F Forte	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (***Pediatric Multivit-Minerals***)	T1	
WesTab Plus	T1	
Liver And Stomach Preparations		
B-12 DOTS (***Cyanocobalamin***)	T1	
B-12 Oral Tablet 100 MCG, 50 MCG, 500 MCG	T1	
B-12 TR Oral Tablet Extended Release 2000 MCG	T1	
CVS B-12 Oral Tablet	T1	
CVS Vitamin B-12 Oral Tablet Extended Release	T1	
Cyanocobalamin Injection Solution 1000 MCG/ML	T1	
EQL Vitamin B-12	T1	
GNP Vitamin B-12 Oral Tablet	T1	
Hydroxocobalamin Acetate	T1	
Neurin-SL	T1	
Vitamin B 12 Oral Tablet	T1	
Vitamin B-12 ER Oral Tablet Extended Release 2000 MCG	T1	
Vitamin B12 TR Oral Tablet Extended Release 2000 MCG	T1	
Platelet-Aggregation Inhibitors		
Aspirin 81	T1	
Aspirin Adult Low Dose	T1	
Aspirin Adult Low Strength Oral Tablet Delayed Release	T1	
Aspirin Childrens	T1	
Aspirin EC Adult Low Dose	T1	
Aspirin EC Low Dose	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Aspirin EC Low Strength	T1	
Aspirin Low Dose Oral Tablet Chewable	T1	
Aspirin Low Dose Oral Tablet Delayed Release	T1	
Aspirin Low Strength	T1	
Aspirin Oral Tablet Chewable	T1	
Aspirin Oral Tablet Delayed Release 81 MG	T1	
Aspirin Regimen	T1	
Aspirin-Dipyridamole ER	T1	
BAYER ASPIRIN EC LOW DOSE (***Aspirin***)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (***Aspirin***)	T1	
Butalbital-Aspirin-Caffeine Oral Capsule	T1	
Childrens Aspirin	T1	
Cilostazol	T1	
Clopidogrel Bisulfate Oral Tablet 300 MG	T1	QL (2 EA per 30 days)
Clopidogrel Bisulfate Oral Tablet 75 MG	T1	
CVS Aspirin Adult Low Dose	T1	
CVS Aspirin EC Oral Tablet Delayed Release 81 MG	T1	
CVS Aspirin Low Dose	T1	
CVS Aspirin Low Strength Oral Tablet Delayed Release	T1	
Dipyridamole Oral	T1	
ECOTRIN LOW STRENGTH (***Aspirin***)	T1	
EQ Aspirin Adult Low Dose	T1	
EQ Aspirin Low Dose Oral Tablet Chewable	T1	
EQL Aspirin Low Dose	T1	
GNP Adult Aspirin Low Strength Oral Tablet Chewable	T1	
GNP Aspirin Low Dose	T1	
GNP Aspirin Oral Tablet Delayed Release 81 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GoodSense Aspirin Low Dose	T1	
GoodSense Aspirin Oral Tablet Chewable	T1	
MEDIQUE ASPIRIN (***Aspirin***)	T1	
MM Aspirin Oral Tablet Delayed Release	T1	
Prasugrel HCl	T1	QL (30 EA per 30 days)
QC Aspirin Low Dose	T1	
Ticagrelor	T1	QL (60 EA per 30 days)
Platelet-Reducing Agents		
Anagrelide HCl Oral Capsule 0.5 MG	T1	
Thrombolytic Agents		
Aspirin 81	T1	
Aspirin Adult Low Dose	T1	
Aspirin Adult Low Strength Oral Tablet Delayed Release	T1	
Aspirin Childrens	T1	
Aspirin EC Adult Low Dose	T1	
Aspirin EC Low Dose	T1	
Aspirin EC Low Strength	T1	
Aspirin Low Dose Oral Tablet Chewable	T1	
Aspirin Low Dose Oral Tablet Delayed Release	T1	
Aspirin Low Strength	T1	
Aspirin Oral Tablet Chewable	T1	
Aspirin Oral Tablet Delayed Release 81 MG	T1	
Aspirin Regimen	T1	
BAYER ASPIRIN EC LOW DOSE (***Aspirin***)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (***Aspirin***)	T1	
Butalbital-Aspirin-Caffeine Oral Capsule	T1	
Childrens Aspirin	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CVS Aspirin Adult Low Dose	T1	
CVS Aspirin EC Oral Tablet Delayed Release 81 MG	T1	
CVS Aspirin Low Dose	T1	
CVS Aspirin Low Strength Oral Tablet Delayed Release	T1	
ECOTRIN LOW STRENGTH (***Aspirin***)	T1	
EQ Aspirin Adult Low Dose	T1	
EQ Aspirin Low Dose Oral Tablet Chewable	T1	
EQL Aspirin Low Dose	T1	
GNP Adult Aspirin Low Strength Oral Tablet Chewable	T1	
GNP Aspirin Low Dose	T1	
GNP Aspirin Oral Tablet Delayed Release 81 MG	T1	
GoodSense Aspirin Low Dose	T1	
GoodSense Aspirin Oral Tablet Chewable	T1	
MEDIQUE ASPIRIN (***Aspirin***)	T1	
MM Aspirin Oral Tablet Delayed Release	T1	
QC Aspirin Low Dose	T1	
Cardiovascular Drugs		
Acl Inhibitors		
NEXLETOL (***Bempedoic Acid***)	T1	PA
NEXLIZET (***Bempedoic Acid-Ezetimibe***)	T1	PA
Alpha-Adrenergic Blocking Agents (24:16)		
Doxazosin Mesylate Oral	T1	
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Prazosin HCl Oral	T1	
Terazosin HCl Oral	T1	
Alpha-Adrenergic Blocking Agt.(Hypoten)		
Carvedilol	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Doxazosin Mesylate Oral	T1	
Labetalol HCl Oral Tablet 100 MG, 200 MG, 300 MG	T1	
Prazosin HCl Oral	T1	
Terazosin HCl Oral	T1	
Angiotensin Ii Recep Antagonist/Neprolys		
ENTRESTO ORAL CAPSULE SPRINKLE (***Sacubitril-Valsartan***)	T1	QL (240 EA per 30 days)
Sacubitril-Valsartan	T1	QL (60 EA per 30 days)
Angiotensin Ii Receptor Antagon.(Hypotn)		
Candesartan Cilexetil	T1	PA
Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG	T1	PA
Irbesartan	T1	
Irbesartan-hydroCHLOROthiazide	T1	
Losartan Potassium Oral	T1	
Losartan Potassium-HCTZ	T1	
Olmesartan Medoxomil Oral	T1	
Olmesartan Medoxomil-HCTZ	T1	
Telmisartan	T1	
Telmisartan-HCTZ	T1	PA
Valsartan Oral Tablet	T1	
Valsartan-hydroCHLOROthiazide	T1	
Angiotensin Ii Receptor Antagonists		
Candesartan Cilexetil	T1	PA
Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG	T1	PA
ENTRESTO ORAL CAPSULE SPRINKLE (***Sacubitril-Valsartan***)	T1	QL (240 EA per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Irbesartan	T1	
Irbesartan-hydroCHLOROthiazide	T1	
Losartan Potassium Oral	T1	
Losartan Potassium-HCTZ	T1	
Olmesartan Medoxomil Oral	T1	
Olmesartan Medoxomil-HCTZ	T1	
Sacubitril-Valsartan	T1	QL (60 EA per 30 days)
Telmisartan	T1	
Telmisartan-HCTZ	T1	PA
Valsartan Oral Tablet	T1	
Valsartan-hydroCHLOROthiazide	T1	
Angiotensin-Convert.Enzyme Inhib(Hypotn)		
amLODIPine Besy-Benazepril HCl	T1	
Benazepril HCl Oral	T1	
Benazepril-hydroCHLOROthiazide	T1	
Captopril Oral	T1	
Captopril-hydroCHLOROthiazide	T1	PA
Enalapril Maleate Oral Tablet	T1	
Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG	T1	
Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG	T1	PA
Fosinopril Sodium	T1	
Fosinopril Sodium-HCTZ	T1	PA
Lisinopril Oral	T1	
Lisinopril-hydroCHLOROthiazide	T1	
Perindopril Erbumine	T1	PA
Quinapril HCl	T1	
Quinapril-hydroCHLOROthiazide	T1	
Ramipril	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Trandolapril	T1	
Angiotensin-Converting Enzyme Inhibitors		
amLODIPine Besy-Benazepril HCl	T1	
Benazepril HCl Oral	T1	
Benazepril-hydroCHLOROthiazide	T1	
Captopril Oral	T1	
Captopril-hydroCHLOROthiazide	T1	PA
Enalapril Maleate Oral Tablet	T1	
Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG	T1	
Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG	T1	PA
Fosinopril Sodium	T1	
Fosinopril Sodium-HCTZ	T1	PA
Lisinopril Oral	T1	
Lisinopril-hydroCHLOROthiazide	T1	
Perindopril Erbumine	T1	PA
Quinapril HCl	T1	
Quinapril-hydroCHLOROthiazide	T1	
Ramipril	T1	
Trandolapril	T1	
Antiarrhythmics, Miscellaneous		
Digoxin (Digox)	T1	
Digoxin Oral Solution	T1	
Digoxin Oral Tablet 125 MCG, 250 MCG	T1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***Digoxin***)	T1	
Magnesium Sulfate Injection Solution 50 %	T1	
Antilipemic Agents, Miscellaneous		
BP Vit 3	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 500 MG (***Niacin***)	T1	
NEXLETOL (***Bempedoic Acid***)	T1	PA
NEXLIZET (***Bempedoic Acid-Ezetimibe***)	T1	PA
Niacin (Antihyperlipidemic)	T1	
Niacin ER (Antihyperlipidemic)	T1	PA
NIAVASC (***Niacin***)	T1	
Omega-3-acid Ethyl Esters	T1	ST
REPATHA (***Evolocumab***)	T1	PA
REPATHA SURECLICK (***Evolocumab***)	T1	PA
Beta-Adrenergic Blocking Agents (24:20)		
Acebutolol HCl Oral	T1	
Atenolol Oral	T1	
Atenolol-Chlorthalidone	T1	
Betaxolol HCl Oral	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***Timolol Hemihydrate***)	T1	
Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Carvedilol	T1	
Doxazosin Mesylate Oral	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	
Labetalol HCl Oral	T1	
Metoprolol Succinate ER	T1	
Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Pindolol	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prazosin HCl Oral	T1	
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Terazosin HCl Oral	T1	
Timolol Maleate (Once-Daily)	T1	
Timolol Maleate (Timolol Maleate Ocudose)	T1	
Timolol Maleate Ophthalmic	T1	
Timolol Maleate Oral	T1	PA
Timolol Maleate PF	T1	
Bile Acid Sequestrants		
Cholestyramine Light	T1	
Cholestyramine Oral	T1	
Colestipol HCl	T1	
Cholestyramine Light (Prevalite)	T1	
Calcium-Channel Block.Agt,Misc(Hypoten)		
Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG	T1	PA
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG	T1	
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour	T1	ST
dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour	T1	PA
dilTIAZem HCl Oral	T1	
Dilt-XR	T1	
Diltiazem HCl (Matzim La)	T1	PA
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl Oral	T1	
Calcium-Channel Blocking Agents		
amLODIPine Besy-Benazepril HCl	T1	
amLODIPine Besylate Oral	T1	
Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG	T1	PA

bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**Coverage Requirements and Limits** **AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG	T1	
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG	T1	PA
dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour	T1	ST
dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour	T1	PA
dilTIAZem HCl Oral	T1	
Dilt-XR	T1	
Felodipine ER	T1	
Isradipine	T1	ST
Diltiazem HCl (Matzim La)	T1	PA
niCARdipine HCl Oral	T1	PA
NIFEdipine ER	T1	
NIFEdipine ER Osmotic Release	T1	
NIFEdipine Oral	T1	
niMODipine Oral Capsule	T1	PA
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**Coverage Requirements and Limits** **AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl Oral	T1	
Calcium-Channel Blocking Agents, Misc.		
Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG	T1	PA
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG	T1	
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG	T1	PA
dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour	T1	ST
dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour	T1	PA
dilTIAZem HCl Oral	T1	
Dilt-XR	T1	
Diltiazem HCl (Matzim La)	T1	PA
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG	T1	PA

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl Oral	T1	
Carbonic Anhydrase Inhibitors (24:36)		
acetaZOLAMIDE ER	T1	
acetaZOLAMIDE Oral	T1	
methazolAMIDE Oral	T1	PA
Carbonic Anhydrase Inhibitors(Hypoten)		
acetaZOLAMIDE ER	T1	
acetaZOLAMIDE Oral	T1	
methazolAMIDE Oral	T1	PA
Cardiotonic Agents		
Digoxin (Digox)	T1	
Digoxin Oral Solution	T1	
Digoxin Oral Tablet 125 MCG, 250 MCG	T1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (***Digoxin***)	T1	
Central Alpha-Agonists		
Acebutolol HCl Oral	T1	
Atenolol Oral	T1	
Atenolol-Chlorthalidone	T1	
Betaxolol HCl Oral	T1	PA
Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Carvedilol	T1	
cloNIDine	T1	
cloNIDine HCl Oral Tablet 0.1 MG, 0.2 MG, 0.3 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
guanFACINE HCl Oral	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	
Labetalol HCl Oral Tablet 100 MG, 200 MG, 300 MG	T1	
Methyldopa Oral	T1	
Metoprolol Succinate ER	T1	
Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Pindolol	T1	PA
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Timolol Maleate Oral	T1	PA
Cgmp Synthesis Agent		
VERQUVO (***Vericiguat***)	T1	PA
Cholesterol Absorption Inhibitors		
Ezetimibe	T1	
NEXLIZET (***Bempedoic Acid-Ezetimibe***)	T1	PA
Class Ia Antiarrhythmics		
Disopyramide Phosphate Oral	T1	
NORPACE CR (***Disopyramide Phosphate***)	T1	
quiNIDine Gluconate ER	T1	
quiNIDine Sulfate Oral	T1	
Class Ib Antiarrhythmics		
DILANTIN INFATABS (***Phenytoin***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DILANTIN ORAL CAPSULE (***Phenytoin Sodium Extended***)	T1	
Mexiletine HCl Oral	T1	
Phenytoin (Phenytoin Infatabs)	T1	
Phenytoin Oral	T1	
Phenytoin Sodium Extended	T1	
Class Ic Antiarrhythmics		
Flecainide Acetate	T1	
Propafenone HCl	T1	
Propafenone HCl ER	T1	
Class Ii Antiarrhythmics		
Acebutolol HCl Oral	T1	
Atenolol Oral	T1	
Atenolol-Chlorthalidone	T1	
Betaxolol HCl	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***Timolol Hemihydrate***)	T1	
BETOPTIC-S (***Betaxolol HCl***)	T1	PA
Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Carvedilol	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	
Labetalol HCl Oral	T1	
Metoprolol Succinate ER	T1	
Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Pindolol	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Timolol Maleate (Once-Daily)	T1	
Timolol Maleate (Timolol Maleate Ocudose)	T1	
Timolol Maleate Ophthalmic	T1	
Timolol Maleate Oral	T1	PA
Timolol Maleate PF	T1	
Class Iii Antiarrhythmics		
Amiodarone HCl Oral	T1	
Dofetilide	T1	
MULTAQ (***Dronedarone HCl***)	T1	PA
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Class Iv Antiarrhythmics		
Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG	T1	PA
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG	T1	
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG	T1	PA
dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour	T1	ST

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour	T1	PA
dilTIAZem HCl Oral	T1	
Dilt-XR	T1	
Diltiazem HCl (Matzim La)	T1	PA
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl Oral	T1	
Dihydropyridines		
amLODIPine Besy-Benazepril HCl	T1	
amLODIPine Besylate Oral	T1	
Felodipine ER	T1	
Isradipine	T1	ST
niCARdipine HCl Oral	T1	PA
NIFEdipine ER	T1	
NIFEdipine ER Osmotic Release	T1	
NIFEdipine Oral	T1	
niMODipine Oral Capsule	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dihydropyridines (Antihypertensive)		
amLODIPine Besy-Benazepril HCl	T1	
amLODIPine Besylate Oral	T1	
Felodipine ER	T1	
Isradipine	T1	ST
niCARdipine HCl Oral	T1	PA
NIFEdipine ER	T1	
NIFEdipine ER Osmotic Release	T1	
NIFEdipine Oral	T1	
niMODipine Oral Capsule	T1	PA
Direct Vasodilators		
cloNIDine	T1	
cloNIDine HCl Oral Tablet 0.1 MG, 0.2 MG, 0.3 MG	T1	
guanFACINE HCl ER	T1	
guanFACINE HCl Oral	T1	
hydrALAZINE HCl Oral	T1	
Methyldopa Oral	T1	
Minoxidil Oral	T1	
Diuretics, Miscellaneous (Hypotensive)		
THEO-24 (***Theophylline***)	T1	
Theophylline ER	T1	
Theophylline Oral Elixir	T1	
Fibric Acid Derivatives		
Fenofibrate Micronized Oral Capsule 130 MG, 43 MG	T1	PA
Fenofibrate Micronized Oral Capsule 134 MG	T1	
Fenofibrate Micronized Oral Capsule 200 MG, 67 MG	T1	QL (30 EA per 30 days)
Fenofibrate Oral Capsule 134 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fenofibrate Oral Capsule 200 MG, 67 MG	T1	QL (30 EA per 30 days)
Fenofibrate Oral Tablet 145 MG, 160 MG, 48 MG, 54 MG	T1	
Gemfibrozil Oral	T1	
Hmg-Coa Reductase Inhibitors		
Atorvastatin Calcium Oral	T1	
Fluvastatin Sodium	T1	PA
Fluvastatin Sodium ER	T1	PA
Lovastatin Oral	T1	
Pravastatin Sodium	T1	QL (30 EA per 30 days)
Rosuvastatin Calcium Oral	T1	QL (30 EA per 30 days)
Simvastatin Oral Tablet	T1	
Loop Diuretics (24:36)		
Bumetanide Oral	T1	
Ethacrynic Acid Oral	T1	
Furosemide Oral Solution 10 MG/ML, 8 MG/ML	T1	
Furosemide Oral Tablet	T1	
Torsemide Oral	T1	
Loop Diuretics (Hypotensive Agents)		
Bumetanide Oral	T1	
Ethacrynic Acid Oral	T1	
Furosemide Oral Solution 10 MG/ML, 8 MG/ML	T1	
Furosemide Oral Tablet	T1	
Torsemide Oral	T1	
Mineralocorticoid (Aldosterone) Antagnts		
Eplerenone	T1	PA
KERENDIA (***Finerenone***)	T1	PA
Spironolactone Oral Tablet	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Spironolactone-HCTZ	T1	
Mineralocorticoid(Aldoster.)Antag(Hypot)		
Eplerenone	T1	PA
Spironolactone Oral Tablet	T1	
Spironolactone-HCTZ	T1	
Nitrates And Nitrites		
Acebutolol HCl Oral	T1	
Atenolol Oral	T1	
Atenolol-Chlorthalidone	T1	
Betaxolol HCl Oral	T1	PA
Bisoprolol Fumarate Oral Tablet 10 MG, 5 MG	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Carvedilol	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	
Isosorbide Dinitrate Oral	T1	
Isosorbide Mononitrate	T1	
Isosorbide Mononitrate ER	T1	
Labetalol HCl Oral Tablet 100 MG, 200 MG, 300 MG	T1	
Metoprolol Succinate ER	T1	
Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	T1	
Nitroglycerin (Nitro-Bid)	T1	
Nitroglycerin Sublingual	T1	
Nitroglycerin Transdermal Patch 24 Hour	T1	
Nitroglycerin Translingual Solution	T1	PA
NITRO-TIME (***Nitroglycerin***)	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pindolol	T1	PA
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Timolol Maleate Oral	T1	PA
Omega-3-Mediated Antilipemics		
Omega-3-acid Ethyl Esters	T1	ST
Pcsk9 Inhibitors		
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Alirocumab***)	T1	PA
REPATHA (***Evolocumab***)	T1	PA
REPATHA SURECLICK (***Evolocumab***)	T1	PA
Phosphodiesterase Type 5 Inhibitors		
Aspirin-Dipyridamole ER	T1	
Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	
Cilostazol	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG	T1	PA
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG	T1	
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG	T1	PA
dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour	T1	ST

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
dilTIAZem HCl Oral	T1	
Dilt-XR	T1	
Dipyridamole Oral	T1	
Diltiazem HCl (Matzim La)	T1	PA
Sildenafil Citrate Oral Tablet 20 MG	T1	PA
Tadalafil (PAH)	T1	PA
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl Oral	T1	
Potassium-Sparing Diuretics (24:36)		
aMILoride HCl Oral	T1	
Eplerenone	T1	PA
Spironolactone Oral Tablet	T1	
Spironolactone-HCTZ	T1	
Triamterene Oral	T1	PA
Potassium-Sparing Diuretics (Hypoten)		
aMILoride HCl Oral	T1	
aMILoride-hydroCHLOROthiazide	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Eplerenone	T1	PA
Spironolactone Oral Tablet	T1	
Spironolactone-HCTZ	T1	
Triamterene Oral	T1	PA
Triamterene-HCTZ Oral Capsule 37.5-25 MG	T1	
Triamterene-HCTZ Oral Tablet	T1	
Renin-Angioten.-Aldost. Sys. Inhib, Misc		
ENTRESTO ORAL CAPSULE SPRINKLE (***Sacubitril-Valsartan***)	T1	QL (240 EA per 30 days)
Sacubitril-Valsartan	T1	QL (60 EA per 30 days)
Steroidal Mineralocorticoid Receptor Ant		
Eplerenone	T1	PA
Spironolactone Oral Tablet	T1	
Spironolactone-HCTZ	T1	
Thiazide Diuretics (24:36)		
hydroCHLOROthiazide Oral	T1	
Thiazide Diuretics(Hypotensive Agents)		
aMILoride-hydroCHLOROthiazide	T1	
Benazepril-hydroCHLOROthiazide	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG	T1	PA
Captopril-hydroCHLOROthiazide	T1	PA
Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG	T1	
Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG	T1	PA
Fosinopril Sodium-HCTZ	T1	PA
hydroCHLOROthiazide Oral	T1	
Irbesartan-hydroCHLOROthiazide	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Lisinopril-hydroCHLOROthiazide	T1	
Losartan Potassium-HCTZ	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Olmesartan Medoxomil-HCTZ	T1	
Quinapril-hydroCHLOROthiazide	T1	
Spironolactone-HCTZ	T1	
Telmisartan-HCTZ	T1	PA
Triamterene-HCTZ Oral Capsule 37.5-25 MG	T1	
Triamterene-HCTZ Oral Tablet	T1	
Valsartan-hydroCHLOROthiazide	T1	
Thiazide-Like Diuretics (24:36)		
Chlorthalidone Oral Tablet 25 MG, 50 MG	T1	
Indapamide Oral	T1	
metOLazone	T1	
THALITONE (***Chlorthalidone***)	T1	
Thiazide-Like Diuretics(Hypotensive Agt)		
Atenolol-Chlorthalidone	T1	
Chlorthalidone Oral Tablet 25 MG, 50 MG	T1	
Indapamide Oral	T1	
metOLazone	T1	
THALITONE (***Chlorthalidone***)	T1	
Vasodilating Agents, Misc (24:08)		
Acebutolol HCl Oral	T1	
amLODIPine Besy-Benazepril HCl	T1	
amLODIPine Besylate Oral	T1	
Betaxolol HCl Oral	T1	PA
Carvedilol	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Doxazosin Mesylate Oral	T1	
Felodipine ER	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	
Isradipine	T1	ST
niCARdipine HCl Oral	T1	PA
NIFEdipine ER	T1	
NIFEdipine ER Osmotic Release	T1	
NIFEdipine Oral	T1	
niMODipine Oral Capsule	T1	PA
Phenoxybenzamine HCl Oral	T1	
Pindolol	T1	PA
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
Sotalol HCl (AF)	T1	
Sotalol HCl Oral	T1	
Terazosin HCl Oral	T1	
Timolol Maleate Oral	T1	PA
VECAMYL (***Mecamylamine HCl***)	T1	PA
Vasodilating Agents, Miscellaneous		
ADEMPAS (***Riociguat***)	T1	PA
Ambrisentan	T1	PA
amLODIPine Besy-Benazepril HCl	T1	
amLODIPine Besylate Oral	T1	
Aspirin-Dipyridamole ER	T1	
Bosentan Oral Tablet	T1	PA
Diltiazem HCl Coated Beads (Cartia Xt Oral Capsule Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	T1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 420 MG	T1	PA
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG, 300 MG	T1	
dilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour 360 MG	T1	PA
dilTIAZem HCl ER Oral Capsule Extended Release 12 Hour	T1	ST
dilTIAZem HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
dilTIAZem HCl ER Oral Tablet Extended Release 24 Hour	T1	PA
dilTIAZem HCl Oral	T1	
Dilt-XR	T1	
Dipyridamole Oral	T1	
Felodipine ER	T1	
Isradipine	T1	ST
Diltiazem HCl (Matzim La)	T1	PA
niCARdipine HCl Oral	T1	PA
NIFEdipine ER	T1	
NIFEdipine ER Osmotic Release	T1	
NIFEdipine Oral	T1	
niMODipine Oral Capsule	T1	PA
OPSUMIT (***Macitentan***)	T1	PA
ORENITRAM (***Treprostinil Diolamine***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
Diltiazem HCl ER Beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
TRACLEER ORAL TABLET SOLUBLE (***Bosentan***)	T1	PA
Treprostinil	T1	PA
TYVASO (***Treprostinil***)	T1	PA
TYVASO REFILL KIT (***Treprostinil***)	T1	PA
TYVASO STARTER KIT (***Treprostinil***)	T1	PA
UPTRAVI ORAL (***Selexipag***)	T1	PA
UPTRAVI TITRATION (***Selexipag***)	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 100 MG, 200 MG, 300 MG, 360 MG	T1	PA
Verapamil HCl ER Oral Capsule Extended Release 24 Hour 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	T1	
Verapamil HCl Oral	T1	
VERQUVO (***Vericiguat***)	T1	PA
Central Nervous System Agents		
Adamantanes (Cns)		
Amantadine HCl Oral Capsule	T1	
Amantadine HCl Oral Solution 50 MG/5ML	T1	
Amantadine HCl Oral Tablet	T1	
Amphetamines		
Amphetamine-Dextroamphet ER	T1	QL (30 EA per 30 days); AL (Max 18 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Amphetamine-Dextroamphetamine	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Dextroamphetamine Sulfate ER	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Dextroamphetamine Sulfate Oral Tablet 10 MG, 5 MG	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Lisdexamfetamine Dimesylate	T1	PA
Methamphetamine HCl	T1	PA
Amyotrophic Lateral Sclerosis(Als) Agent		
Riluzole	T1	
Analgesics And Antipyretics, Misc.		
Acetaminophen-Codeine Oral Solution	T1	QL (5000 ML per 30 days)
Acetaminophen-Codeine Oral Tablet	T1	QL (400 EA per 30 days)
Butalbital-APAP-Caffeine (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
Butalbital-Acetaminophen Oral Tablet 50-325 MG	T1	PA
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Oxycodone-Acetaminophen (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
Oxycodone-Acetaminophen (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
Gabapentin Oral Capsule	T1	
Gabapentin Oral Solution 250 MG/5ML	T1	
Gabapentin Oral Tablet 600 MG, 800 MG	T1	
HYDROcodone-Acetaminophen Oral Solution 2.5-108 MG/5ML, 5-217 MG/10ML, 7.5-325 MG/15ML	T1	QL (5400 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG	T1	QL (360 EA per 30 days)
oxyCODONE-Acetaminophen Oral Solution 5-325 MG/5ML	T1	
oxyCODONE-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG	T1	QL (360 EA per 30 days)
oxyCODONE-Acetaminophen Oral Tablet 2.5-325 MG	T1	PA
Pregabalin Oral Capsule	T1	
Pregabalin Oral Solution	T1	ST
PRIALT (***Ziconotide Acetate***)	T1	
traMADol-Acetaminophen	T1	QL (240 EA per 30 days)
Anorexigenic Agents		
CONTRAVE (***Naltrexone-Bupropion HCl***)	T1	PA
Anorexigenic Agents And Stimulants, Misc		
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-ASA-Caff-Codeine	T1	PA
Dexmethylphenidate HCl	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER (LA) Oral Capsule Extended Release 24 Hour 20 MG, 30 MG, 40 MG	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 18 MG, 27 MG, 54 MG	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 36 MG	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER Oral Tablet Extended Release	T1	QL (90 EA per 30 days); AL (Max 18 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Methylphenidate HCl Oral Solution 10 MG/5ML	T1	QL (450 ML per 30 days); AL (Max 18 Years)
Methylphenidate HCl Oral Solution 5 MG/5ML	T1	QL (900 ML per 30 days); AL (Max 18 Years)
Methylphenidate HCl Oral Tablet	T1	QL (90 EA per 30 days); AL (Max 18 Years)
Modafinil Oral	T1	PA
Anorexigenic Agents, Miscellaneous		
CONTRAVE (***Naltrexone-Bupropion HCl***)	T1	PA
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Liraglutide***)	T1	ST; QL (9 ML per 28 days)
Anticholinergic Agents (Cns)		
Benztropine Mesylate Oral	T1	QL (120 EA per 30 days)
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
Orphenadrine Citrate Injection	T1	
Trihexyphenidyl HCl	T1	
Anticonvulsants, Miscellaneous		
acetaZOLAMIDE ER	T1	
acetaZOLAMIDE Oral	T1	
carBAMazepine ER	T1	
carBAMazepine Oral Suspension 100 MG/5ML	T1	
carBAMazepine Oral Tablet	T1	
carBAMazepine Oral Tablet Chewable	T1	
CARBATROL (***CarBAMazepine***)	T1	
DEPAKOTE (***Divalproex Sodium***)	T1	
DEPAKOTE ER (***Divalproex Sodium***)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE (***Divalproex Sodium***)	T1	
Divalproex Sodium ER Oral Tablet Extended Release 24 Hour	T1	
Divalproex Sodium Oral Capsule Delayed Release Sprinkle	T1	
Divalproex Sodium Oral Tablet Delayed Release	T1	
EPIDIOLEX (***Cannabidiol***)	T1	PA
Felbamate	T1	PA
Gabapentin Oral Capsule	T1	
Gabapentin Oral Solution 250 MG/5ML	T1	
Gabapentin Oral Tablet 600 MG, 800 MG	T1	
Lacosamide Oral Tablet	T1	
lamoTRIgine Oral Tablet	T1	
LamoTRIgine Oral Tablet Chewable	T1	
levETIRAcetam Oral Solution	T1	
levETIRAcetam Oral Tablet	T1	
Magnesium Chloride Injection	T1	
Magnesium Sulfate Injection Solution 50 %	T1	
OXcarbazepine	T1	
Pregabalin Oral Capsule	T1	
Pregabalin Oral Solution	T1	ST
Rufinamide Oral Tablet	T1	PA
LamoTRIgine (Subvenite Oral Tablet)	T1	
TEGRETOL ORAL SUSPENSION (***CarBAMazepine***)	T1	
TEGRETOL ORAL TABLET (***CarBAMazepine***)	T1	
TEGRETOL-XR (***CarBAMazepine***)	T1	
tiaGABine HCl	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Topiramate Oral Capsule Sprinkle	T1	
Topiramate Oral Tablet	T1	
Valproic Acid Oral Capsule	T1	
Valproic Acid Oral Solution 250 MG/5ML	T1	
Zonisamide Oral	T1	
Antidepressants, Miscellaneous		
buPROPion HCl ER (Smoking Det)	T1	QL (60 EA per 30 days)
buPROPion HCl ER (SR)	T1	
buPROPion HCl ER (XL) Oral Tablet Extended Release 24 Hour 150 MG, 300 MG	T1	
buPROPion HCl Oral	T1	
Mirtazapine Oral Tablet	T1	
Mirtazapine Oral Tablet Dispersible 15 MG, 30 MG	T1	
Mirtazapine Oral Tablet Dispersible 45 MG	T1	PA
Antimanic Agents		
ARIPiprazole Oral Solution	T1	
ARIPiprazole Oral Tablet	T1	
Asenapine Maleate	T1	PA
carBAMazepine ER	T1	
carBAMazepine Oral Suspension 100 MG/5ML	T1	
carBAMazepine Oral Tablet	T1	
carBAMazepine Oral Tablet Chewable	T1	
CARBATROL (***CarBAMazepine***)	T1	
DEPAKOTE (***Divalproex Sodium***)	T1	
DEPAKOTE ER (***Divalproex Sodium***)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE (***Divalproex Sodium***)	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Divalproex Sodium ER Oral Tablet Extended Release 24 Hour	T1	
Divalproex Sodium Oral Capsule Delayed Release Sprinkle	T1	
Divalproex Sodium Oral Tablet Delayed Release	T1	
lamoTRIgine Oral Tablet	T1	
LamoTRIgine Oral Tablet Chewable	T1	
Lithium Carbonate ER	T1	
Lithium Carbonate Oral	T1	
LITHOBID (***Lithium Carbonate***)	T1	
OLANZapine Oral Tablet	T1	QL (30 EA per 30 days)
QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG, 200 MG	T1	QL (30 EA per 30 days)
QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 300 MG, 400 MG, 50 MG	T1	QL (60 EA per 30 days)
QUEtiapine Fumarate Oral Tablet 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG	T1	
risperiDONE Oral Solution	T1	
risperiDONE Oral Tablet	T1	
risperiDONE Oral Tablet Dispersible 0.25 MG	T1	QL (60 EA per 30 days)
risperiDONE Oral Tablet Dispersible 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	T1	
LamoTRIgine (Subvenite Oral Tablet)	T1	
TEGRETOL ORAL SUSPENSION (***CarBAMazepine***)	T1	
TEGRETOL ORAL TABLET (***CarBAMazepine***)	T1	
TEGRETOL-XR (***CarBAMazepine***)	T1	
Valproic Acid Oral Capsule	T1	
Valproic Acid Oral Solution 250 MG/5ML	T1	
Ziprasidone HCl	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ziprasidone Mesylate	T1	
Antimigraine Agents, Miscellaneous		
AIMOVIG (***Erenumab-aooe***)	T1	PA
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Fremanezumab-vfrm***)	T1	PA
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Aspirin 81	T1	
Aspirin Adult Low Dose	T1	
Aspirin Adult Low Strength Oral Tablet Delayed Release	T1	
Aspirin Childrens	T1	
Aspirin EC Adult Low Dose	T1	
Aspirin EC Low Dose	T1	
Aspirin EC Low Strength	T1	
Aspirin Low Dose Oral Tablet Chewable	T1	
Aspirin Low Dose Oral Tablet Delayed Release	T1	
Aspirin Low Strength	T1	
Aspirin Oral Tablet Chewable	T1	
Aspirin Oral Tablet Delayed Release 81 MG	T1	
Aspirin Regimen	T1	
BAYER ASPIRIN EC LOW DOSE (***Aspirin***)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (***Aspirin***)	T1	
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-ASA-Caff-Codeine	T1	PA
Butalbital-Aspirin-Caffeine Oral Capsule	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Childrens Aspirin	T1	
CVS Aspirin Adult Low Dose	T1	
CVS Aspirin EC Oral Tablet Delayed Release 81 MG	T1	
CVS Aspirin Low Dose	T1	
CVS Aspirin Low Strength Oral Tablet Delayed Release	T1	
DEPAKOTE (***Divalproex Sodium***)	T1	
DEPAKOTE ER (***Divalproex Sodium***)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE (***Divalproex Sodium***)	T1	
Dihydroergotamine Mesylate Injection	T1	PA
Divalproex Sodium ER Oral Tablet Extended Release 24 Hour	T1	
Divalproex Sodium Oral Capsule Delayed Release Sprinkle	T1	
Divalproex Sodium Oral Tablet Delayed Release	T1	
ECOTRIN LOW STRENGTH (***Aspirin***)	T1	
EQ Aspirin Adult Low Dose	T1	
EQ Aspirin Low Dose Oral Tablet Chewable	T1	
EQL Aspirin Low Dose	T1	
Ergotamine-Caffeine	T1	
GNP Adult Aspirin Low Strength Oral Tablet Chewable	T1	
GNP Aspirin Low Dose	T1	
GNP Aspirin Oral Tablet Delayed Release 81 MG	T1	
GoodSense Aspirin Low Dose	T1	
GoodSense Aspirin Oral Tablet Chewable	T1	
Ibuprofen Oral Suspension 100 MG/5ML	T1	
Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG	T1	
INNOPRAN XL (***Propranolol HCl SR Beads***)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ketoprofen ER	T1	
Ketoprofen Oral Capsule 50 MG	T1	PA
MEDIQUE ASPIRIN (***Aspirin***)	T1	
MIGERGOT (***Ergotamine-Caffeine***)	T1	
MM Aspirin Oral Tablet Delayed Release	T1	
Naproxen Oral	T1	
Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG	T1	
Naproxen Sodium Oral Tablet 275 MG, 550 MG	T1	
Propranolol HCl ER	T1	
Propranolol HCl Oral	T1	
QC Aspirin Low Dose	T1	
Timolol Maleate Oral	T1	PA
Topiramate Oral Capsule Sprinkle	T1	
Topiramate Oral Tablet	T1	
traMADol-Acetaminophen	T1	QL (240 EA per 30 days)
Valproic Acid Oral Capsule	T1	
Valproic Acid Oral Solution 250 MG/5ML	T1	
Antipsychotics, Miscellaneous		
Loxapine Succinate Oral	T1	
Pimozide	T1	
Anxiolytics,Sedatives,And Hypnotics,Misc		
BELSOMRA (***Suvorexant***)	T1	PA
busPIRone HCl Oral	T1	
DAYVIGO (***Lemborexant***)	T1	PA
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
Eszopiclone	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrOXYzine HCl Oral Syrup 10 MG/5ML	T1	
hydrOXYzine HCl Oral Tablet	T1	
hydrOXYzine Pamoate Oral	T1	
Meprobamate	T1	PA
Promethazine HCl Oral Solution 6.25 MG/5ML	T1	
Promethazine HCl Oral Tablet	T1	
Promethazine HCl Rectal Suppository 12.5 MG, 25 MG	T1	
Promethazine HCl (Promethegan)	T1	
Zaleplon Oral Capsule 10 MG	T1	QL (60 EA per 30 days)
Zaleplon Oral Capsule 5 MG	T1	QL (30 EA per 30 days)
Zolpidem Tartrate ER	T1	QL (30 EA per 30 days)
Zolpidem Tartrate Oral Tablet	T1	QL (30 EA per 30 days)
Atypical Antipsychotics		
ARIPiprazole Oral Solution	T1	
ARIPiprazole Oral Tablet	T1	
Asenapine Maleate	T1	PA
cloZAPine Oral Tablet	T1	
cloZAPine Oral Tablet Dispersible 100 MG, 25 MG	T1	
Lurasidone HCl	T1	PA
OLANZapine Oral Tablet	T1	QL (30 EA per 30 days)
QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG, 200 MG	T1	QL (30 EA per 30 days)
QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 300 MG, 400 MG, 50 MG	T1	QL (60 EA per 30 days)
QUEtiapine Fumarate Oral Tablet 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG	T1	
risperiDONE Oral Solution	T1	
risperiDONE Oral Tablet	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
risperiDONE Oral Tablet Dispersible 0.25 MG	T1	QL (60 EA per 30 days)
risperiDONE Oral Tablet Dispersible 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	T1	
Ziprasidone HCl	T1	
Ziprasidone Mesylate	T1	
Barbiturates (Anticonvulsants)		
PB-Hyoscy-Atropine-Scopolamine	T1	
PHENobarbital Oral Elixir	T1	
PHENobarbital Oral Tablet	T1	
PHENobarbital-Belladonna Alk Oral Elixir	T1	
PHENOHYTRO ORAL TABLET (***PB-Hyoscy-Atropine-Scopolamine***)	T1	
Primidone Oral Tablet 250 MG, 50 MG	T1	
Barbiturates (Anxiolytic, Sedative/Hyp)		
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Butalbital-APAP-Caffeine (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
Butalbital-Acetaminophen Oral Tablet 50-325 MG	T1	PA
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-ASA-Caff-Codeine	T1	PA
Butalbital-Aspirin-Caffeine Oral Capsule	T1	
PB-Hyoscy-Atropine-Scopolamine	T1	
PHENobarbital Oral Elixir	T1	
PHENobarbital Oral Tablet	T1	
PHENobarbital-Belladonna Alk Oral Elixir	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHENOHYTRO ORAL TABLET (***PB-Hyoscy-Atropine-Scopolamine***)	T1	
Benzodiazepines (Anticonvulsants)		
cloBAZam Oral Tablet	T1	QL (60 EA per 30 days)
clonazePAM Oral	T1	
Clorazepate Dipotassium	T1	
Diazepam (Diazepam Intensol)	T1	
diazePAM Oral Concentrate	T1	
diazePAM Oral Solution 5 MG/5ML	T1	
diazePAM Oral Tablet	T1	
LORazepam (Lorazepam Intensol)	T1	
LORazepam Oral Concentrate 2 MG/ML	T1	
LORazepam Oral Tablet	T1	
Benzodiazepines (Anxiolytic,Sedativ/Hyp)		
ALPRAZolam ER	T1	
ALPRAZOLAM INTENSOL (***ALPRAZolam***)	T1	
ALPRAZolam Oral Tablet	T1	
ALPRAZolam Oral Tablet Dispersible	T1	PA
ALPRAZolam XR	T1	
chlordiazePOXIDE HCl	T1	
Chlordiazepoxide-Amitriptyline	T1	
chlordiazePOXIDE-Clidinium	T1	
cloBAZam Oral Tablet	T1	QL (60 EA per 30 days)
clonazePAM Oral	T1	
Clorazepate Dipotassium	T1	
Diazepam (Diazepam Intensol)	T1	
diazePAM Oral Concentrate	T1	
diazePAM Oral Solution 5 MG/5ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diazePAM Oral Tablet	T1	
Estazolam	T1	
LORazepam (Lorazepam Intensol)	T1	
LORazepam Oral Concentrate 2 MG/ML	T1	
LORazepam Oral Tablet	T1	
Oxazepam	T1	PA
Temazepam Oral Capsule 15 MG, 30 MG	T1	
Temazepam Oral Capsule 22.5 MG, 7.5 MG	T1	PA
Triazolam	T1	
Butyrophenones		
Haloperidol Decanoate Intramuscular Solution 100 MG/ML, 50 MG/ML	T1	
Haloperidol Lactate Oral Concentrate 2 MG/ML	T1	
Haloperidol Oral	T1	
Calcitonin Gene-Related Peptide Antag.		
AIMOVIG (***Erenumab-aooe***)	T1	PA
AJOVY (***Fremanezumab-vfrm***)	T1	PA
NURTEC (***Rimegepant Sulfate***)	T1	PA
UBRELVY (***Ubrogepant***)	T1	PA
Catechol-O-Methyltransferase(Comt)Inhib.		
Entacapone	T1	
Tolcapone	T1	
Central Nervous System Agents, Misc.		
Acamprosate Calcium	T1	
Atomoxetine HCl Oral Capsule 10 MG, 18 MG, 25 MG, 40 MG, 60 MG	T1	
Atomoxetine HCl Oral Capsule 100 MG, 80 MG	T1	AL (Max 18 Years)
AUSTEDO (***Deutetrabenazine***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Carbidopa Oral	T1	
guanFACINE HCl ER	T1	
guanFACINE HCl Oral	T1	
INGREZZA ORAL CAPSULE 40 MG, 80 MG (***Valbenazine Tosylate***)	T1	PA
Memantine HCl Oral Tablet	T1	
QELBREE (***Viloxazine HCl***)	T1	PA
Riluzole	T1	
Tetrabenazine	T1	PA
Cyclooxygenase-2 (Cox-2) Inhibitors		
Celecoxib Oral Capsule 100 MG, 200 MG	T1	
Celecoxib Oral Capsule 400 MG, 50 MG	T1	PA
Dibenzoxapines		
Loxapine Succinate Oral	T1	
Diphenylbutylperidines		
Pimozide	T1	
Dopamine Precursors		
Carbidopa Oral	T1	
Carbidopa-Levodopa	T1	
Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG, 50-200 MG	T1	
VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML (***Foscarbidopa-Foslevodopa***)	T1	PA
Ergot-Deriv. Dopamine Receptor Agonists		
Bromocriptine Mesylate Oral	T1	
Cabergoline	T1	
Fibromyalgia Agents		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DULoxetine HCl Oral Capsule Delayed Release Particles 20 MG, 30 MG, 60 MG	T1	QL (60 EA per 30 days)
DULoxetine HCl Oral Capsule Delayed Release Particles 40 MG	T1	PA
Milnacipran HCl Oral Tablet	T1	QL (60 EA per 30 days)
Pregabalin Oral Capsule	T1	
Pregabalin Oral Solution	T1	ST
Gaba-Mediated Anticonvulsants		
DEPAKOTE (***Divalproex Sodium***)	T1	
DEPAKOTE ER (***Divalproex Sodium***)	T1	
Divalproex Sodium ER Oral Tablet Extended Release 24 Hour	T1	
Divalproex Sodium Oral Tablet Delayed Release	T1	
Gabapentin Oral Capsule	T1	
Gabapentin Oral Solution 250 MG/5ML	T1	
Gabapentin Oral Tablet 600 MG, 800 MG	T1	
Pregabalin Oral Capsule	T1	
Pregabalin Oral Solution	T1	ST
tiaGABine HCl	T1	
Valproic Acid Oral Solution 250 MG/5ML	T1	
Hydantoins		
DILANTIN INFATABS (***Phenytoin***)	T1	
DILANTIN ORAL CAPSULE (***Phenytoin Sodium Extended***)	T1	
Phenytoin (Phenytoin Infatabs)	T1	
Phenytoin Oral	T1	
Phenytoin Sodium Extended	T1	
Ion Channel Inhibition Agents		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Lacosamide Oral Tablet	T1	
OXcarbazepine	T1	
Rufinamide Oral Tablet	T1	PA
Zonisamide Oral	T1	
Monoamine Oxidase B Inhibitors		
Rasagiline Mesylate Oral	T1	PA
Selegiline HCl Oral	T1	
Monoamine Oxidase Inhibitors		
Phenelzine Sulfate Oral	T1	PA
Rasagiline Mesylate Oral	T1	PA
Selegiline HCl Oral	T1	
Tranylcypromine Sulfate	T1	PA
Non-Benzodiazepine Anxiolytics		
busPIRone HCl Oral	T1	
Meprobamate	T1	PA
Non-Benzodiazepine Hypnotics		
Eszopiclone	T1	
Zaleplon Oral Capsule 10 MG	T1	QL (60 EA per 30 days)
Zaleplon Oral Capsule 5 MG	T1	QL (30 EA per 30 days)
Zolpidem Tartrate ER	T1	QL (30 EA per 30 days)
Zolpidem Tartrate Oral Tablet	T1	QL (30 EA per 30 days)
Nonergot-Deriv.Dopamine Receptor Agonist		
Pramipexole Dihydrochloride	T1	
rOPINIRole HCl	T1	
Non-Opioid Analgesics		
Acetaminophen-Codeine Oral Solution	T1	QL (5000 ML per 30 days)
Acetaminophen-Codeine Oral Tablet	T1	QL (400 EA per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Butalbital-APAP-Caffeine (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
Butalbital-Acetaminophen Oral Tablet 50-325 MG	T1	PA
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Oxycodone-Acetaminophen (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
Oxycodone-Acetaminophen (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
HYDROcodone-Acetaminophen Oral Solution 2.5-108 MG/5ML, 5-217 MG/10ML, 7.5-325 MG/15ML	T1	QL (5400 ML per 30 days)
HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG	T1	QL (360 EA per 30 days)
oxyCODONE-Acetaminophen Oral Solution 5-325 MG/5ML	T1	
oxyCODONE-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG	T1	QL (360 EA per 30 days)
oxyCODONE-Acetaminophen Oral Tablet 2.5-325 MG	T1	PA
PRIALT (***Ziconotide Acetate***)	T1	
traMADol-Acetaminophen	T1	QL (240 EA per 30 days)
Nonsteroidal Anti-Inflamm. Agents, Misc		
Diclofenac Epolamine External	T1	PA
Diclofenac Potassium Oral Tablet 50 MG	T1	
Diclofenac Sodium ER	T1	
Diclofenac Sodium External Gel 1 %	T1	
Diclofenac Sodium Oral	T1	
Diflunisal Oral	T1	
Etodolac ER	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Etodolac Oral	T1	
Flurbiprofen Oral Tablet 100 MG	T1	PA
HYDROcodone-Ibuprofen Oral Tablet 5-200 MG, 7.5-200 MG	T1	
Ibuprofen Oral Suspension 100 MG/5ML	T1	
Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG	T1	
Indomethacin ER	T1	
Indomethacin Oral Capsule 25 MG, 50 MG	T1	
Indomethacin Oral Suspension	T1	
Ketoprofen ER	T1	
Ketoprofen Oral Capsule 50 MG	T1	PA
Ketorolac Tromethamine Intramuscular Solution 60 MG/2ML	T1	
Ketorolac Tromethamine Oral	T1	PA
Meclofenamate Sodium Oral	T1	PA
Mefenamic Acid Oral	T1	PA
Meloxicam Oral Tablet	T1	
Nabumetone Oral	T1	
Naproxen Oral	T1	
Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG	T1	
Naproxen Sodium Oral Tablet 275 MG, 550 MG	T1	
Oxaprozin Oral Tablet	T1	QL (90 EA per 30 days)
Piroxicam Oral	T1	
Sulindac Oral	T1	

Opioid Agonists (28:08)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Acetaminophen-Codeine Oral Solution	T1	QL (5000 ML per 30 days)
Acetaminophen-Codeine Oral Tablet	T1	QL (400 EA per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-ASA-Caff-Codeine	T1	PA
Codeine Sulfate Oral Tablet	T1	
DISKETS (***Methadone HCl***)	T1	
Oxycodone-Acetaminophen (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
Oxycodone-Acetaminophen (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
Fentanyl Cit-Ropivacaine-NaCl Epidural Solution 0.2-0.2-0.9 MG/100ML-%, 0.5-0.2-0.9 MG/250ML-%	T1	
fentaNYL Transdermal Patch 72 Hour 100 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR	T1	PA
Fentanyl-Bupivacaine-NaCl Epidural Solution 0.2-0.1-0.9 MG/100ML-%, 0.2-0.125-0.9 MG/100ML-%, 0.5-0.1-0.9 MG/250ML-%, 0.5-0.125-0.9 MG/250ML-%	T1	
HYDROcodone-Acetaminophen Oral Solution 2.5-108 MG/5ML, 5-217 MG/10ML, 7.5-325 MG/15ML	T1	QL (5400 ML per 30 days)
HYDROcodone-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG	T1	QL (360 EA per 30 days)
HYDROcodone-Ibuprofen Oral Tablet 5-200 MG, 7.5-200 MG	T1	
HYDROmorphone HCl Oral	T1	
HYDROmorphone HCl Rectal	T1	
Levorphanol Tartrate Oral Tablet 2 MG	T1	PA
Meperidine HCl Oral Solution	T1	PA
Meperidine HCl Oral Tablet 50 MG	T1	PA
Methadone HCl (Methadone Hcl Intensol)	T1	
Methadone HCl Oral	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Morphine Sulfate (Concentrate) Oral Solution 10 MG/0.5ML, 100 MG/5ML, 20 MG/ML	T1	
Morphine Sulfate ER Beads Oral Capsule Extended Release 24 Hour 120 MG, 30 MG, 60 MG, 90 MG	T1	PA
Morphine Sulfate ER Oral Tablet Extended Release 15 MG, 30 MG, 60 MG	T1	
Morphine Sulfate Oral	T1	
Morphine Sulfate Rectal	T1	
Opium	T1	PA
oxyCODONE HCl Oral Concentrate 100 MG/5ML	T1	PA
oxyCODONE HCl Oral Solution	T1	PA
oxyCODONE HCl Oral Tablet 15 MG, 20 MG, 30 MG	T1	PA
oxyCODONE HCl Oral Tablet 5 MG	T1	QL (10 EA per 1 day)
oxyCODONE HCl Oral Tablet Abuse-Deterrent 15 MG, 5 MG	T1	PA
oxyCODONE-Acetaminophen Oral Solution 5-325 MG/5ML	T1	
oxyCODONE-Acetaminophen Oral Tablet 10-325 MG, 5-325 MG, 7.5-325 MG	T1	QL (360 EA per 30 days)
oxyCODONE-Acetaminophen Oral Tablet 2.5-325 MG	T1	PA
Promethazine-Codeine	T1	QL (240 ML per 30 days); AL (Min 18 Years)
Tapentadol HCl	T1	PA
Tapentadol HCl ER	T1	PA
traMADol HCl Oral Tablet 50 MG	T1	
traMADol-Acetaminophen	T1	QL (240 EA per 30 days)
Opioid Antagonists (28:10)		
Buprenorphine HCl-Naloxone HCl	T1	
GNP Naloxone HCl	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLOXXADO (***Naloxone HCl***)	T1	QL (4 EA per 180 days)
Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML	T1	
Naloxone HCl Injection Solution Cartridge	T1	
Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML	T1	
Naloxone HCl Nasal	T1	
Naltrexone HCl Oral	T1	
Pentazocine-Naloxone HCl	T1	PA
RELISTOR ORAL (***Methylnaltrexone Bromide***)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***Methylnaltrexone Bromide***)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Methylnaltrexone Bromide***)	T1	PA
REXTOVY (***Naloxone HCl***)	T1	QL (4 EA per 180 days)
RIVIVE (***Naloxone HCl***)	T1	QL (4 EA per 180 days)
VIVITROL (***Naltrexone***)	T1	
Opioid Partial Agonists		
Buprenorphine HCl Sublingual	T1	
Buprenorphine HCl-Naloxone HCl	T1	
Pentazocine-Naloxone HCl	T1	PA
SUBLOCADE (***Buprenorphine***)	T1	
Orexin Receptor Antagonists		
BELSOMRA (***Suvorexant***)	T1	PA
DAYVIGO (***Lemborexant***)	T1	PA
QUVIVIQ (***Daridorexant HCl***)	T1	PA
Phenothiazines		
chlorproMAZINE HCl Oral Concentrate 100 MG/ML	T1	
chlorproMAZINE HCl Oral Tablet	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prochlorperazine (Compro)	T1	
FluPHENAZine HCl Oral	T1	
Perphenazine Oral	T1	
Perphenazine-Amitriptyline	T1	
Prochlorperazine	T1	
Prochlorperazine Maleate Oral	T1	
Thioridazine HCl Oral	T1	
Trifluoperazine HCl Oral	T1	
Respiratory And Cns Stimulants		
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Atomoxetine HCl Oral Capsule 10 MG, 18 MG, 25 MG, 40 MG, 60 MG	T1	
Atomoxetine HCl Oral Capsule 100 MG, 80 MG	T1	AL (Max 18 Years)
Butalbital-APAP-Caffeine (Bac (Butalbital-Acetamin-Caff))	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caff-Cod Oral Capsule 50-325-40-30 MG	T1	PA
Butalbital-APAP-Caffeine Oral Capsule 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	T1	QL (360 EA per 30 days)
Butalbital-ASA-Caff-Codeine	T1	PA
Butalbital-Aspirin-Caffeine Oral Capsule	T1	
Dexmethylphenidate HCl	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 10 MG, 5 MG	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 15 MG, 20 MG	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Ergotamine-Caffeine	T1	
Methylphenidate HCl ER (CD)	T1	QL (30 EA per 30 days); AL (Max 18 Years)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Methylphenidate HCl ER (LA)	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 18 MG, 27 MG, 54 MG, 72 MG	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER (OSM) Oral Tablet Extended Release 36 MG	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER Oral Tablet Extended Release	T1	QL (90 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER Oral Tablet Extended Release 24 Hour 18 MG, 27 MG, 54 MG	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER Oral Tablet Extended Release 24 Hour 36 MG	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER(Diffus) Oral Tablet Extended Release 27 MG, 54 MG	T1	QL (30 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl ER(Diffus) Oral Tablet Extended Release 36 MG	T1	QL (60 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl Oral Solution 10 MG/5ML	T1	QL (450 ML per 30 days); AL (Max 18 Years)
Methylphenidate HCl Oral Solution 5 MG/5ML	T1	QL (900 ML per 30 days); AL (Max 18 Years)
Methylphenidate HCl Oral Tablet	T1	QL (90 EA per 30 days); AL (Max 18 Years)
Methylphenidate HCl Oral Tablet Chewable	T1	QL (30 EA per 30 days); AL (Max 18 Years)
MIGERGOT (***Ergotamine-Caffeine***)	T1	
Norgesic Forte	T1	
Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (***Orphenadrine-Aspirin-Caffeine***)	T1	
QELBREE (***Viloxazine HCl***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THEO-24 (***Theophylline***)	T1	
Theophylline ER	T1	
Theophylline Oral Elixir	T1	
Reversible Cox-1/Cox-2 Inhibitors		
Diflunisal Oral	T1	
Etodolac ER	T1	
Etodolac Oral	T1	
Flurbiprofen Oral Tablet 100 MG	T1	PA
Flurbiprofen Sodium	T1	
HYDROcodone-Ibuprofen Oral Tablet 5-200 MG, 7.5-200 MG	T1	
Ibuprofen Oral Suspension 100 MG/5ML	T1	
Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG	T1	
Indomethacin ER	T1	
Indomethacin Oral Capsule 25 MG, 50 MG	T1	
Indomethacin Oral Suspension	T1	
Ketorolac Tromethamine Intramuscular Solution 60 MG/2ML	T1	
Ketorolac Tromethamine Ophthalmic	T1	
Ketorolac Tromethamine Oral	T1	PA
Meclofenamate Sodium Oral	T1	PA
Mefenamic Acid Oral	T1	PA
Meloxicam Oral Tablet	T1	
Nabumetone Oral	T1	
Naproxen Oral	T1	
Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG	T1	
Naproxen Sodium Oral Tablet 275 MG, 550 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Oxaprozin Oral Tablet	T1	QL (90 EA per 30 days)
Piroxicam Oral	T1	
Sulindac Oral	T1	
Salicylates		
Butalbital-ASA-Caff-Codeine (Ascomp-Codeine)	T1	PA
Aspirin 81	T1	
Aspirin Adult Low Dose	T1	
Aspirin Adult Low Strength Oral Tablet Delayed Release	T1	
Aspirin Childrens	T1	
Aspirin EC Adult Low Dose	T1	
Aspirin EC Low Dose	T1	
Aspirin EC Low Strength	T1	
Aspirin Low Dose Oral Tablet Chewable	T1	
Aspirin Low Dose Oral Tablet Delayed Release	T1	
Aspirin Low Strength	T1	
Aspirin Oral Tablet Chewable	T1	
Aspirin Oral Tablet Delayed Release 81 MG	T1	
Aspirin Regimen	T1	
Aspirin-Dipyridamole ER	T1	
BAYER ASPIRIN EC LOW DOSE (***Aspirin***)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE (***Aspirin***)	T1	
Butalbital-ASA-Caff-Codeine	T1	PA
Butalbital-Aspirin-Caffeine Oral Capsule	T1	
Childrens Aspirin	T1	
CVS Aspirin Adult Low Dose	T1	
CVS Aspirin EC Oral Tablet Delayed Release 81 MG	T1	
CVS Aspirin Low Dose	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CVS Aspirin Low Strength Oral Tablet Delayed Release	T1	
ECOTRIN LOW STRENGTH (***Aspirin***)	T1	
EQ Aspirin Adult Low Dose	T1	
EQ Aspirin Low Dose Oral Tablet Chewable	T1	
EQL Aspirin Low Dose	T1	
GNP Adult Aspirin Low Strength Oral Tablet Chewable	T1	
GNP Aspirin Low Dose	T1	
GNP Aspirin Oral Tablet Delayed Release 81 MG	T1	
GoodSense Aspirin Low Dose	T1	
GoodSense Aspirin Oral Tablet Chewable	T1	
MEDIQUE ASPIRIN (***Aspirin***)	T1	
MM Aspirin Oral Tablet Delayed Release	T1	
Norgesic Forte	T1	
Orphenadrine-Aspirin-Caffeine Oral Tablet 25-385-30 MG	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (***Orphenadrine-Aspirin-Caffeine***)	T1	
QC Aspirin Low Dose	T1	
Salsalate Oral	T1	
Sel.Serotonin,Norepi Reuptake Inhibitor		
DULoxetine HCl Oral Capsule Delayed Release Particles 20 MG, 30 MG, 60 MG	T1	QL (60 EA per 30 days)
DULoxetine HCl Oral Capsule Delayed Release Particles 40 MG	T1	PA
Milnacipran HCl Oral Tablet	T1	QL (60 EA per 30 days)
Venlafaxine HCl	T1	
Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour	T1	
Selective Serotonin Agonists		

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Naratriptan HCl	T1	ST; QL (12 EA per 30 days)
Rizatriptan Benzoate	T1	QL (12 EA per 30 days)
SUMAtriptan Succinate Oral Tablet 100 MG, 50 MG	T1	QL (18 EA per 30 days)
SUMAtriptan Succinate Oral Tablet 25 MG	T1	QL (12 EA per 30 days)
SUMAtriptan Succinate Subcutaneous Solution 6 MG/0.5ML	T1	PA
Selective-Serotonin Reuptake Inhibitors		
Citalopram Hydrobromide Oral Solution	T1	QL (900 ML per 30 days)
Citalopram Hydrobromide Oral Tablet 10 MG, 20 MG	T1	QL (90 EA per 30 days)
Citalopram Hydrobromide Oral Tablet 40 MG	T1	QL (45 EA per 30 days)
Escitalopram Oxalate Oral Solution 5 MG/5ML	T1	
Escitalopram Oxalate Oral Tablet	T1	
FLUoxetine HCl Oral Capsule	T1	
FLUoxetine HCl Oral Capsule Delayed Release	T1	PA
FLUoxetine HCl Oral Solution	T1	
fluvoxaMINE Maleate	T1	
PARoxetine HCl	T1	
PARoxetine HCl ER	T1	PA
Sertraline HCl Oral Concentrate	T1	
Sertraline HCl Oral Tablet	T1	
Serotonin Modulators		
Mirtazapine Oral Tablet	T1	
Mirtazapine Oral Tablet Dispersible 15 MG, 30 MG	T1	
Mirtazapine Oral Tablet Dispersible 45 MG	T1	PA
Nefazodone HCl	T1	
traZODone HCl Oral	T1	
TRINTELLIX (***Vortioxetine HBr***)	T1	PA
Succinimides		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ethosuximide Oral	T1	
Thioxanthenes		
Thiothixene Oral	T1	
Tricyclics, Other Norepi-Ru Inhibitors		
Amitriptyline HCl Oral	T1	
Amoxapine	T1	
Chlordiazepoxide-Amitriptyline	T1	
clomiPRAMINE HCl Oral	T1	
Desipramine HCl Oral	T1	
Doxepin HCl External	T1	
Doxepin HCl Oral Capsule	T1	
Doxepin HCl Oral Concentrate	T1	
Doxepin HCl Oral Tablet	T1	PA
Imipramine HCl Oral	T1	
Imipramine Pamoate	T1	
Nortriptyline HCl Oral	T1	
Perphenazine-Amitriptyline	T1	
Protriptyline HCl	T1	PA
Trimipramine Maleate Oral	T1	
Vesicular Monoamine Transport2 Inhibitor		
AUSTEDO (***Deutetrabenazine***)	T1	PA
AUSTEDO XR (***Deutetrabenazine***)	T1	PA
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (***Deutetrabenazine***)	T1	PA
INGREZZA ORAL CAPSULE (***Valbenazine Tosylate***)	T1	PA
INGREZZA ORAL CAPSULE SPRINKLE (***Valbenazine Tosylate***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tetrabenazine	T1	PA
Wakefulness-Promoting Agents		
Diclofenac Sodium Oral Tablet Delayed Release 75 MG	T1	
Modafinil Oral	T1	PA
Dental Agents		
Dental Agents		
DENTA 5000 PLUS (***Sodium Fluoride***)	T1	
Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG	T1	
PREVIDENT DENTAL (***Sodium Fluoride***)	T1	
SF	T1	
SF 5000 Plus	T1	
Sodium Fluoride 5000 Plus	T1	
Sodium Fluoride Dental Cream	T1	
Sodium Fluoride Dental Gel 1.1 %	T1	
Sodium Fluoride Mouth/Throat	T1	
Sodium Fluoride Oral Solution 1.1 (0.5 F) MG/ML	T1	
Sodium Fluoride Oral Tablet Chewable	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	
Nutritional Supplements		
DENTA 5000 PLUS (***Sodium Fluoride***)	T1	
Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG	T1	
PREVIDENT DENTAL (***Sodium Fluoride***)	T1	
SF	T1	
SF 5000 Plus	T1	
Sodium Fluoride 5000 Plus	T1	
Sodium Fluoride Dental Cream	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sodium Fluoride Dental Gel 1.1 %	T1	
Sodium Fluoride Mouth/Throat	T1	
Sodium Fluoride Oral Solution 1.1 (0.5 F) MG/ML	T1	
Sodium Fluoride Oral Tablet Chewable	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	
Devices		
Devices		
ACCU-CHEK SOFTCLIX LANCETS (***Lancets***)	T1	
ACE AEROSOL CLOUD ENHANCER (***Respiratory Therapy Supplies***)	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU LARGE (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU SMALL (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
AQUALANCE LANCETS 30G (***Lancets***)	T1	
BD DISP NEEDLE 23G X 1" (***Needle (Disp)***)	T1	
BD DISP NEEDLES 18G X 1-1/2" , 25G X 5/8" (***Needle (Disp)***)	T1	
BD INSULIN SYRINGE 29G X 1/2" 1 ML (***Insulin Syringe-Needle U-100***)	T1	
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (***Insulin Syringe-Needle U-100***)	T1	
BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***Insulin Syringe-Needle U-100***)	T1	
BD INTEGRA SYRINGE 21G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML (***Syringe/Needle (Disp)***)	T1	
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML, 20G X 1" 3 ML, 22G X 1" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML (***Syringe/Needle (Disp)***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD PEN NEEDLE MINI U/F (***Insulin Pen Needle***)	T1	
BD PEN NEEDLE MINI ULTRAFINE (***Insulin Pen Needle***)	T1	
BD PEN NEEDLE NANO 2ND GEN (***Insulin Pen Needle***)	T1	
BD PEN NEEDLE NANO ULTRAFINE (***Insulin Pen Needle***)	T1	
BD PEN NEEDLE ORIG ULTRAFINE (***Insulin Pen Needle***)	T1	
BD PEN NEEDLE SHORT ULTRAFINE (***Insulin Pen Needle***)	T1	
BD PLASTIPAK SYRINGE 21G X 1" 3 ML (***Syringe/Needle (Disp)***)	T1	
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML (***Syringe/Needle (Disp)***)	T1	
BD TB SYRINGE 27G X 1/2" 1 ML (***Tuberculin-Allergy Syringes***)	T1	
BD VEO INSULIN SYR ULTRAFINE (***Insulin Syringe-Needle U-100***)	T1	
BINAXNOW COVID-19 AG HOME TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
COMFORT EZ PEN NEEDLES 32G X 4 MM (***Insulin Pen Needle***)	T1	
COMPACT SPACE CHAMBER (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML, 31G X 15/64" 0.5 ML, 31G X 5/16" 1 ML (***Insulin Syringe-Needle U-100***)	T1	
DROPLET MICRON (***Insulin Pen Needle***)	T1	
DROPLET PEN NEEDLES 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM (***Insulin Pen Needle***)	T1	
EASIVENT (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
Easy Comfort Lancets	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (***Insulin Syringe-Needle U-100***)	T1	
EASY TOUCH PEN NEEDLES 31G X 5 MM , 31G X 8 MM (***Insulin Pen Needle***)	T1	
EMBECTA AUTOSHIELD DUO (***Insulin Pen Needle***)	T1	
EMBECTA INS SYR U/F 1/2 UNIT (***Insulin Syringe-Needle U-100***)	T1	
EMBECTA INSULIN SYR ULTRAFINE (***Insulin Syringe-Needle U-100***)	T1	
EMBECTA INSULIN SYRINGE (***Insulin Syringe-Needle U-100***)	T1	
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (***Insulin Syringe-Needle U-100***)	T1	
EMBECTA PEN NEEDLE NANO (***Insulin Pen Needle***)	T1	
EMBECTA PEN NEEDLE NANO 2 GEN (***Insulin Pen Needle***)	T1	
EMBECTA PEN NEEDLE ULTRAFINE (***Insulin Pen Needle***)	T1	
EMBRACE LANCETS ULTRA THIN 30G (***Lancets***)	T1	
EQ Space Chamber Anti-Static	T1	QL (2 EA per 365 days)
FEMCAP (***Cervical Caps***)	T1	
FREESTYLE LANCETS (***Lancets***)	T1	
FREESTYLE LIBRE 14 DAY READER (***Continuous Glucose Receiver***)	T1	PA
FREESTYLE LIBRE 14 DAY SENSOR (***Continuous Glucose Sensor***)	T1	PA
FREESTYLE LIBRE 2 PLUS SENSOR (***Continuous Glucose Sensor***)	T1	PA
FREESTYLE LIBRE 2 READER (***Continuous Glucose Receiver***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 SENSOR (***Continuous Glucose Sensor***)	T1	PA
FREESTYLE LIBRE 3 PLUS SENSOR (***Continuous Glucose Sensor***)	T1	PA
FREESTYLE LIBRE 3 READER (***Continuous Glucose Receiver***)	T1	PA
FREESTYLE LIBRE 3 SENSOR (***Continuous Glucose Sensor***)	T1	PA
GEBAUERS PAIN EASE (***Pentafluoroprop-Tetrafluoroeth***)	T1	
GEBAUERS SPRAY AND STRETCH (***Pentafluoroprop-Tetrafluoroeth***)	T1	
GELCLAIR (***Povidone-NaHyaluron-Glycyrrhet***)	T1	
Heparin Sod (Pork) Lock Flush Intravenous Solution 10 UNIT/ML, 100 UNIT/ML	T1	
Insulin Syringe 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 1 ML	T1	
Lancets 28G Thin	T1	
Lancets Micro Thin 33G	T1	
Lancets Super Thin 28G	T1	
Lancets Ultra Thin 30G	T1	
Lancing Device	T1	
MICROCHAMBER (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
MICROLET LANCETS (***Lancets***)	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (***Sodium Chloride***)	T1	
NOVOFINE PEN NEEDLE (***Insulin Pen Needle***)	T1	
ONETOUCH DELICA PLUS LANCET30G (***Lancets***)	T1	
ONETOUCH DELICA PLUS LANCET33G (***Lancets***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTICHAMBER DIAMOND (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-LG MASK (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-MD MASK (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-SM MASK (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
ORAMAGICRX (***Oral Wound Care Products***)	T1	
POCKET CHAMBER (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
ProChamber VHC	T1	QL (2 EA per 365 days)
QUICKVUE AT-HOME COVID-19 TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
RADIAPLEXRX (***Wound Dressings***)	T1	
REGENECARE (***Lidocaine-Collagen-Aloe Vera***)	T1	
RELION TRUE MET AIR GLUC METER (***Blood Glucose Monitoring Suppl***)	T1	QL (100 EA per 90 days)
Sodium Chloride Inhalation Nebulization Solution 0.9 %, 10 %, 3 %	T1	
Sure Comfort Insulin Syringe 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML	T1	
Sure Comfort Lancets 30G	T1	
Sure Comfort Pen Needles 31G X 8 MM	T1	
TechLITE Insulin Syringe 31G X 5/16" 0.3 ML	T1	
TECHLITE PEN NEEDLES 31G X 8 MM (***Insulin Pen Needle***)	T1	
TRUE METRIX AIR GLUCOSE METER KIT (***Blood Glucose Monitoring Suppl***)	T1	QL (1 EA per 365 days)
TRUE METRIX METER KIT (***Blood Glucose Monitoring Suppl***)	T1	QL (1 EA per 365 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM (***Insulin Pen Needle***)	T1	
TRUEPLUS LANCETS 28G (***Lancets***)	T1	
TRUEPLUS LANCETS 30G (***Lancets***)	T1	
TRUEPLUS LANCETS 33G (***Lancets***)	T1	
TRUEPLUS SAFETY LANCETS 28G (***Lancets***)	T1	
ULTICARE MICRO PEN NEEDLES 32G X 4 MM (***Insulin Pen Needle***)	T1	
UNIFINE PENTIPS PLUS 31G X 8 MM (***Insulin Pen Needle***)	T1	
VORTEX VALVED HOLDING CHAMBER (***Spacer/Aero-Holding Chambers***)	T1	QL (2 EA per 365 days)
Diagnostic Agents		
Adrenocortical Insufficiency		
CORTROPHIN (***Corticotropin***)	T1	PA
CORTROPHIN GEL (***Corticotropin***)	T1	PA
Cardiac Function		
Aspirin-Dipyridamole ER	T1	
Dipyridamole Oral	T1	
Diabetes Mellitus		
RELION TRUE METRIX TEST STRIPS (***Glucose Blood***)	T1	QL (100 EA per 90 days)
TRUE METRIX BLOOD GLUCOSE TEST (***Glucose Blood***)	T1	QL (100 EA per 90 days)
TRUE METRIX PRO BLOOD GLUCOSE (***Glucose Blood***)	T1	QL (100 EA per 90 days)
TRUETRACK TEST (***Glucose Blood***)	T1	QL (100 EA per 90 days)
Diagnostic Agents		
BINAXNOW COVID-19 AG HOME TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARESTART COVID-19 HOME TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
Ellume Covid-19 Home Test	T1	QL (8 EA per 30 days)
FaStep COVID-19 Antigen Test	T1	QL (8 EA per 30 days)
FLOWFLEX COVID-19 AG HOME TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
IHEALTH COVID-19 RAPID TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
INTELISWAB COVID-19 RAPID TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
LUCIRA CHECK IT COVID-19 TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
QUICKVUE AT-HOME COVID-19 TEST (***COVID-19 At Home Test***)	T1	QL (8 EA per 30 days)
Myasthenia Gravis		
Neostigmine Methylsulfate Intravenous Solution Prefilled Syringe 3 MG/3ML	T1	PA
Pheochromocytoma		
metyroSINE	T1	
Electrolytic, Caloric, And Water Balance		
Acidifying Agents		
K-PHOS (***Potassium Phosphate Monobasic***)	T1	
K-PHOS NO 2 (***Pot & Sod Ac Phosphates***)	T1	
PHOSPHA 250 NEUTRAL (***K Phos Mono-Sod Phos Di & Mono***)	T1	
Phosphorous	T1	
Alkalinizing Agents		
ORACIT (***Sod Citrate-Citric Acid***)	T1	
Pot & Sod Cit-Cit Ac	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**Coverage Requirements and Limits** **AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Potassium Citrate ER Oral Tablet Extended Release 10 MEQ (1080 MG), 5 MEQ (540 MG)	T1	
Potassium Citrate-Citric Acid Oral Solution	T1	
Sod Citrate-Citric Acid Oral Solution 500-334 MG/5ML	T1	
Tricitrates	T1	
Ammonia Detoxicants		
Constulose	T1	
Enulose	T1	
Generlac	T1	
Lactulose Encephalopathy Oral Solution 10 GM/15ML	T1	
Lactulose Oral Solution	T1	
LITHOSTAT (***Acetohydroxamic Acid***)	T1	PA
Sodium Phenylbutyrate Oral Powder 3 GM/TSP	T1	
Sodium Phenylbutyrate Oral Tablet	T1	
Caloric Agents		
BUPivacaine in Dextrose Intrathecal	T1	
Bupivacaine Spinal	T1	
CVS Jock Itch	T1	
ELLIOTTS B (***Intrathecal Elec-Dextrose***)	T1	
NUTRIVIT (***B Complex-Lysine-Min-Fe-FA***)	T1	
Carbonic Anhydrase Inhibitors (40:28)		
acetaZOLAMIDE ER	T1	
acetaZOLAMIDE Oral	T1	
Diuretics, Miscellaneous		
THEO-24 (***Theophylline***)	T1	
Theophylline ER	T1	
Theophylline Oral Elixir	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Irrigating Solutions		
Acetic Acid Glacial Solution 99 %	T1	
Acetic Acid Irrigation	T1	
Acetic Acid Solution 5 %	T1	
ARGYLE STERILE SALINE (***Sodium Chloride (GU Irrigant)***)	T1	
Glycine Irrigation	T1	
Glycine Urologic	T1	
Lactated Ringers Irrigation	T1	
PHYSIOLYTE (***Irrigation Solns Physiological***)	T1	
Ringers Irrigation	T1	
Sodium Chloride Irrigation Solution 0.9 %	T1	
Sorbitol-Mannitol	T1	
Sterile Water for Irrigation	T1	
Water For Irrigation, Sterile	T1	
Loop Diuretics (40:28)		
Bumetanide Oral	T1	
Ethacrynic Acid Oral	T1	
Furosemide Oral Solution 10 MG/ML, 8 MG/ML	T1	
Furosemide Oral Tablet	T1	
Torsemide Oral	T1	
Osmotic Diuretics (40:28)		
Sorbitol-Mannitol	T1	
Phosphate-Removing Agents		
Calcium Acetate (Phos Binder)	T1	
Calcium Acetate Oral Tablet 667 MG	T1	
Lanthanum Carbonate	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sevelamer Carbonate Oral Tablet	T1	
Sevelamer HCl	T1	PA
Potassium-Removing Agents		
LOKELMA (***Sodium Zirconium Cyclosilicate***)	T1	QL (30 EA per 30 days)
VELTASSA ORAL PACKET 1 GM (***Patiromer Sorbitex Calcium***)	T1	ST; QL (60 EA per 30 days)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (***Patiromer Sorbitex Calcium***)	T1	ST; QL (30 EA per 30 days)
Potassium-Sparing Diuretics (40:28)		
aMILoride HCl Oral	T1	
aMILoride-hydroCHLOROthiazide	T1	
Eplerenone	T1	PA
Spironolactone Oral Tablet	T1	
Spironolactone-HCTZ	T1	
Triamterene Oral	T1	PA
Triamterene-HCTZ Oral Capsule 37.5-25 MG	T1	
Triamterene-HCTZ Oral Tablet	T1	
Replacement Preparations		
Actical	T1	
B-Complex/Vitamin C	T1	
Bupivacaine HCl-NaCl Epidural Solution 0.125-0.9 %	T1	
Calcium Acetate (Phos Binder)	T1	
Calcium Acetate Oral Tablet 667 MG	T1	
Centravites 50 Plus	T1	
Classic Prenatal	T1	
Complete Natal DHA Oral 29-1-200 & 200 MG	T1	
CVS One Daily Essential	T1	
DIALYVITE 3000 (***B Complex-C-Biotin-E-Min-FA***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIALYVITE/ZINC (***B Complex-C-Zn-Folic Acid***)	T1	
EFFER-K ORAL TABLET EFFERVESCENT 25 MEQ (***Potassium Bicarbonate***)	T1	
ELLIOTTS B (***Intrathecal Elec-Dextrose***)	T1	
EQL Prenatal Formula	T1	
Essential One Daily Multivit	T1	
Fentanyl Cit-Ropivacaine-NaCl Epidural Solution 0.2-0.2-0.9 MG/100ML-%, 0.5-0.2-0.9 MG/250ML-%	T1	
Fentanyl-Bupivacaine-NaCl Epidural Solution 0.2-0.1-0.9 MG/100ML-%, 0.2-0.125-0.9 MG/100ML-%, 0.5-0.1-0.9 MG/250ML-%, 0.5-0.125-0.9 MG/250ML-%	T1	
GALZIN (***Zinc Acetate (Oral)***)	T1	PA
GNP PreNatal	T1	
GUMMI BEAR MULTIVITAMIN/MIN (***Pediatric Multivit-Minerals***)	T1	
Hematinic Plus Vit/Minerals	T1	
INFASURF INTRATRACHEAL (***Calfactant in NaCl***)	T1	
Potassium Chloride Crys ER (Klor-Con M10)	T1	
Potassium Chloride Crys ER (Klor-Con M20)	T1	
Potassium Chloride (Klor-Con Oral Packet 20 Meq)	T1	PA
K-PHOS (***Potassium Phosphate Monobasic***)	T1	
Lactated Ringers Irrigation	T1	
LYSIPLEX PLUS ORAL LIQUID (***Multiple Vitamins-Minerals***)	T1	
Magnesium Chloride Injection	T1	
Magnesium Oral Tablet 400 MG	T1	
MAGNESIUM-OXIDE ORAL TABLET 400 (240 MG) MG (***Magnesium Oxide***)	T1	
MgO Oral Tablet 400 (240 Mg) MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
M-Natal Plus	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (***Sodium Chloride***)	T1	
NUTRIVIT (***B Complex-Lysine-Min-Fe-FA***)	T1	
PHOSPHA 250 NEUTRAL (***K Phos Mono-Sod Phos Di & Mono***)	T1	
Phosphorous	T1	
PHOSPHO-TRIN K500 (***Potassium Phosphate Monobasic***)	T1	
Potassium Chloride Crys ER	T1	
Potassium Chloride ER	T1	
Potassium Chloride Oral Packet 20 MEQ	T1	PA
Potassium Chloride Oral Solution 10 %, 20 MEQ/15ML (10%), 40 MEQ/15ML (20%)	T1	
Prenatal Gummies/DHA & FA	T1	
PRENATAL MULTIVITAMIN + DHA (***Prenatal MV-Min-Fe Fum-FA-DHA***)	T1	
Prenatal One Daily	T1	
Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG	T1	
Prenatal Plus	T1	
Prenatal Vitamins Oral Tablet 28-0.8 MG	T1	
Prenatal/Iron Oral Tablet	T1	
Ropivacaine HCl-NaCl Injection Solution 0.2-0.9 %	T1	
Saline Bacteriostatic	T1	
Sodium Chloride (PF)	T1	
Sodium Chloride Bacteriostatic	T1	
Sodium Chloride Inhalation Nebulization Solution 0.9 %, 10 %, 3 %	T1	
Sodium Chloride Injection Solution 2.5 MEQ/ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Stress Formula	T1	
Support	T1	
SUPPORT-500 (***Multiple Vitamins-Minerals***)	T1	
V-C Forte	T1	
VIC-FORTE (***Multiple Vitamins-Minerals***)	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (***Pediatric Multivit-Minerals***)	T1	
Wes-Phos 250 Neutral	T1	
WesTab Plus	T1	
Salt And Sugar Substitutes		
Aspartame (For Compounding)	T1	
Thiazide Diuretics (40:28)		
aMILoride-hydroCHLOROthiazide	T1	
Benazepril-hydroCHLOROthiazide	T1	
Bisoprolol-hydroCHLOROthiazide	T1	
Candesartan Cilexetil-HCTZ Oral Tablet 16-12.5 MG, 32-12.5 MG	T1	PA
Captopril-hydroCHLOROthiazide	T1	PA
Enalapril-Hydrochlorothiazide Oral Tablet 10-25 MG	T1	
Enalapril-Hydrochlorothiazide Oral Tablet 5-12.5 MG	T1	PA
Fosinopril Sodium-HCTZ	T1	PA
hydroCHLOROthiazide Oral	T1	
Irbesartan-hydroCHLOROthiazide	T1	
Lisinopril-hydroCHLOROthiazide	T1	
Losartan Potassium-HCTZ	T1	
Metoprolol-hydroCHLOROthiazide	T1	PA
Olmesartan Medoxomil-HCTZ	T1	
Quinapril-hydroCHLOROthiazide	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Spironolactone-HCTZ	T1	
Telmisartan-HCTZ	T1	PA
Triamterene-HCTZ Oral Capsule 37.5-25 MG	T1	
Triamterene-HCTZ Oral Tablet	T1	
Valsartan-hydroCHLOROthiazide	T1	
Thiazide-Like Diuretics (40:28)		
Atenolol-Chlorthalidone	T1	
Chlorthalidone Oral Tablet 25 MG, 50 MG	T1	
Indapamide Oral	T1	
metOLazone	T1	
THALITONE (***Chlorthalidone***)	T1	
Uricosuric Agents		
Colchicine-Probenecid	T1	
Probenecid Oral	T1	
Enzymes		
Enzyme Inhibitors		
Nitisinone Oral Capsule 10 MG, 2 MG, 5 MG	T1	
Enzymes		
AMPHADASE (***Hyaluronidase Bovine***)	T1	
CREON (***Pancrelipase (Lip-Prot-Amyl)***)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (***Dornase Alfa***)	T1	PA
SANTYL (***Collagenase***)	T1	
SUCRAID (***Sacrosidase***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***Pancrelipase (Lip-Prot-Amyl)***)	T1	
Eye, Ear, Nose And Throat (Eent) Preps.		
Alpha-Adrenergic Agonists (52:40)		
Apraclonidine HCl	T1	
Brimonidine Tartrate Ophthalmic Solution 0.15 %	T1	PA
Brimonidine Tartrate Ophthalmic Solution 0.2 %	T1	
Brimonidine Tartrate-Timolol	T1	PA
IOPIDINE OPHTHALMIC SOLUTION 1 % (***Apraclonidine HCl***)	T1	
Antiallergic Agents		
ALOCRIL (***Nedocromil Sodium***)	T1	PA
Azelastine HCl Nasal Solution 0.1 %, 137 MCG/SPRAY	T1	
Azelastine HCl Ophthalmic	T1	QL (6 ML per 30 days)
Cromolyn Sodium Inhalation	T1	
Cromolyn Sodium Ophthalmic	T1	
Cromolyn Sodium Oral	T1	
Epinastine HCl	T1	PA
Olopatadine HCl Ophthalmic	T1	
Antibacterials (52:04)		
Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM	T1	
Bacitra-Neomycin-Polymyxin-HC	T1	
CILOXAN OPHTHALMIC OINTMENT (***Ciprofloxacin HCl***)	T1	
Ciprofloxacin HCl Ophthalmic	T1	
Ciprofloxacin-Dexamethasone	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs UPPERCASE = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ciprofloxacin-Hydrocortisone	T1	
CORTISPORIN-TC (***Neomycin-Colist-HC-Thonzonium***)	T1	
Doxycycline Hyclate Oral Tablet 20 MG	T1	PA
EQL Bacitracin Zinc	T1	
Ery	T1	
Erythromycin External Gel	T1	
Erythromycin External Solution	T1	
Erythromycin Ophthalmic	T1	
Gentamicin Sulfate External	T1	
Gentamicin Sulfate Ophthalmic Solution	T1	
Minocycline HCl Oral Capsule 100 MG	T1	QL (60 EA per 30 days)
Minocycline HCl Oral Capsule 50 MG	T1	
Moxifloxacin HCl (2X Day)	T1	PA
Moxifloxacin HCl Ophthalmic Solution	T1	
Neomycin Sulfate Oral	T1	
Neomycin-Bacitracin Zn-Polymyx Ophthalmic Ointment 5-400-10000	T1	
Neomycin-Polymyxin-Dexameth	T1	
Neomycin-Polymyxin-Gramicidin Ophthalmic Solution 1.75-10000-.025	T1	
Neomycin-Polymyxin-HC Ophthalmic Suspension 3.5-10000-1	T1	
Neomycin-Polymyxin-HC Otic	T1	
Ofloxacin Ophthalmic	T1	
Ofloxacin Otic	T1	
Polymyxin B-Trimethoprim	T1	
Sulfacetamide Sodium Ophthalmic Solution	T1	
Sulfacetamide-prednisoLONE Ophthalmic Solution	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOBRADEX OPHTHALMIC OINTMENT (***Tobramycin-Dexamethasone***)	T1	
Tobramycin Inhalation Nebulization Solution 300 MG/5ML	T1	PA
Tobramycin Ophthalmic	T1	
Tobramycin-Dexamethasone	T1	
TOBREX OPHTHALMIC OINTMENT (***Tobramycin***)	T1	
ZYLET (***Loteprednol-Tobramycin***)	T1	
Antifungals (Eent)		
NATACYN (***Natamycin***)	T1	
Antiglaucoma Agents, Miscellaneous		
EPINEPHrine Injection Solution 1 MG/ML	T1	
EPINEPHrine PF Injection Solution	T1	
ROCKLATAN (***Netarsudil-Latanoprost***)	T1	PA
Anti-Infectives, Miscellaneous (52:04)		
Acetic Acid Otic	T1	
BETADINE OPHTHALMIC PREP (***Povidone-Iodine***)	T1	
Chlorhexidine Gluconate Mouth/Throat	T1	
Hydrocortisone-Acetic Acid	T1	
Chlorhexidine Gluconate (Periogard)	T1	
Silver Nitrate External Solution 0.5 %	T1	
Anti-Inflammatory Agents (Eent)		
CEQUA (***CycloSPORINE***)	T1	PA
cycloSPORINE (PF)	T1	PA
CycloSPORINE Modified	T1	
CycloSPORINE Oral Capsule	T1	
CycloSPORINE Modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEORAL (***CycloSPORINE Modified***)	T1	
SANDIMMUNE ORAL CAPSULE (***CycloSPORINE***)	T1	
XIIDRA (***Lifitegrast***)	T1	PA
Antivirals (Eent)		
Trifluridine Ophthalmic	T1	
Astringents (52:04)		
Chlorhexidine Gluconate Mouth/Throat	T1	
Chlorhexidine Gluconate (Periogard)	T1	
Beta-Adrenergic Blocking Agents (52:40)		
Betaxolol HCl Ophthalmic	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (***Timolol Hemihydrate***)	T1	
BETOPTIC-S (***Betaxolol HCl***)	T1	PA
Brimonidine Tartrate-Timolol	T1	PA
Carteolol HCl	T1	
Dorzolamide HCl-Timolol Mal	T1	
Levobunolol HCl Ophthalmic Solution 0.5 %	T1	
Timolol Maleate (Once-Daily)	T1	
Timolol Maleate (Timolol Maleate Ocudose)	T1	
Timolol Maleate Ophthalmic	T1	
Timolol Maleate PF	T1	
Carbonic Anhydrase Inhibitors (52:40)		
acetaZOLAMIDE ER	T1	
acetaZOLAMIDE Oral	T1	
Brinzolamide	T1	PA
Dorzolamide HCl Ophthalmic	T1	
Dorzolamide HCl-Timolol Mal	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methazolAMIDE Oral	T1	PA
Corticosteroids (Eent)		
Ala-Cort External Cream 1 %	T1	
ALREX (***Loteprednol Etabonate***)	T1	
Anucort-HC	T1	
ANUSOL-HC EXTERNAL (***Hydrocortisone***)	T1	
Bacitra-Neomycin-Polymyxin-HC	T1	
Ciprofloxacin-Dexamethasone	T1	
Ciprofloxacin-Hydrocortisone	T1	
CORTANE-B EXTERNAL (***HC-Pramoxine-Chloroxylenol***)	T1	
CORTIFOAM EXTERNAL (***Hydrocortisone Acetate***)	T1	PA
CORTISPORIN-TC (***Neomycin-Colist-HC-Thonzonium***)	T1	
DEXAMETHASONE INTENSOL (***Dexamethasone***)	T1	
Dexamethasone Oral Elixir	T1	
Dexamethasone Oral Solution	T1	
Dexamethasone Oral Tablet	T1	
Dexamethasone Oral Tablet Therapy Pack 1.5 MG (51)	T1	
Dexamethasone Sodium Phosphate Ophthalmic	T1	
Difluprednate	T1	ST; QL (5 ML per 30 days)
FLAREX (***Fluorometholone Acetate***)	T1	
Flunisolide Nasal Solution 25 MCG/ACT (0.025%)	T1	PA
Fluocinolone Acetonide Body	T1	
Fluocinolone Acetonide External	T1	
Fluocinolone Acetonide Scalp	T1	
Fluorometholone Ophthalmic	T1	
Fluticasone Furoate Ellipta	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT	T1	
Fluticasone Propionate Diskus	T1	
Fluticasone Propionate HFA	T1	
Fluticasone Propionate Nasal	T1	
Fluticasone-Salmeterol Inhalation Aerosol	T1	PA
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT	T1	
FML FORTE (***Fluorometholone***)	T1	
Hydrocortisone (Perianal)	T1	
Hydrocortisone Ace-Pramoxine External Cream 1-1 %	T1	
Hydrocortisone Acetate Rectal	T1	
Hydrocortisone Butyrate External Cream	T1	PA
Hydrocortisone Butyrate External Ointment	T1	PA
Hydrocortisone Butyrate External Solution	T1	PA
Hydrocortisone External Cream 1 %, 2.5 %	T1	
Hydrocortisone External Lotion 2.5 %	T1	
Hydrocortisone External Ointment 1 %, 2.5 %	T1	
Hydrocortisone Oral	T1	
Hydrocortisone Rectal Enema	T1	
Hydrocortisone Valerate	T1	PA
Hydrocortisone-Acetic Acid	T1	
Hydrocort-Pramoxine (Perianal)	T1	
Loteprednol Etabonate Ophthalmic Suspension 0.5 %	T1	
MAXIDEX (***Dexamethasone***)	T1	
Mometasone Furoate External	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Neomycin-Polymyxin-Dexameth	T1	
Neomycin-Polymyxin-HC Ophthalmic Suspension 3.5-10000-1	T1	
Neomycin-Polymyxin-HC Otic	T1	
PRED MILD (***PrednisoLONE Acetate***)	T1	
prednisoLONE Acetate Ophthalmic	T1	
prednisoLONE Oral Solution	T1	
prednisoLONE Oral Tablet	T1	
PrednisoLONE Sodium Phosphate Ophthalmic	T1	
prednisoLONE Sodium Phosphate Oral Solution 15 MG/5ML, 5 MG/5ML	T1	
PROCTOFOAM HC EXTERNAL (***Hydrocortisone Ace-Pramoxine***)	T1	PA
Hydrocortisone (Procto-Med Hc External)	T1	
Hydrocortisone (Proctosol Hc External)	T1	
Hydrocortisone (Proctozone-Hc External)	T1	
Sulfacetamide-prednisoLONE Ophthalmic Solution	T1	
TEXACORT (***Hydrocortisone***)	T1	
TOBRADEX OPHTHALMIC OINTMENT (***Tobramycin-Dexamethasone***)	T1	
Tobramycin-Dexamethasone	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***Fluticasone-Umeclidin-Vilant***)	T1	PA
Fluticasone-Salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
ZYLET (***Loteprednol-Tobramycin***)	T1	
Eent Anti-Inflammatory Agents, Misc.		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CEQUA (***CycloSPORINE***)	T1	PA
cycloSPORINE (PF)	T1	PA
XIIDRA (***Lifitegrast***)	T1	PA
Eent Drugs, Miscellaneous		
Acetic Acid Otic	T1	
AMVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE (***Sodium Hyaluronate***)	T1	
Apraclonidine HCl	T1	
Carteolol HCl	T1	
Cromolyn Sodium Inhalation	T1	
Cromolyn Sodium Ophthalmic	T1	
Cromolyn Sodium Oral	T1	
DEBACTEROL (***Sulfuric Acid-Sulf Phenolics***)	T1	
GELFILM OPHTHALMIC (***Gelatin Adsorbable***)	T1	PA
Hydrocortisone-Acetic Acid	T1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (***Apraclonidine HCl***)	T1	
Ipratropium Bromide Nasal	T1	
Polysorbate 80	T1	
TYRVAYA (***Varenicline Tartrate***)	T1	PA
Eent Nonsteroidal Anti-Inflam. Agents		
Diclofenac Sodium Ophthalmic	T1	
Flurbiprofen Oral Tablet 100 MG	T1	PA
Flurbiprofen Sodium	T1	
Ketorolac Tromethamine Intramuscular Solution 60 MG/2ML	T1	
Ketorolac Tromethamine Ophthalmic	T1	
Ketorolac Tromethamine Oral	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Local Anesthetics (Eent)		
Lidocaine HCl (Glydo External Prefilled Syringe)	T1	
Lidocaine HCl External Solution	T1	PA
Lidocaine HCl Urethral/Mucosal External Prefilled Syringe	T1	
Lidocaine Viscous HCl	T1	
Proparacaine HCl Ophthalmic	T1	
Tetracaine HCl Ophthalmic	T1	
Miotics		
MIOCHOL-E (***Acetylcholine Chloride***)	T1	PA
MIOSTAT (***Carbachol***)	T1	PA
Pilocarpine HCl Ophthalmic Solution 1 %, 2 %, 4 %	T1	
Pilocarpine HCl Oral Tablet 5 MG	T1	
Pilocarpine HCl Oral Tablet 7.5 MG	T1	PA
Mydriatics		
Atropine Sulfate Injection Solution 8 MG/20ML	T1	
Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML	T1	
Atropine Sulfate Ophthalmic Solution 1 %	T1	
CYCLOMYDRIL (***Cyclopentolate-Phenylephrine***)	T1	
Cyclopentolate HCl Ophthalmic Solution 1 %	T1	
EPINEPHrine Injection Solution 1 MG/ML	T1	
EPINEPHrine PF Injection Solution	T1	
HOMATROPAIRE (***Homatropine HBr***)	T1	
Phenylephrine HCl Ophthalmic Solution 10 %, 2.5 %	T1	
Tropicamide Ophthalmic	T1	
Prostaglandin Analogs		
Bimatoprost Ophthalmic	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Latanoprost Ophthalmic	T1	
ROCKLATAN (***Netarsudil-Latanoprost***)	T1	PA
Travoprost (BAK Free)	T1	PA
Rho Kinase Inhibitors		
ROCKLATAN (***Netarsudil-Latanoprost***)	T1	PA
Vasoconstrictors		
CYCLOMYDRIL (***Cyclopentolate-Phenylephrine***)	T1	
EPINEPHrine Injection Solution 1 MG/ML	T1	
EPINEPHrine PF Injection Solution	T1	
Phenylephrine HCl Ophthalmic Solution 10 %, 2.5 %	T1	
Gastrointestinal Drugs		
5-Ht3 Receptor Antagonists		
AKYNZEO ORAL (***Netupitant-Palonosetron***)	T1	PA
Granisetron HCl Intravenous Solution 1 MG/ML, 4 MG/4ML	T1	PA
Granisetron HCl Oral	T1	ST; QL (12 EA per 30 days)
Ondansetron HCl Oral Solution 4 MG/5ML	T1	
Ondansetron HCl Oral Tablet 4 MG, 8 MG	T1	
Ondansetron Oral Tablet Dispersible 4 MG, 8 MG	T1	
Antacids And Adsorbents		
Magnesium Oral Tablet 400 MG	T1	
Magnesium Oxide Oral Tablet 400 MG	T1	
Omeprazole-Sodium Bicarbonate Oral Capsule 20-1100 MG	T1	
Antidiarrhea Agents		
Diphenoxylate-Atropine Oral Liquid	T1	
Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Loperamide HCl Oral Capsule	T1	
MOTOFEN (***Difenoxin-Atropine***)	T1	
Opium	T1	PA
Antiemetics, Miscellaneous		
AKYNZEO ORAL (***Netupitant-Palonosetron***)	T1	PA
Dronabinol	T1	PA
OLANZapine Oral Tablet	T1	QL (30 EA per 30 days)
Promethazine HCl Oral Solution 6.25 MG/5ML	T1	
Promethazine HCl Oral Tablet	T1	
Promethazine HCl Rectal Suppository 12.5 MG, 25 MG	T1	
Promethazine HCl (Promethegan)	T1	
Antihistamines (Gi Drugs)		
Prochlorperazine (Compro)	T1	
Meclizine HCl Oral Tablet 12.5 MG, 25 MG	T1	
Meclizine HCl Oral Tablet Chewable	T1	
Prochlorperazine	T1	
Prochlorperazine Maleate Oral	T1	
TIGAN INTRAMUSCULAR (***Trimethobenzamide HCl***)	T1	
Trimethobenzamide HCl Oral	T1	
Anti-Inflammatory Agents (Gi Drugs)		
Alosetron HCl	T1	PA
Balsalazide Disodium	T1	
Mesalamine ER Oral Capsule Extended Release 24 Hour	T1	
Mesalamine Oral	T1	
Mesalamine Rectal	T1	
sulfaSALAzine Oral	T1	
Antiulcer Agents And Acid Suppressants		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Amoxicillin Oral Capsule	T1	
Amoxicillin Oral Suspension Reconstituted	T1	
Amoxicillin Oral Tablet	T1	
Amoxicillin Oral Tablet Chewable 125 MG, 250 MG	T1	
Clarithromycin ER	T1	PA
Clarithromycin Oral Suspension Reconstituted	T1	PA
Clarithromycin Oral Tablet	T1	
Magnesium Oxide Oral Tablet 400 MG	T1	
metroNIDAZOLE Oral Capsule	T1	
metroNIDAZOLE Oral Tablet 250 MG, 500 MG	T1	
Tetracycline HCl Oral Capsule	T1	
Cathartics And Laxatives		
GAVILYTE-C (***PEG 3350-KCl-NaBcb-NaCl-NaSulf***)	T1	
PEG 3350-KCl-NaBcb-NaCl-NaSulf (Gavilyte-G)	T1	
PEG 3350-KCl-Na Bicarb-NaCl (Gavilyte-N With Flavor Pack)	T1	
Lubiprostone	T1	PA
Na Sulfate-K Sulfate-Mg Sulf Oral Solution 17.5-3.13-1.6 GM/177ML	T1	
PEG 3350-KCl-Na Bicarb-NaCl	T1	
PEG-3350/Electrolytes	T1	
PLURONIC F127 POWDER (***Poloxamer***)	T1	
Sorbitol Solution 70 %	T1	
SUTAB (***Sodium Sulfate-Mag Sulfate-KCl***)	T1	
Chloride Channel Activators		
Lubiprostone	T1	PA
Cholelitholytic Agents		
Ursodiol Oral Capsule 300 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ursodiol Oral Tablet	T1	
Digestants		
CREON (***Pancrelipase (Lip-Prot-Amyl)***)	T1	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (***Pancrelipase (Lip-Prot-Amyl)***)	T1	
Dopamine Receptor Antagonists		
Promethazine HCl Rectal Suppository 12.5 MG, 25 MG	T1	
Promethazine HCl (Promethegan)	T1	
Gi Drugs, Miscellaneous		
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML	T1	QL (4 EA per 28 days)
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Pen)	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Syringe)	T1	QL (2 EA per 28 days)
Adalimumab-aaty CD/UC/HS Start	T1	QL (2 EA per 28 days)
Adalimumab-bwwd	T1	QL (1 ML per 28 days)
Adalimumab-fkjp (2 Pen)	T1	QL (4 EA per 28 days)
Adalimumab-fkjp (2 Syringe)	T1	QL (4 EA per 28 days)
AVSOLA (***inFLIXimab-axxq***)	T1	PA
Dronabinol	T1	PA
ENTYVIO INTRAVENOUS (***Vedolizumab***)	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
IBSRELA (***Tenapanor HCl***)	T1	PA
INFLECTRA (***InFLIXimab-dyyb***)	T1	PA
inFLIXimab	T1	PA
LINZESS (***Linaclotide***)	T1	PA
Lubiprostone	T1	PA
MOVANTIK (***Naloxegol Oxalate***)	T1	PA
Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML	T1	
Prucalopride Succinate	T1	PA
RELISTOR ORAL (***Methylnaltrexone Bromide***)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***Methylnaltrexone Bromide***)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Methylnaltrexone Bromide***)	T1	PA
RENFLEXIS (***InFLIXimab-abda***)	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (***Golimumab***)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Golimumab***)	T1	PA
SYMPROIC (***Naldemedine Tosylate***)	T1	PA
TRULANCE (***Plecanatide***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Guanylate Cyclase C (Gcc) Recept Agonist		
LINZESS (***Linaclotide***)	T1	PA
TRULANCE (***Plecanatide***)	T1	PA
Histamine H2-Antagonists		
Cimetidine Oral	T1	
Famotidine Oral Suspension Reconstituted	T1	
Famotidine Oral Tablet 20 MG, 40 MG	T1	
Immunomodulatory Agents (56:44)		
ENTYVIO INTRAVENOUS (***Vedolizumab***)	T1	PA
Lipotropic Agents		
B Complex Formula 1 (Lipotrop)	T1	
B Complex-C Oral Tablet	T1	
Neurokinin-1 Receptor Antagonists		
AKYNZEO ORAL (***Netupitant-Palonosetron***)	T1	PA
Aprepitant Oral Capsule 125 MG, 80 MG	T1	QL (30 EA per 30 days)
Aprepitant Oral Capsule 40 MG	T1	QL (1 EA per 30 days)
Aprepitant Oral Capsule Therapy Pack	T1	QL (30 EA per 30 days)
Opioid Antagonists (56:18)		
MOVANTIK (***Naloxegol Oxalate***)	T1	PA
RELISTOR ORAL (***Methylnaltrexone Bromide***)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (***Methylnaltrexone Bromide***)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Methylnaltrexone Bromide***)	T1	PA
SYMPROIC (***Naldemedine Tosylate***)	T1	PA
Prokinetic Agents		
Metoclopramide HCl +RFID	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Metoclopramide HCl Injection	T1	
Metoclopramide HCl Oral Solution 10 MG/10ML, 5 MG/5ML	T1	
Metoclopramide HCl Oral Tablet	T1	
Prostaglandins		
miSOPROStol Oral	T1	
Protectants		
Sucralfate Oral	T1	
Proton-Pump Inhibitors		
Amoxicill-Clarithro-Lansopraz Oral Therapy Pack	T1	PA
Esomeprazole Magnesium Oral Capsule Delayed Release	T1	
Lansoprazole Oral Capsule Delayed Release	T1	
Lansoprazole Oral Tablet Delayed Release Dispersible 15 MG	T1	
Lansoprazole Oral Tablet Delayed Release Dispersible 30 MG	T1	QL (30 EA per 30 days); AL (Max 9 Years)
Omeprazole Oral Capsule Delayed Release 10 MG, 20 MG	T1	
Omeprazole Oral Capsule Delayed Release 40 MG	T1	QL (60 EA per 30 days)
Omeprazole-Sodium Bicarbonate Oral Capsule 20-1100 MG	T1	
Pantoprazole Sodium Intravenous	T1	PA
Pantoprazole Sodium Oral Tablet Delayed Release	T1	
RABEprazole Sodium Oral Tablet Delayed Release	T1	
Heavy Metal Antagonists		
Heavy Metal Antagonists		
CHEMET (***Succimer***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Deferasirox	T1	PA
Deferasirox Granules	T1	PA
Deferiprone	T1	PA
Deferoxamine Mesylate	T1	PA
FERRIPROX ORAL SOLUTION (***Deferiprone***)	T1	PA
FERRIPROX TWICE-A-DAY (***Deferiprone***)	T1	PA
GALZIN (***Zinc Acetate (Oral)***)	T1	PA
penicillAMINE Oral	T1	PA
Pentetate Calcium Trisodium	T1	
Pentetate Zinc Trisodium	T1	
Trientine HCl Oral Capsule 250 MG	T1	PA
Hormones And Synthetic Substitutes		
Adrenals		
Ala-Cort External Cream 1 %	T1	
Anucort-HC	T1	
ANUSOL-HC EXTERNAL (***Hydrocortisone***)	T1	
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (***Mometasone Furoate***)	T1	
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (***Mometasone Furoate***)	T1	
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT (***Mometasone Furoate***)	T1	
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (***Mometasone Furoate***)	T1	
ASMANEX HFA (***Mometasone Furoate***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Betamethasone Dipropionate Aug External Cream	T1	
Betamethasone Dipropionate Aug External Gel	T1	
Betamethasone Dipropionate Aug External Lotion	T1	PA
Betamethasone Dipropionate Aug External Ointment	T1	PA
Betamethasone Dipropionate External	T1	
Betamethasone Valerate External Cream	T1	
Betamethasone Valerate External Foam	T1	PA
Betamethasone Valerate External Lotion	T1	
Betamethasone Valerate External Ointment	T1	
BREZTRI AEROSPHERE (***Budeson-Glycopyrrol-Formoterol***)	T1	PA
Budesonide ER Oral Tablet Extended Release 24 Hour	T1	PA
Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML	T1	QL (120 ML per 30 days)
Budesonide Inhalation Suspension 1 MG/2ML	T1	QL (60 ML per 30 days)
Budesonide Oral	T1	QL (90 EA per 30 days)
Budesonide-Formoterol Fumarate	T1	QL (20.4 GM per 30 days)
CORTANE-B EXTERNAL (***HC-Pramoxine-Chloroxylenol***)	T1	
CORTIFOAM EXTERNAL (***Hydrocortisone Acetate***)	T1	PA
DEXAMETHASONE INTENSOL (***Dexamethasone***)	T1	
Dexamethasone Oral Elixir	T1	
Dexamethasone Oral Solution	T1	
Dexamethasone Oral Tablet	T1	
Dexamethasone Oral Tablet Therapy Pack 1.5 MG (51)	T1	
DULERA (***Mometasone Furo-Formoterol Fum***)	T1	
Fludrocortisone Acetate Oral	T1	
Flunisolide Nasal Solution 25 MCG/ACT (0.025%)	T1	PA
Fluticasone Furoate Ellipta	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT	T1	
Fluticasone Propionate Diskus	T1	
Fluticasone Propionate External Cream	T1	
Fluticasone Propionate External Ointment	T1	
Fluticasone Propionate HFA	T1	
Fluticasone Propionate Nasal	T1	
Fluticasone-Salmeterol Inhalation Aerosol	T1	PA
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT	T1	
Hydrocortisone (Perianal)	T1	
Hydrocortisone Ace-Pramoxine External Cream 1-1 %	T1	
Hydrocortisone Acetate Rectal	T1	
Hydrocortisone Butyrate External Cream	T1	PA
Hydrocortisone Butyrate External Ointment	T1	PA
Hydrocortisone Butyrate External Solution	T1	PA
Hydrocortisone External Cream 1 %, 2.5 %	T1	
Hydrocortisone External Lotion 2.5 %	T1	
Hydrocortisone External Ointment 1 %, 2.5 %	T1	
Hydrocortisone Oral	T1	
Hydrocortisone Rectal Enema	T1	
Hydrocortisone Valerate	T1	PA
Hydrocortisone-Acetic Acid	T1	
Hydrocort-Pramoxine (Perianal)	T1	
MEDROL ORAL TABLET 2 MG (***MethylPREDNISolone***)	T1	
methylPREDNISolone Oral	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Mometasone Furoate External	T1	
PRED MILD (***PrednisoLONE Acetate***)	T1	
prednisoLONE Acetate Ophthalmic	T1	
prednisoLONE Oral Solution	T1	
prednisoLONE Oral Tablet	T1	
PrednisoLONE Sodium Phosphate Ophthalmic	T1	
prednisoLONE Sodium Phosphate Oral Solution 15 MG/5ML, 5 MG/5ML	T1	
PREDNISONE INTENSOL (***PredniSONE***)	T1	
PredniSONE Oral Solution	T1	
predniSONE Oral Tablet	T1	
predniSONE Oral Tablet Therapy Pack	T1	
PROCTOFOAM HC EXTERNAL (***Hydrocortisone Ace-Pramoxine***)	T1	PA
Hydrocortisone (Procto-Med Hc External)	T1	
Hydrocortisone (Proctosol Hc External)	T1	
Hydrocortisone (Proctozone-Hc External)	T1	
PULMICORT FLEXHALER (***Budesonide***)	T1	
QVAR REDIHALER (***Beclomethasone Diprop HFA***)	T1	
TEXACORT (***Hydrocortisone***)	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***Fluticasone-Umeclidin-Vilant***)	T1	PA
Triamcinolone Acetonide External Aerosol Solution	T1	PA
Triamcinolone Acetonide External Cream	T1	
Triamcinolone Acetonide External Lotion	T1	
Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %	T1	
Triamcinolone Acetonide External Ointment 0.05 %	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Triamcinolone in Absorbase	T1	PA
Triamcinolone Acetonide (Triderm External Cream 0.5 %)	T1	
Fluticasone-Salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Alpha-Glucosidase Inhibitors		
Acarbose Oral	T1	
Miglitol	T1	ST
Androgens		
COVARYX (***Est Estrogens-Methyltest***)	T1	
COVARYX HS (***Est Estrogens-Methyltest***)	T1	
Danazol Oral	T1	PA
EEMT (***Est Estrogens-Methyltest***)	T1	
EEMT HS (***Est Estrogens-Methyltest***)	T1	
Est Estrogens-Methyltest DS	T1	
Est Estrogens-Methyltest HS	T1	
Est Estrogens-Methyltest Oral Tablet 1.25-2.5 MG	T1	
methylTESTOSTERone Oral	T1	PA
Testosterone Cypionate Injection Solution 200 MG/ML	T1	QL (4 ML per 28 days)
Testosterone Cypionate Intramuscular Solution 200 MG/ML	T1	QL (4 ML per 28 days)
Testosterone Enanthate Intramuscular Solution	T1	
Testosterone Transdermal Gel 12.5 MG/ACT (1%), 25 MG/2.5GM (1%), 50 MG/5GM (1%)	T1	PA
Antiestrogens		
Anastrozole Oral	T1	QL (30 EA per 30 days)
Exemestane	T1	
Letrozole Oral	T1	QL (30 EA per 30 days)

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antigonadtropins		
Cetrorelix Acetate	T1	PA
ECONTRA ONE-STEP (***Levonorgestrel***)	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***Degarelix Acetate***)	T1	QL (1 EA per 30 days)
Ganirelix Acetate Subcutaneous Solution Prefilled Syringe	T1	PA
HER STYLE (***Levonorgestrel***)	T1	
KYLEENA (***Levonorgestrel***)	T1	
Levonorgestrel Oral Tablet 1.5 MG	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (***Levonorgestrel***)	T1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/DAY (***Levonorgestrel***)	T1	
MY CHOICE (***Levonorgestrel***)	T1	
MY WAY (***Levonorgestrel***)	T1	
NEW DAY (***Levonorgestrel***)	T1	
NEXPLANON (***Etonogestrel***)	T1	
OPCICON ONE-STEP (***Levonorgestrel***)	T1	
OPTION 2 (***Levonorgestrel***)	T1	
ORILISSA (***Elagolix Sodium***)	T1	PA
SKYLA (***Levonorgestrel***)	T1	
SLYND (***Drospirenone***)	T1	
Testosterone Cypionate Injection Solution 200 MG/ML	T1	QL (4 ML per 28 days)
Testosterone Cypionate Intramuscular Solution 200 MG/ML	T1	QL (4 ML per 28 days)
Testosterone Enanthate Intramuscular Solution	T1	
Testosterone Transdermal Gel 12.5 MG/ACT (1%), 25 MG/2.5GM (1%), 50 MG/5GM (1%)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihypoglycemic Agents, Miscellaneous		
Diazoxide Oral	T1	PA
Antiparathyroid Agents		
Calcitonin (Salmon) Nasal	T1	
Antithyroid Agents		
Iodine Strong Oral	T1	
methIMAzole Oral	T1	
Propylthiouracil Oral	T1	
Biguanides		
Alogliptin-metFORMIN HCl	T1	ST
glipiZIDE-metFORMIN HCl	T1	
GlyBURIDE-MetFORMIN Oral Tablet 1.25-250 MG	T1	PA
glyBURIDE-metFORMIN Oral Tablet 2.5-500 MG, 5-500 MG	T1	
INVOKAMET (***Canagliflozin-Metformin HCl***)	T1	QL (60 EA per 30 days)
JANUMET (***SITagliptin Phos-metFORMIN HCl***)	T1	ST
JANUMET XR (***SITagliptin Phos-metFORMIN HCl***)	T1	ST
metFORMIN HCl ER	T1	
metFORMIN HCl Oral Tablet 1000 MG, 500 MG, 850 MG	T1	
SYNJARDY (***Empagliflozin-Metformin HCl***)	T1	QL (60 EA per 30 days)
SYNJARDY XR (***Empagliflozin-Metformin HCl***)	T1	QL (30 EA per 30 days)
XIGDUO XR (***Dapagliflozin Base-metFORMIN***)	T1	QL (30 EA per 30 days)
Contraceptives		
Levonorgestrel-Ethinyl Estrad (Afirmelle)	T1	
Levonorgestrel-Ethinyl Estrad (Altavera)	T1	
Alyacen 1/35	T1	
Alyacen 7/7/7	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANNOVERA (***Segesterone-Ethinyl Estradiol***)	T1	
Desogestrel-Ethinyl Estradiol (Apri)	T1	
ARANELLE (***Norethin-Eth Estrad Triphasic***)	T1	
Levonorgestrel-Ethinyl Estrad (Aubra Eq)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1/20)	T1	
AVERI (***Desogestrel-Eth Estrad-FE***)	T1	
Levonorgestrel-Ethinyl Estrad (Aviane)	T1	
Levonorgestrel-Ethinyl Estrad (Ayuna)	T1	
Desogestrel-Ethinyl Estradiol (Azurette)	T1	
Norethindrone-Eth Estradiol (Balziva)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1/20)	T1	
Briellyn	T1	
Levonorgestrel-Ethinyl Estrad (Chateal Eq)	T1	
Norgestrel-Ethinyl Estradiol (Cryselle)	T1	
Norgestrel-Ethinyl Estradiol (Cryselle-28)	T1	
Desogestrel-Ethinyl Estradiol (Cyred Eq)	T1	
Norethindrone-Eth Estradiol (Dasetta 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Dasetta 7/7/7)	T1	
Norethindrone (Deblitane)	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (***MedroxyPROGESTERone Acetate***)	T1	PA
Desogestrel-Ethinyl Estradiol Oral Tablet 0.15-0.02/0.01 MG (21/5)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Drospiren-Eth Estrad-Levomefol	T1	
Drospirenone-Ethinyl Estradiol	T1	
ECONTRA ONE-STEP (***Levonorgestrel***)	T1	
Norgestrel-Ethinyl Estradiol (Elinest)	T1	
ELLA (***Ulipristal Acetate***)	T1	
Etonogestrel-Ethinyl Estradiol (Eluryng)	T1	
Desogestrel-Ethinyl Estradiol (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
Norgestimate-Eth Estradiol (Estarylla)	T1	
Etonogestrel-Ethinyl Estradiol	T1	
Levonorgestrel-Ethinyl Estrad (Falmina)	T1	
Norethin Ace-Eth Estrad-FE (Feirza 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Feirza 1/20)	T1	
FEMLYV (***Norethindrone Acet-Ethinyl Est***)	T1	
Norethin-Eth Estradiol-Fe (Galbriela)	T1	
Norethindrone Acet-Ethinyl Est (Hailey 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Hailey Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Hailey Fe 1/20)	T1	
Norethindrone (Heather)	T1	
HER STYLE (***Levonorgestrel***)	T1	
Levonorgest-Eth Estrad 91-Day (Iclevia)	T1	
Norethindrone (Incassia)	T1	
Desogestrel-Ethinyl Estradiol (Isibloom)	T1	
Drospirenone-Ethinyl Estradiol (Jasmiel)	T1	
Levonorgest-Eth Estrad 91-Day (Jolessa)	T1	
Desogestrel-Ethinyl Estradiol (Juleber)	T1	
Norethindrone Acet-Ethinyl Est (Junel 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Junel 1/20)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethin Ace-Eth Estrad-FE (Junel Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Junel Fe 1/20)	T1	
Desogestrel-Ethinyl Estradiol (Kalliga)	T1	
Desogestrel-Ethinyl Estradiol (Kariva)	T1	
Ethynodiol Diac-Eth Estradiol (Kelnor 1/35)	T1	
KYLEENA (***Levonorgestrel***)	T1	
Norethindrone Acet-Ethinyl Est (Larin 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Larin 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Larin Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Larin Fe 1/20)	T1	
Levonorgestrel-Ethinyl Estrad (Lessina)	T1	
Levonorg-Eth Estrad Triphasic (Levonest)	T1	
Levonorgest-Eth Estrad 91-Day	T1	
Levonorgest-Eth Estradiol-Iron	T1	
Levonorgestrel Oral Tablet 1.5 MG	T1	
Levonorgestrel-Ethinyl Estrad	T1	
Levonorg-Eth Estrad Triphasic Oral Tablet 50-30/75-40/ 125-30 MCG	T1	
Levonorgestrel-Ethinyl Estrad (Levora 0.15/30 (28))	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (***Levonorgestrel***)	T1	
LO LOESTRIN FE (***Norethin-Eth Estrad-Fe Biphas***)	T1	
Drospirenone-Ethinyl Estradiol (Loryna)	T1	
Norgestrel-Ethinyl Estradiol (Low-Ogestrel)	T1	
Drospirenone-Ethinyl Estradiol (Lo-Zumandimine)	T1	
Norethindrone (Lyleq)	T1	
Norethindrone (Lyza)	T1	
Marlissa	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
medroxyPROGESTERone Acetate Intramuscular	T1	
Norethindrone Acet-Ethinyl Est (Microgestin 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Microgestin 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Microgestin Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Microgestin Fe 1/20)	T1	
Norgestimate-Eth Estradiol (Mili)	T1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/DAY (***Levonorgestrel***)	T1	
Norgestimate-Eth Estradiol (Mono-Linyah)	T1	
MY CHOICE (***Levonorgestrel***)	T1	
MY WAY (***Levonorgestrel***)	T1	
NATAZIA (***Estradiol Valerate-Dienogest***)	T1	
Norethindrone-Eth Estradiol (Necon 0.5/35 (28))	T1	
NEW DAY (***Levonorgestrel***)	T1	
NEXPLANON (***Etonogestrel***)	T1	
NEXTSTELLIS (***Drospirenone-Estetrol***)	T1	
Drospirenone-Ethinyl Estradiol (Nikki)	T1	
Norethindrone (Nora-Be)	T1	
Norelgestromin-Eth Estradiol	T1	
Norethin Ace-Eth Estrad-FE Oral Capsule	T1	
Norethin Ace-Eth Estrad-FE Oral Tablet Chewable	T1	
Norethindrone Acet-Ethinyl Est Oral Tablet 1-20 MG-MCG	T1	
Norethindrone Oral	T1	
Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG	T1	
Norgestim-Eth Estrad Triphasic	T1	
Norethindrone (Norlyda)	T1	
Norethindrone-Eth Estradiol (Nortrel 0.5/35 (28))	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethindrone-Eth Estradiol (Nortrel 1/35 (21))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Nortrel 7/7/7)	T1	
Norethindrone-Eth Estradiol (Nylia 1/35)	T1	
Norethin-Eth Estrad Triphasic (Nylia 7/7/7)	T1	
OPCICON ONE-STEP (***Levonorgestrel***)	T1	
OPILL (***Norgestrel***)	T1	
OPTION 2 (***Levonorgestrel***)	T1	
Levonorgestrel-Ethinyl Estrad (Orsythia)	T1	
Norethindrone-Eth Estradiol (Philith)	T1	
Desogestrel-Ethinyl Estradiol (Pimtrea)	T1	
Norethin-Eth Estrad Triphasic (Pirmella 7/7/7)	T1	
Levonorgestrel-Ethinyl Estrad (Portia-28)	T1	
Desogestrel-Ethinyl Estradiol (Reclipsen)	T1	
Levonorgest-Eth Estrad 91-Day (Rosyrah)	T1	
Levonorgest-Eth Estrad 91-Day (Setlakin)	T1	
Norethindrone (Sharobel)	T1	
Desogestrel-Ethinyl Estradiol (Simliya)	T1	
SKYLA (***Levonorgestrel***)	T1	
SLYND (***Drospirenone***)	T1	
Norgestimate-Eth Estradiol (Sprintec 28)	T1	
Levonorgestrel-Ethinyl Estrad (Sronyx)	T1	
Drospirenone-Ethinyl Estradiol (Syeda)	T1	
Norethin Ace-Eth Estrad-FE (Tarina Fe 1/20 Eq)	T1	
Norethindron-Ethinyl Estrad-Fe (Tilia Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri Femynor)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Estarylla)	T1	
Norethindron-Ethinyl Estrad-Fe (Tri-Legest Fe)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norgestim-Eth Estrad Triphasic (Tri-Linyah)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Estarylla)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Marzia)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Sprintec)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Sprintec)	T1	
Levonorg-Eth Estrad Triphasic (Trivora (28))	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra Lo)	T1	
TWIRLA (***Levonorgestrel-Eth Estradiol***)	T1	
TYBLUME ORAL TABLET CHEWABLE (***Levonorgestrel-Ethinyl Estrad***)	T1	
Ethynodiol Diac-Eth Estradiol (Valtya 1/35)	T1	
VALTYA 1/50 (***Ethynodiol Diac-Eth Estradiol***)	T1	
VELIVET (***Desogestrel-Ethinyl Estradiol***)	T1	
Drospirenone-Ethinyl Estradiol (Vestura)	T1	
Levonorgestrel-Ethinyl Estrad (Vienva)	T1	
Viorele	T1	
Desogestrel-Ethinyl Estradiol (Volnea)	T1	
Norgestimate-Eth Estradiol (Vylibra)	T1	
Norethindrone-Eth Estradiol (Wera)	T1	
Norethin-Eth Estradiol-Fe (Xelria Fe)	T1	
Ethynodiol Diac-Eth Estradiol (Zovia 1/35 (28))	T1	
Drospirenone-Ethinyl Estradiol (Zumandimine)	T1	
Dipeptidyl Peptidase-4(Dpp-4) Inhibitors		
Alogliptin Benzoate	T1	ST
Alogliptin-metFORMIN HCl	T1	ST

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alogliptin-Pioglitazone Oral Tablet 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	T1	ST
JANUMET (***SITagliptin Phos-metFORMIN HCl***)	T1	ST
JANUMET XR (***SITagliptin Phos-metFORMIN HCl***)	T1	ST
JANUVIA (***SitaGLIPtin Phosphate***)	T1	ST
Estrogen Agonist-Antagonists		
clomiPHENE Citrate Oral	T1	PA
Raloxifene HCl	T1	
Tamoxifen Citrate Oral	T1	
Toremifene Citrate	T1	
Estrogens		
Levonorgestrel-Ethinyl Estrad (Afirmelle)	T1	
Levonorgestrel-Ethinyl Estrad (Altavera)	T1	
Alyacen 1/35	T1	
Alyacen 7/7/7	T1	
ANNOVERA (***Segesterone-Ethinyl Estradiol***)	T1	
Desogestrel-Ethinyl Estradiol (Apri)	T1	
ARANELLE (***Norethin-Eth Estrad Triphasic***)	T1	
Levonorgestrel-Ethinyl Estrad (Aubra Eq)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1/20)	T1	
AVERI (***Desogestrel-Eth Estrad-FE***)	T1	
Levonorgestrel-Ethinyl Estrad (Aviane)	T1	
Levonorgestrel-Ethinyl Estrad (Ayuna)	T1	
Desogestrel-Ethinyl Estradiol (Azurette)	T1	
Norethindrone-Eth Estradiol (Balziva)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1/20)	T1	
Briellyn	T1	
Levonorgestrel-Ethinyl Estrad (Chateal Eq)	T1	
CLIMARA PRO (***Estradiol-Levonorgestrel***)	T1	PA
COMBIPATCH (***Estradiol-Norethindrone Acet***)	T1	ST
COVARYX (***Est Estrogens-Methyltest***)	T1	
COVARYX HS (***Est Estrogens-Methyltest***)	T1	
Norgestrel-Ethinyl Estradiol (Cryselle)	T1	
Norgestrel-Ethinyl Estradiol (Cryselle-28)	T1	
Desogestrel-Ethinyl Estradiol (Cyred Eq)	T1	
Norethindrone-Eth Estradiol (Dasetta 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Dasetta 7/7/7)	T1	
DEPO-ESTRADIOL (***Estradiol Cypionate***)	T1	PA
Desogestrel-Ethinyl Estradiol Oral Tablet 0.15-0.02/0.01 MG (21/5)	T1	
Estradiol (Dotti)	T1	QL (8 EA per 28 days)
Drospiren-Eth Estrad-Levomefol	T1	
Drospirenone-Ethinyl Estradiol	T1	
EEMT (***Est Estrogens-Methyltest***)	T1	
EEMT HS (***Est Estrogens-Methyltest***)	T1	
Norgestrel-Ethinyl Estradiol (Elinest)	T1	
Etonogestrel-Ethinyl Estradiol (Eluryng)	T1	
Desogestrel-Ethinyl Estradiol (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
Est Estrogens-Methyltest DS	T1	
Est Estrogens-Methyltest HS	T1	
Est Estrogens-Methyltest Oral Tablet 1.25-2.5 MG	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norgestimate-Eth Estradiol (Estarylla)	T1	
Estradiol Oral	T1	
Estradiol Transdermal Gel 0.75 MG/1.25 GM (0.06%)	T1	
Estradiol Transdermal Patch Twice Weekly	T1	QL (8 EA per 28 days)
Estradiol Transdermal Patch Weekly	T1	
Estradiol Vaginal Cream 0.01 %	T1	
Estradiol Vaginal Tablet	T1	
Estradiol Valerate Intramuscular	T1	PA
Estradiol-Norethindrone Acet Oral Tablet 1-0.5 MG	T1	PA
Etonogestrel-Ethinyl Estradiol	T1	
Levonorgestrel-Ethinyl Estrad (Falmina)	T1	
Norethin Ace-Eth Estrad-FE (Feirza 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Feirza 1/20)	T1	
FEMLYV (***Norethindrone Acet-Ethinyl Est***)	T1	
FEMRING (***Estradiol Acetate***)	T1	PA
Norethindrone-Eth Estradiol (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
Norethin-Eth Estradiol-Fe (Galbriela)	T1	
Norethindrone Acet-Ethinyl Est (Hailey 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Hailey Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Hailey Fe 1/20)	T1	
Levonorgest-Eth Estrad 91-Day (Iclevia)	T1	
Desogestrel-Ethinyl Estradiol (Isibloom)	T1	
Drospirenone-Ethinyl Estradiol (Jasmiel)	T1	
Norethindrone-Eth Estradiol (Jinteli)	T1	PA
Levonorgest-Eth Estrad 91-Day (Jolessa)	T1	
Desogestrel-Ethinyl Estradiol (Juleber)	T1	
Norethindrone Acet-Ethinyl Est (Junel 1.5/30)	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethindrone Acet-Ethinyl Est (Junel 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Junel Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Junel Fe 1/20)	T1	
Desogestrel-Ethinyl Estradiol (Kalliga)	T1	
Desogestrel-Ethinyl Estradiol (Kariva)	T1	
Ethynodiol Diac-Eth Estradiol (Kelnor 1/35)	T1	
Norethindrone Acet-Ethinyl Est (Larin 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Larin 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Larin Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Larin Fe 1/20)	T1	
Levonorgestrel-Ethinyl Estrad (Lessina)	T1	
Levonorg-Eth Estrad Triphasic (Levonest)	T1	
Levonorgest-Eth Estrad 91-Day	T1	
Levonorgest-Eth Estradiol-Iron	T1	
Levonorgestrel-Ethinyl Estrad	T1	
Levonorg-Eth Estrad Triphasic Oral Tablet 50-30/75-40/ 125-30 MCG	T1	
Levonorgestrel-Ethinyl Estrad (Levora 0.15/30 (28))	T1	
LO LOESTRIN FE (***Norethin-Eth Estrad-Fe Biphas***)	T1	
Drospirenone-Ethinyl Estradiol (Loryna)	T1	
Norgestrel-Ethinyl Estradiol (Low-Ogestrel)	T1	
Drospirenone-Ethinyl Estradiol (Lo-Zumandimine)	T1	
Estradiol (Lyllana)	T1	QL (8 EA per 28 days)
Marlissa	T1	
Norethindrone Acet-Ethinyl Est (Microgestin 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Microgestin 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Microgestin Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Microgestin Fe 1/20)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norgestimate-Eth Estradiol (Mili)	T1	
Estradiol-Norethindrone Acet (Mimvey)	T1	PA
Norgestimate-Eth Estradiol (Mono-Linyah)	T1	
NATAZIA (***Estradiol Valerate-Dienogest***)	T1	
Norethindrone-Eth Estradiol (Necon 0.5/35 (28))	T1	
NEXTSTELLIS (***Drospirenone-Estetrol***)	T1	
Drospirenone-Ethinyl Estradiol (Nikki)	T1	
Norelgestromin-Eth Estradiol	T1	
Norethin Ace-Eth Estrad-FE Oral Capsule	T1	
Norethin Ace-Eth Estrad-FE Oral Tablet Chewable	T1	
Norethindrone Acet-Ethinyl Est Oral Tablet 1-20 MG-MCG	T1	
Norethindrone-Eth Estradiol Oral Tablet 1-5 MG-MCG	T1	PA
Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG	T1	
Norgestim-Eth Estrad Triphasic	T1	
Norethindrone-Eth Estradiol (Nortrel 0.5/35 (28))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (21))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Nortrel 7/7/7)	T1	
Norethindrone-Eth Estradiol (Nylia 1/35)	T1	
Norethin-Eth Estrad Triphasic (Nylia 7/7/7)	T1	
Levonorgestrel-Ethinyl Estrad (Orsythia)	T1	
Norethindrone-Eth Estradiol (Philith)	T1	
Desogestrel-Ethinyl Estradiol (Pimtrea)	T1	
Norethin-Eth Estrad Triphasic (Pirmella 7/7/7)	T1	
Levonorgestrel-Ethinyl Estrad (Portia-28)	T1	
PREMARIN ORAL (***Estrogens Conjugated***)	T1	
PREMARIN VAGINAL (***Estrogens, Conjugated***)	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMPHASE (***Conj Estrog-Medroxyprogest Ace***)	T1	
PREMPRO (***Conj Estrog-Medroxyprogest Ace***)	T1	
Desogestrel-Ethinyl Estradiol (Reclipsen)	T1	
Levonorgest-Eth Estrad 91-Day (Rosyrah)	T1	
Levonorgest-Eth Estrad 91-Day (Setlakin)	T1	
Desogestrel-Ethinyl Estradiol (Simliya)	T1	
Norgestimate-Eth Estradiol (Sprintec 28)	T1	
Levonorgestrel-Ethinyl Estrad (Sronyx)	T1	
Drospirenone-Ethinyl Estradiol (Syeda)	T1	
Norethin Ace-Eth Estrad-FE (Tarina Fe 1/20 Eq)	T1	
Norethindron-Ethinyl Estrad-Fe (Tilia Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri Femynor)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Estarylla)	T1	
Norethindron-Ethinyl Estrad-Fe (Tri-Legest Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Linyah)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Estarylla)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Marzia)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Sprintec)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Sprintec)	T1	
Levonorg-Eth Estrad Triphasic (Trivora (28))	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra Lo)	T1	
TWIRLA (***Levonorgestrel-Eth Estradiol***)	T1	
TYBLUME ORAL TABLET CHEWABLE (***Levonorgestrel-Ethinyl Estrad***)	T1	
Ethynodiol Diac-Eth Estradiol (Valtya 1/35)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VALTYA 1/50 (***Ethynodiol Diac-Eth Estradiol***)	T1	
VELIVET (***Desogestrel-Ethinyl Estradiol***)	T1	
Drospirenone-Ethinyl Estradiol (Vestura)	T1	
Levonorgestrel-Ethinyl Estrad (Vienva)	T1	
Viorele	T1	
Desogestrel-Ethinyl Estradiol (Volnea)	T1	
Norgestimate-Eth Estradiol (Vylibra)	T1	
Norethindrone-Eth Estradiol (Wera)	T1	
Norethin-Eth Estradiol-Fe (Xelria Fe)	T1	
Estradiol (Yuvafem)	T1	
Ethynodiol Diac-Eth Estradiol (Zovia 1/35 (28))	T1	
Drospirenone-Ethinyl Estradiol (Zumandimine)	T1	
Glycogenolytic Agents		
BAQSIMI ONE PACK (***Glucagon***)	T1	
BAQSIMI TWO PACK (***Glucagon***)	T1	
Glucagon Emergency Injection Solution Reconstituted	T1	
Gonadotropins		
Chorionic Gonadotropin Intramuscular	T1	PA
ELIGARD (***Leuprolide Acetate (3 Month)***)	T1	
FOLLISTIM AQ SUBCUTANEOUS (***Follitropin Beta***)	T1	PA
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (***Follitropin Alfa***)	T1	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (***Follitropin Alfa***)	T1	PA
LUPRON DEPOT (1-MONTH) (***Leuprolide Acetate***)	T1	PA
LUPRON DEPOT (3-MONTH) (***Leuprolide Acetate (3 Month)***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT (4-MONTH) (***Leuprolide Acetate (4 Month)***)	T1	PA
LUPRON DEPOT-PED (1-MONTH) (***Leuprolide Acetate***)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (***Leuprolide Acetate (3 Month)***)	T1	PA
LUPRON DEPOT-PED (6-MONTH) (***Leuprolide Acetate (6 Month)***)	T1	PA
MENOPUR (***Menotropins***)	T1	PA
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (***Chorionic Gonadotropin***)	T1	PA
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Choriogonadotropin Alfa***)	T1	PA
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (***Triptorelin Pamoate***)	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (***Triptorelin Pamoate***)	T1	
ZOLADEX (***Goserelin Acetate***)	T1	
Gonadotropins And Antigonadotropins		
Chorionic Gonadotropin Intramuscular	T1	PA
ELIGARD (***Leuprolide Acetate (3 Month)***)	T1	
FOLLISTIM AQ SUBCUTANEOUS (***Follitropin Beta***)	T1	PA
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (***Follitropin Alfa***)	T1	PA
LUPRON DEPOT (1-MONTH) (***Leuprolide Acetate***)	T1	PA
LUPRON DEPOT (3-MONTH) (***Leuprolide Acetate (3 Month)***)	T1	PA
LUPRON DEPOT (4-MONTH) (***Leuprolide Acetate (4 Month)***)	T1	PA
LUPRON DEPOT-PED (1-MONTH) (***Leuprolide Acetate***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (***Leuprolide Acetate (3 Month)***)	T1	PA
MENOPUR (***Menotropins***)	T1	PA
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (***Chorionic Gonadotropin***)	T1	PA
ZOLADEX (***Goserelin Acetate***)	T1	
Incretin Mimetics		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Tirzepatide***)	T1	PA
OZEMPIC (***Semaglutide***)	T1	ST; QL (30 EA per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (***Semaglutide***)	T1	ST; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (***Semaglutide***)	T1	ST; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) (***Semaglutide***)	T1	ST; QL (3 ML per 28 days)
RYBELSUS (***Semaglutide***)	T1	ST; QL (30 EA per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Dulaglutide***)	T1	ST; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Liraglutide***)	T1	ST; QL (9 ML per 28 days)
Insulins		
APIDRA (***Insulin Glulisine***)	T1	QL (30 ML per 30 days)
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Glulisine***)	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin Lispro Prot & Lispro***)	T1	QL (20 ML per 30 days)
HUMALOG MIX 75/25 (***Insulin Lispro Prot & Lispro***)	T1	QL (30 ML per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (***Insulin Lispro***)	T1	QL (30 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN 70/30 (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
HUMULIN N (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
HUMULIN R (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Regular Human***)	T1	QL (12 ML per 30 days)
Insulin Asp Prot & Asp FlexPen	T1	QL (30 ML per 30 days)
Insulin Aspart FlexPen	T1	QL (30 ML per 30 days)
Insulin Lispro (1 Unit Dial)	T1	QL (30 ML per 30 days)
Insulin Lispro Prot & Lispro	T1	QL (30 ML per 30 days)
LANTUS (***Insulin Glargine***)	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Glargine***)	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
NOVOLIN 70/30 FLEXPEN (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
NOVOLIN N (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
NOVOLIN N FLEXPEN (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
NOVOLIN R (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
NOVOLIN R FLEXPEN (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
NOVOLIN R RELION (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG MIX 70/30 (***Insulin Aspart Prot & Aspart***)	T1	QL (20 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin Aspart Prot & Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE (***Insulin Aspart***)	T1	QL (20 ML per 30 days)
Intermediate-Acting Insulins		
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin Lispro Prot & Lispro***)	T1	QL (20 ML per 30 days)
HUMALOG MIX 75/25 (***Insulin Lispro Prot & Lispro***)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
HUMULIN N (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
Insulin Asp Prot & Asp FlexPen	T1	QL (30 ML per 30 days)
Insulin Lispro Prot & Lispro	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
NOVOLIN 70/30 FLEXPEN (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
NOVOLIN N (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
NOVOLIN N FLEXPEN (***Insulin NPH Human (Isophane)***)	T1	QL (20 ML per 30 days)
NOVOLOG MIX 70/30 (***Insulin Aspart Prot & Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin Aspart Prot & Aspart***)	T1	QL (20 ML per 30 days)
Long-Acting Insulins		
Insulin Glargine-yfgn	T1	QL (30 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LANTUS (***Insulin Glargine***)	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Glargine***)	T1	QL (30 ML per 30 days)
REZVOGLAR KWIKPEN (***Insulin Glargine-aglr***)	T1	QL (30 ML per 30 days)
Meglitinides		
Nateglinide	T1	PA
Repaglinide	T1	PA
Parathyroid Agents		
Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML	T1	PA
Parathyroid And Antiparathyroid Agents		
Calcitonin (Salmon) Nasal	T1	
Pituitary		
CORTROPHIN (***Corticotropin***)	T1	PA
CORTROPHIN GEL (***Corticotropin***)	T1	PA
Desmopressin Ace Spray Refrig	T1	PA
Desmopressin Acetate Injection	T1	PA
Desmopressin Acetate Nasal	T1	PA
Desmopressin Acetate Oral	T1	
Desmopressin Acetate PF	T1	PA
Desmopressin Acetate Spray	T1	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (***Somatropin***)	T1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE (***Somatropin***)	T1	PA
HUMATROPE INJECTION CARTRIDGE (***Somatropin***)	T1	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML (***Somatropin***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Somatropin***)	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***Somatropin***)	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***Somatropin (Non-Refrigerated)***)	T1	PA
ZOMACTON (***Somatropin***)	T1	PA
Progestins		
Levonorgestrel-Ethinyl Estrad (Afirmelle)	T1	
Levonorgestrel-Ethinyl Estrad (Altavera)	T1	
Alyacen 1/35	T1	
Alyacen 7/7/7	T1	
ANNOVERA (***Segesterone-Ethinyl Estradiol***)	T1	
Desogestrel-Ethinyl Estradiol (Apri)	T1	
ARANELLE (***Norethin-Eth Estrad Triphasic***)	T1	
Levonorgestrel-Ethinyl Estrad (Aubra Eq)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Aurovela 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Aurovela Fe 1/20)	T1	
AVERI (***Desogestrel-Eth Estrad-FE***)	T1	
Levonorgestrel-Ethinyl Estrad (Aviane)	T1	
Levonorgestrel-Ethinyl Estrad (Ayuna)	T1	
Desogestrel-Ethinyl Estradiol (Azurette)	T1	
Norethindrone-Eth Estradiol (Balziva)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Blisovi Fe 1/20)	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Briellyn	T1	
Levonorgestrel-Ethinyl Estrad (Chateal Eq)	T1	
CLIMARA PRO (***Estradiol-Levonorgestrel***)	T1	PA
COMBIPATCH (***Estradiol-Norethindrone Acet***)	T1	ST
CRINONE (***Progesterone***)	T1	PA
Norgestrel-Ethinyl Estradiol (Cryselle)	T1	
Norgestrel-Ethinyl Estradiol (Cryselle-28)	T1	
Desogestrel-Ethinyl Estradiol (Cyred Eq)	T1	
Norethindrone-Eth Estradiol (Dasetta 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Dasetta 7/7/7)	T1	
Norethindrone (Deblitane)	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE (***MedroxyPROGESTERone Acetate***)	T1	PA
Desogestrel-Ethinyl Estradiol Oral Tablet 0.15-0.02/0.01 MG (21/5)	T1	
Drospiren-Eth Estrad-Levomefol	T1	
Drospirenone-Ethinyl Estradiol	T1	
ECONTRA ONE-STEP (***Levonorgestrel***)	T1	
Norgestrel-Ethinyl Estradiol (Elinest)	T1	
ELLA (***Ulipristal Acetate***)	T1	
Etonogestrel-Ethinyl Estradiol (Eluryng)	T1	
Desogestrel-Ethinyl Estradiol (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
Norgestimate-Eth Estradiol (Estarylla)	T1	
Estradiol-Norethindrone Acet Oral Tablet 1-0.5 MG	T1	PA
Etonogestrel-Ethinyl Estradiol	T1	
Levonorgestrel-Ethinyl Estrad (Falmina)	T1	
Norethin Ace-Eth Estrad-FE (Feirza 1.5/30)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethin Ace-Eth Estrad-FE (Feirza 1/20)	T1	
FEMLYV (***Norethindrone Acet-Ethinyl Est***)	T1	
Norethindrone-Eth Estradiol (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
Norethin-Eth Estradiol-Fe (Galbriela)	T1	
Norethindrone Acet-Ethinyl Est (Hailey 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Hailey Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Hailey Fe 1/20)	T1	
Norethindrone (Heather)	T1	
HER STYLE (***Levonorgestrel***)	T1	
Levonorgest-Eth Estrad 91-Day (Iclevia)	T1	
Norethindrone (Incassia)	T1	
Desogestrel-Ethinyl Estradiol (Isibloom)	T1	
Drospirenone-Ethinyl Estradiol (Jasmiel)	T1	
Norethindrone-Eth Estradiol (Jinteli)	T1	PA
Levonorgest-Eth Estrad 91-Day (Jolessa)	T1	
Desogestrel-Ethinyl Estradiol (Juleber)	T1	
Norethindrone Acet-Ethinyl Est (Junel 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Junel 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Junel Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Junel Fe 1/20)	T1	
Desogestrel-Ethinyl Estradiol (Kalliga)	T1	
Desogestrel-Ethinyl Estradiol (Kariva)	T1	
Ethynodiol Diac-Eth Estradiol (Kelnor 1/35)	T1	
KYLEENA (***Levonorgestrel***)	T1	
Norethindrone Acet-Ethinyl Est (Larin 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Larin 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Larin Fe 1.5/30)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethin Ace-Eth Estrad-FE (Larin Fe 1/20)	T1	
Levonorgestrel-Ethinyl Estrad (Lessina)	T1	
Levonorg-Eth Estrad Triphasic (Levonest)	T1	
Levonorgest-Eth Estrad 91-Day	T1	
Levonorgest-Eth Estradiol-Iron	T1	
Levonorgestrel Oral Tablet 1.5 MG	T1	
Levonorgestrel-Ethinyl Estrad	T1	
Levonorg-Eth Estrad Triphasic Oral Tablet 50-30/75-40/ 125-30 MCG	T1	
Levonorgestrel-Ethinyl Estrad (Levora 0.15/30 (28))	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (***Levonorgestrel***)	T1	
LO LOESTRIN FE (***Norethin-Eth Estrad-Fe Biphas***)	T1	
Drospirenone-Ethinyl Estradiol (Loryna)	T1	
Norgestrel-Ethinyl Estradiol (Low-Ogestrel)	T1	
Drospirenone-Ethinyl Estradiol (Lo-Zumandimine)	T1	
Norethindrone (Lyleq)	T1	
Norethindrone (Lyza)	T1	
Marlissa	T1	
medroxyPROGESTERone Acetate Intramuscular	T1	
medroxyPROGESTERone Acetate Oral	T1	
Megestrol Acetate Oral Suspension 40 MG/ML	T1	
Megestrol Acetate Oral Tablet	T1	
Norethindrone Acet-Ethinyl Est (Microgestin 1.5/30)	T1	
Norethindrone Acet-Ethinyl Est (Microgestin 1/20)	T1	
Norethin Ace-Eth Estrad-FE (Microgestin Fe 1.5/30)	T1	
Norethin Ace-Eth Estrad-FE (Microgestin Fe 1/20)	T1	
Norgestimate-Eth Estradiol (Mili)	T1	

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	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Estradiol-Norethindrone Acet (Mimvey)	T1	PA
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/DAY (***Levonorgestrel***)	T1	
Norgestimate-Eth Estradiol (Mono-Linyah)	T1	
MY CHOICE (***Levonorgestrel***)	T1	
MY WAY (***Levonorgestrel***)	T1	
NATAZIA (***Estradiol Valerate-Dienogest***)	T1	
Norethindrone-Eth Estradiol (Necon 0.5/35 (28))	T1	
NEW DAY (***Levonorgestrel***)	T1	
NEXPLANON (***Etonogestrel***)	T1	
NEXTSTELLIS (***Drospirenone-Estetrol***)	T1	
Drospirenone-Ethinyl Estradiol (Nikki)	T1	
Norethindrone (Nora-Be)	T1	
Norelgestromin-Eth Estradiol	T1	
Norethin Ace-Eth Estrad-FE Oral Capsule	T1	
Norethin Ace-Eth Estrad-FE Oral Tablet Chewable	T1	
Norethindrone Acetate Oral	T1	
Norethindrone Acet-Ethinyl Est Oral Tablet 1-20 MG-MCG	T1	
Norethindrone Oral	T1	
Norethindrone-Eth Estradiol Oral Tablet 1-5 MG-MCG	T1	PA
Norgestimate-Eth Estradiol Oral Tablet 0.25-35 MG-MCG	T1	
Norgestim-Eth Estrad Triphasic	T1	
Norethindrone (Norlyda)	T1	
Norethindrone-Eth Estradiol (Nortrel 0.5/35 (28))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (21))	T1	
Norethindrone-Eth Estradiol (Nortrel 1/35 (28))	T1	
Norethin-Eth Estrad Triphasic (Nortrel 7/7/7)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norethindrone-Eth Estradiol (Nylia 1/35)	T1	
Norethin-Eth Estrad Triphasic (Nylia 7/7/7)	T1	
OPCICON ONE-STEP (***Levonorgestrel***)	T1	
OPILL (***Norgestrel***)	T1	
OPTION 2 (***Levonorgestrel***)	T1	
Levonorgestrel-Ethinyl Estrad (Orsythia)	T1	
Norethindrone-Eth Estradiol (Philith)	T1	
Desogestrel-Ethinyl Estradiol (Pimtrea)	T1	
Norethin-Eth Estrad Triphasic (Pirmella 7/7/7)	T1	
Levonorgestrel-Ethinyl Estrad (Portia-28)	T1	
PREMPHASE (***Conj Estrog-Medroxyprogest Ace***)	T1	
PREMPRO (***Conj Estrog-Medroxyprogest Ace***)	T1	
Progesterone Oral	T1	QL (30 EA per 30 days)
Desogestrel-Ethinyl Estradiol (Reclipsen)	T1	
Levonorgest-Eth Estrad 91-Day (Rosyrah)	T1	
Levonorgest-Eth Estrad 91-Day (Setlakin)	T1	
Norethindrone (Sharobel)	T1	
Desogestrel-Ethinyl Estradiol (Simliya)	T1	
SKYLA (***Levonorgestrel***)	T1	
SLYND (***Drospirenone***)	T1	
Norgestimate-Eth Estradiol (Sprintec 28)	T1	
Levonorgestrel-Ethinyl Estrad (Sronyx)	T1	
Drospirenone-Ethinyl Estradiol (Syeda)	T1	
Norethin Ace-Eth Estrad-FE (Tarina Fe 1/20 Eq)	T1	
Norethindron-Ethinyl Estrad-Fe (Tilia Fe)	T1	
Norgestim-Eth Estrad Triphasic (Tri Femynor)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Estarylla)	T1	
Norethindron-Ethinyl Estrad-Fe (Tri-Legest Fe)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Norgestim-Eth Estrad Triphasic (Tri-Linyah)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Estarylla)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Marzia)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Lo-Sprintec)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Mili)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Sprintec)	T1	
Levonorg-Eth Estrad Triphasic (Trivora (28))	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra)	T1	
Norgestim-Eth Estrad Triphasic (Tri-Vylibra Lo)	T1	
TWIRLA (***Levonorgestrel-Eth Estradiol***)	T1	
TYBLUME ORAL TABLET CHEWABLE (***Levonorgestrel-Ethinyl Estrad***)	T1	
Ethynodiol Diac-Eth Estradiol (Valtya 1/35)	T1	
VALTYA 1/50 (***Ethynodiol Diac-Eth Estradiol***)	T1	
VELIVET (***Desogestrel-Ethinyl Estradiol***)	T1	
Drospirenone-Ethinyl Estradiol (Vestura)	T1	
Levonorgestrel-Ethinyl Estrad (Vienva)	T1	
Viorele	T1	
Desogestrel-Ethinyl Estradiol (Volnea)	T1	
Norgestimate-Eth Estradiol (Vylibra)	T1	
Norethindrone-Eth Estradiol (Wera)	T1	
Norethin-Eth Estradiol-Fe (Xelria Fe)	T1	
Ethynodiol Diac-Eth Estradiol (Zovia 1/35 (28))	T1	
Drospirenone-Ethinyl Estradiol (Zumandimine)	T1	
Rapid-Acting Insulins		
APIDRA (***Insulin Glulisine***)	T1	QL (30 ML per 30 days)

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Glulisine***)	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin Lispro Prot & Lispro***)	T1	QL (20 ML per 30 days)
HUMALOG MIX 75/25 (***Insulin Lispro Prot & Lispro***)	T1	QL (30 ML per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE (***Insulin Lispro***)	T1	QL (30 ML per 30 days)
Insulin Asp Prot & Asp FlexPen	T1	QL (30 ML per 30 days)
Insulin Aspart FlexPen	T1	QL (30 ML per 30 days)
Insulin Aspart Injection	T1	QL (30 ML per 30 days)
Insulin Lispro (1 Unit Dial)	T1	QL (30 ML per 30 days)
Insulin Lispro Injection	T1	QL (30 ML per 30 days)
Insulin Lispro Prot & Lispro	T1	QL (30 ML per 30 days)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG INJECTION (***Insulin Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG MIX 70/30 (***Insulin Aspart Prot & Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin Aspart Prot & Aspart***)	T1	QL (20 ML per 30 days)
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE (***Insulin Aspart***)	T1	QL (20 ML per 30 days)
Short-Acting Insulins		
HUMULIN 70/30 (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
HUMULIN R (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Insulin Regular Human***)	T1	QL (12 ML per 30 days)
NOVOLIN 70/30 (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
NOVOLIN 70/30 FLEXPEN (***Insulin NPH Isophane & Regular***)	T1	QL (20 ML per 30 days)
NOVOLIN R (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
NOVOLIN R FLEXPEN (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
NOVOLIN R RELION (***Insulin Regular Human***)	T1	QL (20 ML per 30 days)
Sodium-Gluc Cotransport 2 (Sglt2) Inhib		
FARXIGA (***Dapagliflozin***)	T1	QL (30 EA per 30 days)
INVOKAMET (***Canagliflozin-Metformin HCl***)	T1	QL (60 EA per 30 days)
INVOKANA (***Canagliflozin***)	T1	QL (30 EA per 30 days)
JARDIANCE (***Empagliflozin***)	T1	QL (30 EA per 30 days)
SYNJARDY (***Empagliflozin-Metformin HCl***)	T1	QL (60 EA per 30 days)
SYNJARDY XR (***Empagliflozin-Metformin HCl***)	T1	QL (30 EA per 30 days)
XIGDUO XR (***Dapagliflozin Base-metFORMIN***)	T1	QL (30 EA per 30 days)
Somatostatin Agonists		
Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML	T1	
Somatotropin Agonists		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE (***Somatropin***)	T1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE (***Somatropin***)	T1	PA
HUMATROPE INJECTION CARTRIDGE (***Somatropin***)	T1	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML (***Somatropin***)	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR (***Somatropin***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (***Somatropin***)	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (***Somatropin (Non-Refrigerated)***)	T1	PA
ZOMACTON (***Somatropin***)	T1	PA
Somatotropin Antagonists		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG (***Pegvisomant***)	T1	
Sulfonylureas		
Glimepiride Oral Tablet 1 MG, 2 MG, 4 MG	T1	
glipiZIDE ER	T1	
glipiZIDE Oral Tablet 10 MG, 5 MG	T1	
glipiZIDE-metFORMIN HCl	T1	
glyBURIDE Oral	T1	
GlyBURIDE-MetFORMIN Oral Tablet 1.25-250 MG	T1	PA
glyBURIDE-metFORMIN Oral Tablet 2.5-500 MG, 5-500 MG	T1	
Thiazolidinediones		
Alogliptin-Pioglitazone Oral Tablet 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	T1	ST
Pioglitazone HCl	T1	
Thyroid Agents		
ARMOUR THYROID (***Thyroid***)	T1	
Levothyroxine Sodium (Levo-T)	T1	
Levothyroxine Sodium Oral Tablet	T1	
Levothyroxine Sodium (Levoxyl)	T1	
Liothyronine Sodium Oral	T1	
Niva Thyroid	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NP THYROID (***Thyroid***)	T1	
SYNTHROID (***Levothyroxine Sodium***)	T1	
Thyroid Oral Tablet 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	T1	
Levothyroxine Sodium (Unithroid)	T1	
Immunomodulatory Agents (90:00)		
Amino Acid Polymers		
Glatiramer Acetate	T1	
Antimetabolites, Immunosupp Therapy Misc		
azaTHIOprine Oral Tablet 50 MG	T1	
AzaTHIOprine Sodium	T1	PA
Mycophenolate Mofetil Oral Capsule	T1	
Calcineurin Inhibitors, Misc (90:28)		
CEQUA (***CycloSPORINE***)	T1	PA
cycloSPORINE (PF)	T1	PA
CycloSPORINE Modified	T1	
CycloSPORINE Oral Capsule	T1	
CycloSPORINE Modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
NEORAL (***CycloSPORINE Modified***)	T1	
PROGRAF ORAL CAPSULE (***Tacrolimus***)	T1	
SANDIMMUNE ORAL CAPSULE (***CycloSPORINE***)	T1	
Tacrolimus External Ointment	T1	QL (30 GM per 30 days)
Tacrolimus Oral	T1	
Disease-Modifying Antirheumat Drugs Misc		
ENTYVIO INTRAVENOUS (***Vedolizumab***)	T1	PA
ORENCIA INTRAVENOUS (***Abatacept***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***Abatacept***)	T1	PA
Disease-Modifying Antirheumatic Drugs		
AVSOLA (***inFLIXimab-axxq***)	T1	PA
Hydroxychloroquine Sulfate Oral Tablet 200 MG	T1	
INFLECTRA (***InFLIXimab-dyyb***)	T1	PA
inFLIXimab	T1	PA
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Oral	T1	
RENFLEXIS (***InFLIXimab-abda***)	T1	PA
sulfaSALAzine Oral	T1	
Fumarates		
Dimethyl Fumarate Oral	T1	
Dimethyl Fumarate Starter Pack Oral Capsule Delayed Release Therapy Pack	T1	
Immunomodulatory Agents (90:00)		
Cyclophosphamide Oral Tablet 50 MG	T1	
Mercaptopurine Oral Tablet	T1	
Interferons		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (***Interferon Beta-1a***)	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (***Interferon Beta-1a***)	T1	
BETASERON SUBCUTANEOUS KIT (***Interferon Beta-1b***)	T1	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Peginterferon alfa-2a***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Interferon Beta-1a***)	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Interferon Beta-1a***)	T1	
Interleukin Inhibitor Agents, Misc		
XOLAIR (***Omalizumab***)	T1	PA
Interleukin-Mediated Agents, Misc		
AVTOZMA (***Tocilizumab-anoh***)	T1	PA
IMULDOSA SUBCUTANEOUS (***Ustekinumab-srlf***)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Sarilumab***)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***Sarilumab***)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Anakinra***)	T1	PA
OTULFI SUBCUTANEOUS (***Ustekinumab-aauz***)	T1	PA
SELARSDI SUBCUTANEOUS (***Ustekinumab-aekn***)	T1	PA
STARJEMZA SUBCUTANEOUS SOLUTION (***Ustekinumab-hmny***)	T1	QL (1 ML per 84 days)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (***Ustekinumab-hmny***)	T1	QL (1 ML per 84 days)
STARJEMZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (***Ustekinumab-hmny***)	T1	QL (1 ML per 56 days)
TOFIDENCE (***Tocilizumab-bavi***)	T1	PA
TYENNE (***Tocilizumab-aazg***)	T1	PA
Ustekinumab-aauz Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML	T1	QL (1 ML per 28 days)
Ustekinumab-aauz Subcutaneous Solution Prefilled Syringe 90 MG/ML	T1	QL (1 ML per 56 days)
YESINTEK SUBCUTANEOUS (***Ustekinumab-kfce***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Janus Kinase Inhibitors, Miscellaneous		
OLUMIANT (***Baricitinib***)	T1	PA
XELJANZ (***Tofacitinib Citrate***)	T1	PA
XELJANZ XR (***Tofacitinib Citrate***)	T1	PA
Monocarboxylic Acid Amide Agents		
Leflunomide Oral	T1	
Mtor Inhibitors, Miscellaneous		
Sirolimus Oral	T1	
Phosphodiesterase-4 Inhibitors, Misc		
OTEZLA ORAL TABLET (***Apremilast***)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK (***Apremilast***)	T1	PA
OTEZLA XR (***Apremilast***)	T1	PA
OTEZLA/OTEZLA XR INITIATION PK (***Apremilast***)	T1	PA
Sphingosine 1-Phosphate (S1p) Agents		
Fingolimod HCl	T1	PA
Tumor Necrosis Factor Inhibitors, Misc		
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML	T1	QL (4 EA per 28 days)
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Pen)	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Syringe)	T1	QL (2 EA per 28 days)
Adalimumab-aaty CD/UC/HS Start	T1	QL (2 EA per 28 days)
Adalimumab-bwwd	T1	QL (1 ML per 28 days)
Adalimumab-fkjp (2 Pen)	T1	QL (4 EA per 28 days)
Adalimumab-fkjp (2 Syringe)	T1	QL (4 EA per 28 days)
AVSOLA (***inFLIXimab-axxq***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***Etanercept***)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Etanercept***)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Etanercept***)	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
INFLECTRA (***InFLIXimab-dyyb***)	T1	PA
inFLIXimab	T1	PA
RENFLEXIS (***InFLIXimab-abda***)	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (***Adalimumab-ryvk***)	T1	QL (2 EA per 28 days)
SIMLANDI (2 PEN) (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (***Golimumab***)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Golimumab***)	T1	PA
Local Anesthetics		
Local Anesthetics		
BUPivacaine Fisiopharma Injection Solution 0.5 %, 2.5 MG/ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bupivacaine HCl (PF)	T1	
BUPivacaine HCl Injection Solution 0.25 %, 0.5 %	T1	
Bupivacaine HCl-NaCl Epidural Solution 0.125-0.9 %	T1	
BUPivacaine in Dextrose Intrathecal	T1	
Bupivacaine Spinal	T1	
Bupivacaine-Epinephrine (PF) Injection Solution 0.25% - 1:200000, 0.5% -1:200000	T1	
BUPivacaine-EPINEPHrine Injection Solution 0.25% - 1:200000, 0.5% -1:200000	T1	
Chloroprocaine HCl (PF) Injection Solution 2 %	T1	
Chloroprocaine HCl (PF) Injection Solution 3 %	T1	PA
Fentanyl Cit-Ropivacaine-NaCl Epidural Solution 0.2-0.2-0.9 MG/100ML-%, 0.5-0.2-0.9 MG/250ML-%	T1	
Fentanyl-Bupivacaine-NaCl Epidural Solution 0.2-0.1-0.9 MG/100ML-%, 0.2-0.125-0.9 MG/100ML-%, 0.5-0.1-0.9 MG/250ML-%, 0.5-0.125-0.9 MG/250ML-%	T1	
Lidocaine HCl (PF) Injection Solution 0.5 %	T1	
Lidocaine HCl Injection Solution 0.5 %, 1 %, 2 %	T1	
Lidocaine HCl Injection Solution Prefilled Syringe 200 MG/10ML	T1	
Lidocaine-EPINEPHrine Injection Solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000	T1	
POLOCAINE (***Mepivacaine HCl***)	T1	
POLOCAINE-MPF (***Mepivacaine HCl***)	T1	
ROPivacaine HCl Injection Solution 10 MG/ML, 2 MG/ML, 5 MG/ML, 7.5 MG/ML	T1	
Ropivacaine HCl-NaCl Injection Solution 0.2-0.9 %	T1	
Bupivacaine-Epinephrine (Sensorcaine/Epinephrine)	T1	
Bupivacaine HCl (Sensorcaine-Mpf Injection Solution 0.75 %)	T1	

bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**Coverage Requirements and Limits** **AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bupivacaine-Epinephrine (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (***Bupivacaine-Epinephrine***)	T1	
Tetracaine HCl Ophthalmic	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 (***Lidocaine-Epinephrine***)	T1	
Miscellaneous Therapeutic Agents		
5-Alpha-Reductase Inhibitors		
Finasteride Oral Tablet 5 MG	T1	
5-Alpha-Reductase Inhibitors (92:04)		
Disulfiram Oral	T1	
Finasteride Oral Tablet 5 MG	T1	
Naltrexone HCl Oral	T1	
VIVITROL (***Naltrexone***)	T1	
Antidotes (92:12)		
Acetylcysteine Inhalation	T1	
Atropine Sulfate Injection Solution 8 MG/20ML	T1	
Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML	T1	
BAQSIMI ONE PACK (***Glucagon***)	T1	
BAQSIMI TWO PACK (***Glucagon***)	T1	
CHEMET (***Succimer***)	T1	
Deferoxamine Mesylate	T1	PA
Glucagon Emergency Injection Solution Reconstituted	T1	
Iodine Strong Oral	T1	
Lanthanum Carbonate	T1	PA
LEDERLE LEUCOVORIN (***Leucovorin Calcium***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary Medication; QY = Quantity; DY = Days; DS = Days Supply; EA = Each; GM = Gram; FL = Fill; ML = Milliliter; MIN = Minimum; MAX = Maximum

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Leucovorin Calcium Oral Tablet 5 MG	T1	
Magnesium Sulfate Injection Solution 50 %	T1	
Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML	T1	
Naloxone HCl Injection Solution Cartridge	T1	
Naloxone HCl Injection Solution Prefilled Syringe 2 MG/2ML	T1	
Naltrexone HCl Oral	T1	
Phytonadione Injection Solution 1 MG/0.5ML, 10 MG/ML	T1	
Phytonadione Oral	T1	
Sevelamer Carbonate Oral Tablet	T1	
Sevelamer HCl	T1	PA
Vitamin K1 Injection Solution 1 MG/0.5ML, 10 MG/ML	T1	
VIVITROL (***Naltrexone***)	T1	
Antigout Agents		
Allopurinol Oral Tablet 100 MG, 300 MG	T1	
Colchicine Oral Capsule	T1	PA
Colchicine Oral Tablet	T1	QL (30 EA per 30 days)
Colchicine-Probenecid	T1	
Indomethacin ER	T1	
Indomethacin Oral Capsule 25 MG, 50 MG	T1	
Indomethacin Oral Suspension	T1	
Naproxen Oral	T1	
Naproxen Sodium ER Oral Tablet Extended Release 24 Hour 375 MG, 500 MG	T1	
Naproxen Sodium Oral Tablet 275 MG, 550 MG	T1	
Probenecid Oral	T1	
Bone Anabolic Agents		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML	T1	PA
Bone Resorption Inhibitors		
Alendronate Sodium Oral Solution	T1	QL (75 ML per 30 days)
Alendronate Sodium Oral Tablet 10 MG, 35 MG, 70 MG	T1	
Calcitonin (Salmon) Nasal	T1	
DEPO-ESTRADIOL (***Estradiol Cypionate***)	T1	PA
Estradiol (Dotti)	T1	QL (8 EA per 28 days)
Estradiol Oral	T1	
Estradiol Transdermal Gel 0.75 MG/1.25 GM (0.06%)	T1	
Estradiol Transdermal Patch Twice Weekly	T1	QL (8 EA per 28 days)
Estradiol Transdermal Patch Weekly	T1	
Estradiol Vaginal Cream 0.01 %	T1	
Estradiol Vaginal Tablet	T1	
Estradiol Valerate Intramuscular	T1	PA
FEMRING (***Estradiol Acetate***)	T1	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT (***Alendronate-Cholecalciferol***)	T1	PA
Ibandronate Sodium Oral	T1	QL (1 EA per 28 days)
Estradiol (Lyllana)	T1	QL (8 EA per 28 days)
PREMARIN ORAL (***Estrogens Conjugated***)	T1	
PREMARIN VAGINAL (***Estrogens, Conjugated***)	T1	
Raloxifene HCl	T1	
Risedronate Sodium Oral Tablet 150 MG	T1	QL (1 EA per 30 days)
Risedronate Sodium Oral Tablet 35 MG	T1	QL (4 EA per 30 days)
Risedronate Sodium Oral Tablet 5 MG	T1	QL (30 EA per 30 days)
Estradiol (Yuvafem)	T1	
Cariostatic Agents		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DENTA 5000 PLUS (***Sodium Fluoride***)	T1	
Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG	T1	
PREVIDENT DENTAL (***Sodium Fluoride***)	T1	
SF	T1	
SF 5000 Plus	T1	
Sodium Fluoride 5000 Plus	T1	
Sodium Fluoride Dental Cream	T1	
Sodium Fluoride Dental Gel 1.1 %	T1	
Sodium Fluoride Mouth/Throat	T1	
Sodium Fluoride Oral Solution 1.1 (0.5 F) MG/ML	T1	
Sodium Fluoride Oral Tablet Chewable	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	
Disease-Modifying Antirheumatic Agents		
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML	T1	QL (4 EA per 28 days)
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Pen)	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Syringe)	T1	QL (2 EA per 28 days)
Adalimumab-aaty CD/UC/HS Start	T1	QL (2 EA per 28 days)
Adalimumab-bwwd	T1	QL (1 ML per 28 days)
Adalimumab-fkjp (2 Pen)	T1	QL (4 EA per 28 days)
Adalimumab-fkjp (2 Syringe)	T1	QL (4 EA per 28 days)
AVSOLA (***inFLIXimab-axxq***)	T1	PA
azaTHIOprine Oral Tablet 50 MG	T1	
AzaTHIOprine Sodium	T1	PA
CycloSPORINE Modified	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CycloSPORINE Oral Capsule	T1	
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***Etanercept***)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Etanercept***)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Etanercept***)	T1	PA
CycloSPORINE Modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
Hydroxychloroquine Sulfate Oral Tablet 200 MG	T1	
INFLECTRA (***InFLIXimab-dyyb***)	T1	PA
inFLIXimab	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Sarilumab***)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***Sarilumab***)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Anakinra***)	T1	PA
Leflunomide Oral	T1	
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Methotrexate Sodium Oral	T1	
NEORAL (***CycloSPORINE Modified***)	T1	
OLUMIANT (***Baricitinib***)	T1	PA
ORENCIA INTRAVENOUS (***Abatacept***)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***Abatacept***)	T1	PA
OTEZLA ORAL TABLET 30 MG (***Apremilast***)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (***Apremilast***)	T1	PA
penicillAMINE Oral	T1	PA
RENFLEXIS (***InFLIXimab-abda***)	T1	PA
SANDIMMUNE ORAL CAPSULE (***CycloSPORINE***)	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (***Golimumab***)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Golimumab***)	T1	PA
sulfaSALAzine Oral	T1	
TOFIDENCE (***Tocilizumab-bavi***)	T1	PA
TYENNE INTRAVENOUS (***Tocilizumab-aazg***)	T1	PA
XELJANZ (***Tofacitinib Citrate***)	T1	PA
XELJANZ XR (***Tofacitinib Citrate***)	T1	PA
Gonadotropin-Releasing Hormone Antagnts		
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (***Degarelix Acetate***)	T1	QL (1 EA per 30 days)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ganirelix Acetate Subcutaneous Solution Prefilled Syringe	T1	PA
Immunomodulatory Agents		
ACTIMMUNE (***Interferon Gamma-1B***)	T1	
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 40 MG/0.4ML	T1	QL (4 EA per 28 days)
Adalimumab-aaty (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Pen)	T1	QL (2 EA per 28 days)
Adalimumab-aaty (2 Syringe)	T1	QL (2 EA per 28 days)
Adalimumab-aaty CD/UC/HS Start	T1	QL (2 EA per 28 days)
Adalimumab-bwwd	T1	QL (1 ML per 28 days)
Adalimumab-fkjp (2 Pen)	T1	QL (4 EA per 28 days)
Adalimumab-fkjp (2 Syringe)	T1	QL (4 EA per 28 days)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT (***Interferon Beta-1a***)	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT (***Interferon Beta-1a***)	T1	
AVSOLA (***inFLIXimab-axxq***)	T1	PA
azaTHIOprine Oral Tablet 50 MG	T1	
AzaTHIOprine Sodium	T1	PA
BETASERON SUBCUTANEOUS KIT (***Interferon Beta-1b***)	T1	
CycloSPORINE Modified	T1	
CycloSPORINE Oral Capsule	T1	
Dimethyl Fumarate Oral	T1	
Dimethyl Fumarate Starter Pack Oral Capsule Delayed Release Therapy Pack	T1	
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***Etanercept***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Etanercept***)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Etanercept***)	T1	PA
ENTYVIO INTRAVENOUS (***Vedolizumab***)	T1	PA
Fingolimod HCl	T1	PA
CycloSPORINE Modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
Glatiramer Acetate	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***Adalimumab-bwwd***)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (***Adalimumab-bwwd***)	T1	QL (3.2 ML per 28 days)
Hydroxychloroquine Sulfate Oral Tablet 200 MG	T1	
INFLECTRA (***InFLIXimab-dyyb***)	T1	PA
inFLIXimab	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Sarilumab***)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (***Sarilumab***)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Anakinra***)	T1	PA
Leflunomide Oral	T1	
Lenalidomide	T1	PA
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Oral	T1	
NEORAL (***CycloSPORINE Modified***)	T1	
OLUMIANT ORAL TABLET 1 MG, 2 MG (***Baricitinib***)	T1	PA
ORENCIA INTRAVENOUS (***Abatacept***)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (***Abatacept***)	T1	PA
OTEZLA ORAL TABLET (***Apremilast***)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK (***Apremilast***)	T1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Peginterferon alfa-2a***)	T1	PA
Pomalidomide	T1	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Interferon Beta-1a***)	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Interferon Beta-1a***)	T1	
RENFLEXIS (***InFLIXimab-abda***)	T1	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG (***Lenalidomide***)	T1	PA
SANDIMMUNE ORAL CAPSULE (***CycloSPORINE***)	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (***Adalimumab-ryvk***)	T1	QL (4 EA per 28 days)
SIMPONI ARIA (***Golimumab***)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Golimumab***)	T1	PA
sulfaSALAzine Oral	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
THALOMID ORAL CAPSULE 100 MG, 50 MG (***Thalidomide***)	T1	PA
TOFIDENCE (***Tocilizumab-bavi***)	T1	PA
TYENNE INTRAVENOUS (***Tocilizumab-aazg***)	T1	PA
XELJANZ (***Tofacitinib Citrate***)	T1	PA
XELJANZ XR (***Tofacitinib Citrate***)	T1	PA
Immunosuppressive Agents		
azaTHIOprine Oral Tablet 50 MG	T1	
AzaTHIOprine Sodium	T1	PA
Cyclophosphamide Oral Tablet 50 MG	T1	
CycloSPORINE Modified	T1	
CycloSPORINE Oral Capsule	T1	
CycloSPORINE Modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
Leflunomide Oral	T1	
Mercaptopurine Oral Tablet	T1	
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 1000 MG/40ML, 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML	T1	
Methotrexate Sodium Oral	T1	
Mycophenolate Mofetil Oral	T1	
Mycophenolate Sodium	T1	
NEORAL (***CycloSPORINE Modified***)	T1	
Pimecrolimus	T1	PA
PROGRAF ORAL CAPSULE (***Tacrolimus***)	T1	
SANDIMMUNE ORAL CAPSULE (***CycloSPORINE***)	T1	
Sirolimus Oral	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tacrolimus External Ointment	T1	QL (30 GM per 30 days)
Tacrolimus Oral	T1	
Other Miscellaneous Therapeutic Agents		
Acetic Acid Glacial Solution 99 %	T1	
Acetic Acid Solution 5 %	T1	
Acetylcysteine Inhalation	T1	
Betaine	T1	
BP Vit 3	T1	
Complete Natal DHA Oral 29-1-200 & 200 MG	T1	
CYSTAGON (***Cysteamine Bitartrate***)	T1	
Dalfampridine ER	T1	PA
DYSPORT (***AbobotulinumtoxinA***)	T1	PA
ELMIRON (***Pentosan Polysulfate Sodium***)	T1	PA
levOCARNitine Oral Tablet	T1	
levOCARNitine SF	T1	
LODOCO (***Colchicine***)	T1	PA
metyroSINE	T1	
Nitisinone Oral Capsule 10 MG, 2 MG, 5 MG	T1	
Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML	T1	
Prenatal Gummies/DHA & FA	T1	
PRENATAL MULTIVITAMIN + DHA (***Prenatal MV-Min-Fe Fum-FA-DHA***)	T1	
Tiopronin Oral Tablet	T1	PA
XEOMIN (***IncobotulinumtoxinA***)	T1	PA
Protective Agents		
Adapalene External Gel 0.1 %	T1	
Adapalene External Pad	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Adapalene External Solution	T1	
Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %	T1	QL (45 GM per 30 days); AL (Max 30 Years)
Dalfampridine ER	T1	PA
ELMIRON (***Pentosan Polysulfate Sodium***)	T1	PA
Mesna Oral	T1	
Nonhormonal Contraceptives		
Nonhormonal Contraceptives		
Aimsco Lubricated	T1	
CAYA (***Diaphragm Arc-Spring***)	T1	
DUREX REALFEEL (***Condoms Non-Latex Lubricated***)	T1	
FANTASY LUBRICATED (***Condoms Latex Lubricated***)	T1	
FANTASY LUBRICATED/SPERMICIDE (***Condoms Latex Lubricated***)	T1	
FC2 FEMALE CONDOM (***Condoms - Female***)	T1	
FEMCAP (***Cervical Caps***)	T1	
Kimono	T1	
Kimono Micro Thin	T1	
Kimono Micro Thin Plus	T1	
Kimono Sensation	T1	
Kimono Sensation Plus	T1	
Maxx	T1	
MIUDELLA INTRAUTERINE COPPER (***Copper***)	T1	
OPTIONS GYNOL II CONTRACEPTIVE (***Nonoxynol-9***)	T1	
PARAGARD INTRAUTERINE COPPER (***Copper***)	T1	
TODAY SPONGE (***Nonoxynol-9***)	T1	
TRUSTEX LUB/RIBBED/STUDDED (***Condoms Latex Lubricated***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSTEX LUB/SPERMICIDE EX ST (***Condoms Latex Lubricated***)	T1	
TRUSTEX LUB/SPERMICIDE XL (***Condoms Latex Lubricated***)	T1	
TRUSTEX LUBRICATED (***Condoms Latex Lubricated***)	T1	
TRUSTEX LUBRICATED EX LARGE (***Condoms Latex Lubricated***)	T1	
TRUSTEX LUBRICATED EXTRA ST (***Condoms Latex Lubricated***)	T1	
TRUSTEX LUBRICATED/SPERMICIDE (***Condoms Latex Lubricated***)	T1	
TRUSTEX NON-LUBRICATED (***Condoms Latex Non-Lubricated***)	T1	
TRUSTEX RIA LUB/SPERMICIDE (***Condoms Latex Lubricated***)	T1	
TRUSTEX RIA LUBRICATED (***Condoms Latex Lubricated***)	T1	
TRUSTEX RIA NON-LUBRICATED (***Condoms Latex Non-Lubricated***)	T1	
TRUSTEX-NONOXYNOL-9/RIB/STUD (***Condoms Latex Lubricated***)	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM (***Nonoxynol-9***)	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL (***Nonoxynol-9***)	T1	
WIDE-SEAL DIAPHRAGM 60 (***Diaphragm Wide Seal***)	T1	
WIDE-SEAL DIAPHRAGM 65 (***Diaphragm Wide Seal***)	T1	
WIDE-SEAL DIAPHRAGM 70 (***Diaphragm Wide Seal***)	T1	
WIDE-SEAL DIAPHRAGM 75 (***Diaphragm Wide Seal***)	T1	
WIDE-SEAL DIAPHRAGM 80 (***Diaphragm Wide Seal***)	T1	
WIDE-SEAL DIAPHRAGM 85 (***Diaphragm Wide Seal***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 90 (***Diaphragm Wide Seal***)	T1	
WIDE-SEAL DIAPHRAGM 95 (***Diaphragm Wide Seal***)	T1	
Oxytocics		
Oxytocics		
Methylergonovine Maleate Injection	T1	
Methylergonovine Maleate Oral	T1	QL (28 EA per 7 days)
miFEPRIStone Oral Tablet 200 MG	T1	
Oxytocin Injection	T1	
Pharmaceutical Aids		
Pharmaceutical Aids		
Bacteriostatic Water(Benz Alc)	T1	
ELLIOTTS B (***Intrathecal Elec-Dextrose***)	T1	
Emollient Base	T1	
Hydrogen Peroxide Solution 30 %	T1	
PLURONIC F127 POWDER (***Poloxamer***)	T1	
Sterile Water for Injection Injection	T1	
Respiratory Tract Agents		
Alpha And Beta Adrenergic Agonist(Respr)		
EPINEPHrine Injection Solution 1 MG/ML	T1	
EPINEPHrine Injection Solution Auto-Injector 0.15 MG/0.3ML, 0.3 MG/0.3ML	T1	QL (4 EA per 180 days)
EPINEPHrine PF Injection Solution	T1	
Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML	T1	PA
Anticholinergic Agents (Respir.Tract)		
Atropine Sulfate Injection Solution 8 MG/20ML	T1	
Atropine Sulfate Injection Solution Prefilled Syringe 0.25 MG/5ML, 0.5 MG/5ML, 1 MG/10ML	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs UPPERCASE = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Atropine Sulfate Ophthalmic Solution 1 %	T1	
ATROVENT HFA (***Ipratropium Bromide HFA***)	T1	
BREZTRI AEROSPHERE (***Budeson-Glycopyrrol-Formoterol***)	T1	PA
COMBIVENT RESPIMAT (***Ipratropium-Albuterol***)	T1	
Diphenoxylate-Atropine Oral Liquid	T1	
Diphenoxylate-Atropine Oral Tablet 2.5-0.025 MG	T1	
Hyoscyamine Sulfate ER Oral Tablet Extended Release 12 Hour	T1	
Hyoscyamine Sulfate Oral	T1	
Hyoscyamine Sulfate Sublingual	T1	
Hyosyne	T1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (***Umeclidinium Bromide***)	T1	QL (30 EA per 30 days)
Ipratropium Bromide Inhalation	T1	
Ipratropium Bromide Nasal	T1	
Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML	T1	
NULEV (***Hyoscyamine Sulfate***)	T1	
Oscimin Oral Tablet	T1	
Oscimin Sublingual	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (***Tiotropium Bromide***)	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***Tiotropium Bromide-Olodaterol***)	T1	
Tiotropium Bromide	T1	
Antifibrotic Agents		
Nintedanib Esylate	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pirfenidone	T1	PA
Anti-Inflammatory Agents (Respiratory)		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Mepolizumab***)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (***Mepolizumab***)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (***Mepolizumab***)	T1	PA
Antitussives		
Benzonatate Oral Capsule 100 MG, 200 MG	T1	
Codeine Sulfate Oral Tablet	T1	
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
Hydrocod Poli-Chlorphe Poli ER	T1	QL (240 ML per 30 days); AL (Min 18 Years)
HYDROcodone Bit-Homatrop MBr	T1	QL (45 ML per 30 days); AL (Min 18 Years)
Promethazine-Codeine	T1	QL (240 ML per 30 days); AL (Min 18 Years)
Promethazine-DM Oral Syrup 6.25-15 MG/5ML	T1	
Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML	T1	PA
Corticosteroids (Respiratory Tract)		
Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML	T1	QL (120 ML per 30 days)
Budesonide Inhalation Suspension 1 MG/2ML	T1	QL (60 ML per 30 days)
Flunisolide Nasal Solution 25 MCG/ACT (0.025%)	T1	PA
Fluticasone Furoate Ellipta	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT, 200-25 MCG/ACT	T1	
Fluticasone Propionate Diskus	T1	
Fluticasone Propionate HFA	T1	
Fluticasone Propionate Nasal	T1	
Fluticasone-Salmeterol Inhalation Aerosol	T1	PA
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT, 113-14 MCG/ACT, 232-14 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT, 55-14 MCG/ACT	T1	
Mometasone Furoate External	T1	
PULMICORT FLEXHALER (***Budesonide***)	T1	
QVAR REDIHALER (***Beclomethasone Diprop HFA***)	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (***Fluticasone-Umeclidin-Vilant***)	T1	PA
Fluticasone-Salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Endothelin Receptor Antagonists (48:48)		
Ambrisentan	T1	PA
Bosentan Oral Tablet	T1	PA
OPSUMIT (***Macitentan***)	T1	PA
TRACLEER ORAL TABLET SOLUBLE (***Bosentan***)	T1	PA
Expectorants		
Iodine Strong Oral	T1	
Potassium Iodide (Expectorant)	T1	
First Generation Antihist.(Respir Tract)		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Carbinoxamine Maleate Oral Solution	T1	
Carbinoxamine Maleate Oral Tablet 4 MG	T1	
Clemastine Fumarate Oral Syrup	T1	
Clemastine Fumarate Oral Tablet 2.68 MG	T1	
Cyproheptadine HCl Oral	T1	
diphenhydrAMINE HCl Oral Capsule 25 MG	T1	
diphenhydrAMINE HCl Oral Elixir	T1	
Promethazine HCl Oral Solution 6.25 MG/5ML	T1	
Promethazine HCl Oral Tablet	T1	
Promethazine HCl Rectal Suppository 12.5 MG, 25 MG	T1	
Promethazine-Codeine	T1	QL (240 ML per 30 days); AL (Min 18 Years)
Promethazine-DM Oral Syrup 6.25-15 MG/5ML	T1	
Promethazine HCl (Promethegan)	T1	
Pseudoeph-Bromphen-DM Oral Syrup 30-2-10 MG/5ML	T1	PA
Interleukin Antagonists		
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (***Dupilumab***)	T1	PA
FASENRA (***Benralizumab***)	T1	PA
FASENRA PEN (***Benralizumab***)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Mepolizumab***)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED (***Mepolizumab***)	T1	PA
TEZSPIRE (***Tezepelumab-ekko***)	T1	PA
Leukotriene Modifiers		
Montelukast Sodium Oral Packet	T1	PA
Montelukast Sodium Oral Tablet	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Montelukast Sodium Oral Tablet Chewable	T1	
Zafirlukast	T1	PA
Mast-Cell Stabilizers		
ALOCRIL (***Nedocromil Sodium***)	T1	PA
Cromolyn Sodium Inhalation	T1	
Cromolyn Sodium Ophthalmic	T1	
Cromolyn Sodium Oral	T1	
Mucolytic Agents		
Acetylcysteine Inhalation	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (***Sodium Chloride***)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (***Dornase Alfa***)	T1	PA
Sodium Chloride Inhalation Nebulization Solution 0.9 %, 10 %, 3 %	T1	
Nasal Preparations (Steroids)		
Flunisolide Nasal Solution 25 MCG/ACT (0.025%)	T1	PA
Fluticasone Propionate Nasal	T1	
Orally Inhaled Preparations (Steroids)		
ASMANEX HFA (***Mometasone Furoate***)	T1	
BREZTRI AEROSPHERE (***Budeson-Glycopyrrol-Formoterol***)	T1	PA
Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML	T1	QL (120 ML per 30 days)
Budesonide Inhalation Suspension 1 MG/2ML	T1	QL (60 ML per 30 days)
Budesonide-Formoterol Fumarate	T1	QL (20.4 GM per 30 days)
DULERA (***Mometasone Furo-Formoterol Fum***)	T1	
Fluticasone Furoate Ellipta	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluticasone Propionate Diskus	T1	
Fluticasone Propionate HFA	T1	
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	T1	
PULMICORT FLEXHALER (***Budesonide***)	T1	
QVAR REDIHALER (***Beclomethasone Diprop HFA***)	T1	
Phosphodiesterase-5 Inhibitors (Respir)		
Sildenafil Citrate Oral Tablet 20 MG	T1	PA
Tadalafil (PAH)	T1	PA
Prostacyclin & Prostacyclin Derivatives		
ORENITRAM (***Treprostinil Diolamine***)	T1	PA
Treprostinil	T1	PA
TYVASO (***Treprostinil***)	T1	PA
TYVASO REFILL KIT (***Treprostinil***)	T1	PA
TYVASO STARTER KIT (***Treprostinil***)	T1	PA
Pulmonary Surfactants		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5ML, 240 MG/3ML (***Poractant Alfa***)	T1	
INFASURF INTRATRACHEAL (***Calfactant in NaCl***)	T1	
Respiratory Tract Agents, Miscellaneous		
Pirfenidone	T1	PA
TEZSPIRE (***Tezepelumab-ekko***)	T1	PA
XOLAIR (***Omalizumab***)	T1	PA
Second Generation Antihist(Respir Tract)		
All Day Allergy Childrens Oral Solution 5 MG/5ML	T1	
All-Day Allergy Childrens	T1	
Allergy Childrens Oral Solution	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Allergy Childrens Oral Suspension	T1	ST
Allergy Rel Child (Loratadine)	T1	
Allergy Relief Childrens Oral Solution 1 MG/ML	T1	
Allergy Relief Oral Tablet 5 MG	T1	
Azelastine HCl Nasal Solution 0.1 %, 137 MCG/SPRAY	T1	
Azelastine HCl Ophthalmic	T1	QL (6 ML per 30 days)
Cetirizine HCl Allergy Child	T1	
Cetirizine HCl Childrens Alrgy Oral Solution	T1	
Cetirizine HCl Oral Solution 1 MG/ML	T1	
Cetirizine HCl Oral Tablet Chewable	T1	
Childrens 24 Hour Allergy	T1	
Childrens Loratadine Oral Solution	T1	
CVS Allergy Childrens Oral Solution	T1	
CVS Allergy Relief Childrens Oral Solution	T1	
CVS Allergy Relief Childrens Oral Suspension	T1	ST
CVS Allergy Relief Oral Tablet 5 MG	T1	
CVS Allergy Relief(Cetirizine)	T1	
Desloratadine Oral Tablet	T1	PA
Desloratadine Oral Tablet Dispersible 5 MG	T1	PA
EQ Allerg Relief Child (Cetir)	T1	
EQ Allerg Relief Child (Lorat)	T1	
EQ Allergy Childrens Oral Solution	T1	
EQ Allergy Relief (Cetirizine) Oral Solution	T1	
EQ Cetirizine HCl Oral Solution	T1	
EQL All Day Allergy Childrens	T1	
GNP All Day Allergy Childrens Oral Solution	T1	
GNP Allergy Relief 24 HR	T1	
GNP Loratadine Childrens Oral Solution	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GNP Loratadine Oral Solution	T1	
GoodSense All Day Allergy Oral Solution	T1	
KLS ALLER-TEC CHILDRENS ORAL SOLUTION 5 MG/5ML (***Cetirizine HCl***)	T1	
Levocetirizine Dihydrochloride Oral Tablet	T1	
Loratadine Childrens Oral Solution	T1	
Loratadine Oral Solution	T1	
QC All Day Allergy	T1	
WAL-ITIN CHILDRENS (***Loratadine***)	T1	
WAL-ITIN ORAL SOLUTION (***Loratadine***)	T1	
WAL-ZYR ALL DAY ALLERGY CHILD (***Cetirizine HCl***)	T1	
WAL-ZYR ALLERGY CHILDRENS (***Cetirizine HCl***)	T1	
WAL-ZYR CHILDRENS ORAL SOLUTION (***Cetirizine HCl***)	T1	
WAL-ZYR CHILDRENS ORAL TABLET CHEWABLE 10 MG (***Cetirizine HCl***)	T1	
Select.Beta-2-Adrenergic Agonist(Respir)		
Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT	T1	QL (36 GM per 30 days)
Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, (5 MG/ML) 0.5%, 2.5 MG/0.5ML	T1	
Albuterol Sulfate Inhalation Nebulization Solution 0.63 MG/3ML, 1.25 MG/3ML	T1	PA
Albuterol Sulfate Oral Syrup 2 MG/5ML	T1	
Albuterol Sulfate Oral Tablet	T1	
BREZTRI AEROSPHERE (***Budeson-Glycopyrrol-Formoterol***)	T1	PA
Budesonide-Formoterol Fumarate	T1	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT (***Ipratropium-Albuterol***)	T1	
DULERA (***Mometasone Furo-Formoterol Fum***)	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT	T1	
Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML	T1	
Levalbuterol HCl Inhalation Nebulization Solution 0.31 MG/3ML, 0.63 MG/3ML, 1.25 MG/0.5ML, 1.25 MG/3ML	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (***Salmeterol Xinafoate***)	T1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (***Tiotropium Bromide-Olodaterol***)	T1	
Terbutaline Sulfate Oral	T1	
Vasodilating Agents (Respiratory Tract)		
ADEMPAS (***Riociguat***)	T1	PA
Ambrisentan	T1	PA
Bosentan Oral Tablet	T1	PA
OPSUMIT (***Macitentan***)	T1	PA
ORENITRAM (***Treprostinil Diolamine***)	T1	PA
Sildenafil Citrate Oral Tablet 20 MG	T1	PA
Tadalafil (PAH)	T1	PA
TRACLEER ORAL TABLET SOLUBLE (***Bosentan***)	T1	PA
Treprostinil	T1	PA
TYVASO (***Treprostinil***)	T1	PA
TYVASO REFILL KIT (***Treprostinil***)	T1	PA
TYVASO STARTER KIT (***Treprostinil***)	T1	PA
UPTRAVI ORAL (***Selexipag***)	T1	PA
UPTRAVI TITRATION (***Selexipag***)	T1	PA
Vasodilating Agents, Misc (48:48)		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADEMPAS (***Riociguat***)	T1	PA
UPTRAVI ORAL (***Selexipag***)	T1	PA
UPTRAVI TITRATION (***Selexipag***)	T1	PA
Xanthine Derivatives		
THEO-24 (***Theophylline***)	T1	
Theophylline ER	T1	
Theophylline Oral Elixir	T1	
Skin And Mucous Membrane Agents		
Adrenergic Agonists		
Brimonidine Tartrate Ophthalmic Solution 0.15 %	T1	PA
Brimonidine Tartrate Ophthalmic Solution 0.2 %	T1	
Brimonidine Tartrate-Timolol	T1	PA
Allylamines (Skin And Mucous Membrane)		
Athletes Foot (Terbinafine)	T1	
CVS Athletes Foot External Cream	T1	
CVS Jock Itch	T1	
EQ Athletes Foot (Terbinafine)	T1	
GNP Terbinafine Hydrochloride	T1	
LAMISIL AT ATHLETES FOOT (***Terbinafine HCl***)	T1	
Naftifine HCl External Cream 1 %	T1	
Terbinafine HCl External	T1	
Antibacterials (84:04)		
AVAR-E EMOLLIENT (***Sulfacetamide Sodium-Sulfur***)	T1	
Avidoxy	T1	
Azelaic Acid External	T1	PA
Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bacitra-Neomycin-Polymyxin-HC	T1	
CLEOCIN VAGINAL SUPPOSITORY (***Clindamycin Phosphate***)	T1	ST
Clindamycin Phosphate (Clindacin Etz External Swab)	T1	
Clindamycin Phosphate (Clindacin-P)	T1	
Clindamycin HCl Oral	T1	
Clindamycin Phos (Once-Daily)	T1	
Clindamycin Phos (Twice-Daily)	T1	
Clindamycin Phos-Benzoyl Perox External Gel 1-5 %	T1	PA
Clindamycin Phosphate External Lotion	T1	
Clindamycin Phosphate External Solution	T1	
Clindamycin Phosphate External Swab	T1	
Clindamycin Phosphate Vaginal	T1	
Dapsone Oral	T1	
Doxycycline Hyclate (Doxy 100)	T1	
Doxycycline Hyclate Oral Capsule	T1	
Doxycycline Hyclate Oral Tablet 100 MG	T1	
Doxycycline Hyclate Oral Tablet 20 MG	T1	PA
Doxycycline Monohydrate Oral Capsule 100 MG, 50 MG	T1	
Doxycycline Monohydrate Oral Suspension Reconstituted	T1	
Doxycycline Monohydrate Oral Tablet 100 MG, 50 MG, 75 MG	T1	
EQL Bacitracin Zinc	T1	
Ery	T1	
Erythromycin External Gel	T1	
Erythromycin External Solution	T1	
FINACEA EXTERNAL FOAM (***Azelaic Acid***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gentamicin Sulfate External	T1	
Gentamicin Sulfate Ophthalmic Solution	T1	
levoFLOXacin Oral Solution	T1	
levoFLOXacin Oral Tablet	T1	QL (30 EA per 30 days)
metroNIDAZOLE External Cream	T1	QL (45 GM per 30 days)
metroNIDAZOLE External Gel 0.75 %	T1	QL (45 GM per 30 days)
metroNIDAZOLE External Gel 1 %	T1	QL (60 GM per 30 days)
metroNIDAZOLE Oral Capsule	T1	
metroNIDAZOLE Oral Tablet 250 MG, 500 MG	T1	
metroNIDAZOLE Vaginal	T1	
Minocycline HCl Oral Capsule 100 MG	T1	QL (60 EA per 30 days)
Minocycline HCl Oral Capsule 50 MG	T1	
Doxycycline Monohydrate (Mondoxyne Nl Oral Capsule 100 Mg)	T1	
Moxifloxacin HCl Oral	T1	QL (21 EA per 21 days)
Mupirocin External	T1	
Neomycin Sulfate Oral	T1	
NORITATE (***MetroNIDAZOLE***)	T1	PA
Polymyxin B-Trimethoprim	T1	
Sodium Sulfacetamide External Shampoo 10 %	T1	
SSS 10-5 External Cream	T1	
Sulfacetamide Sodium-Sulfur External Cream 10-5 %	T1	
Sulfacetamide Sodium-Sulfur External Lotion 10-5 %	T1	
Sulfacetamide Sodium-Sulfur External Suspension 10-5 %	T1	
Sulfacetamide-Sulfur in Urea External Emulsion	T1	
SULFAMYLON EXTERNAL CREAM (***Mafenide Acetate***)	T1	PA
Tetracycline HCl Oral Capsule	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antifulgals (Skin, Mucous Membrane),Misc		
EXODERM EXTERNAL LOTION (***Sod Thiosulfate-Salicylic Acd***)	T1	
Anti-Inflammatory Agents (Skin, Mucous)		
Ala-Cort External Cream 1 %	T1	
Alclometasone Dipropionate	T1	PA
Anucort-HC	T1	
ANUSOL-HC EXTERNAL (***Hydrocortisone***)	T1	
Betamethasone Dipropionate Aug External Cream	T1	
Betamethasone Dipropionate Aug External Gel	T1	
Betamethasone Dipropionate Aug External Lotion	T1	PA
Betamethasone Dipropionate Aug External Ointment	T1	PA
Betamethasone Dipropionate External	T1	
Betamethasone Valerate External Cream	T1	
Betamethasone Valerate External Foam	T1	PA
Betamethasone Valerate External Lotion	T1	
Betamethasone Valerate External Ointment	T1	
Calcipotriene-Betameth Diprop External Suspension	T1	PA
Clobetasol Prop Emollient Base	T1	
Clobetasol Propionate E	T1	
Clobetasol Propionate External Cream 0.05 %	T1	
Clobetasol Propionate External Foam	T1	
Clobetasol Propionate External Gel	T1	
Clobetasol Propionate External Lotion	T1	
Clobetasol Propionate External Ointment	T1	
Clobetasol Propionate External Shampoo	T1	PA
Clobetasol Propionate External Solution	T1	
Clocortolone Pivalate	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Clobetasol Propionate (Clodan External Shampoo)	T1	PA
Clotrimazole-Betamethasone	T1	
CORDRAN EXTERNAL TAPE (***Flurandrenolide***)	T1	PA
CORTIFOAM EXTERNAL (***Hydrocortisone Acetate***)	T1	PA
Desonide External Cream	T1	
Desonide External Lotion	T1	PA
Desonide External Ointment	T1	
Desoximetasone External Cream	T1	PA
Desoximetasone External Gel	T1	PA
Desoximetasone External Ointment 0.25 %	T1	PA
Diflorasone Diacetate External	T1	PA
EPIFOAM (***Pramoxine-HC***)	T1	PA
Fluocinolone Acetonide Body	T1	
Fluocinolone Acetonide External	T1	
Fluocinolone Acetonide Scalp	T1	
Fluocinonide Emulsified Base	T1	
Fluocinonide External	T1	
Flurandrenolide External Lotion	T1	PA
Fluticasone Propionate External Cream	T1	
Fluticasone Propionate External Ointment	T1	
Halcinonide External Cream	T1	PA
Halobetasol Propionate External Cream	T1	
Halobetasol Propionate External Ointment	T1	
HALOG EXTERNAL SOLUTION (***Halcinonide***)	T1	PA
Hydrocortisone (Perianal)	T1	
Hydrocortisone Ace-Pramoxine External Cream 1-1 %, 2.5-1 %	T1	
Hydrocortisone Acetate Rectal	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs UPPERCASE = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hydrocortisone Butyrate External Cream	T1	PA
Hydrocortisone Butyrate External Ointment	T1	PA
Hydrocortisone Butyrate External Solution	T1	PA
Hydrocortisone External Cream 1 %, 2.5 %	T1	
Hydrocortisone External Lotion 2.5 %	T1	
Hydrocortisone External Ointment 1 %, 2.5 %	T1	
Hydrocortisone Rectal Enema	T1	
Hydrocortisone Valerate	T1	PA
Hydrocort-Pramoxine (Perianal)	T1	
Lidocaine-Hydrocort (Perianal)	T1	
Lidocaine-Hydrocortisone Ace Rectal Kit 3-0.5 %	T1	
LIDOCORT EXTERNAL (***Lidocaine-Hydrocortisone Ace***)	T1	
Mometasone Furoate External	T1	
Triamcinolone Acetonide (Oralone)	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (***Pramoxine-HC***)	T1	
PRAMOSONE EXTERNAL LOTION (***Pramoxine-HC***)	T1	PA
PROCTOFOAM HC EXTERNAL (***Hydrocortisone Ace-Pramoxine***)	T1	PA
Hydrocortisone (Procto-Med Hc External)	T1	
Hydrocortisone (Proctosol Hc External)	T1	
Hydrocortisone (Proctozone-Hc External)	T1	
TEXACORT (***Hydrocortisone***)	T1	
Triamcinolone Acetonide External Aerosol Solution	T1	PA
Triamcinolone Acetonide External Cream	T1	
Triamcinolone Acetonide External Lotion	T1	
Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Triamcinolone Acetonide External Ointment 0.05 %	T1	PA
Triamcinolone Acetonide Mouth/Throat	T1	
Triamcinolone in Absorbase	T1	PA
Triamcinolone Acetonide (Triderm External Cream 0.5 %)	T1	
Antiproliferants		
Bexarotene Oral	T1	PA
Fluorouracil External Cream 5 %	T1	
Fluorouracil External Solution	T1	
Imiquimod External Cream 5 %	T1	
Antipruritics And Local Anesthetics		
CETACAINE EXTERNAL AEROSOL (***Butamben-Tetracaine-Benzocaine***)	T1	
CORTANE-B EXTERNAL (***HC-Pramoxine-Chloroxylenol***)	T1	
CRYODOSE TA (***Pentafluoroprop-Tetrafluoroeth***)	T1	
CVS Itch Relief External Gel	T1	
Doxepin HCl External	T1	
Doxepin HCl Oral Capsule	T1	
Doxepin HCl Oral Concentrate	T1	
Doxepin HCl Oral Tablet	T1	PA
EPIFOAM (***Pramoxine-HC***)	T1	PA
Ethyl Chloride	T1	
GEBAUERS PAIN EASE (***Pentafluoroprop-Tetrafluoroeth***)	T1	
GEBAUERS SPRAY AND STRETCH (***Pentafluoroprop-Tetrafluoroeth***)	T1	
Lidocaine HCl (Glydo External Prefilled Syringe)	T1	
Hydrocortisone Ace-Pramoxine External Cream 1-1 %, 2.5-1 %	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hydrocort-Pramoxine (Perianal)	T1	
Lidocaine External Ointment 5 %	T1	QL (60 GM per 30 days)
Lidocaine External Patch 5 %	T1	PA
Lidocaine HCl External Cream 3 %	T1	
Lidocaine HCl External Solution	T1	PA
Lidocaine HCl Urethral/Mucosal External Prefilled Syringe	T1	
Lidocaine-Hydrocort (Perianal)	T1	
Lidocaine-Hydrocortisone Ace Rectal Kit 3-0.5 %	T1	
Lidocaine-Prilocaine External Cream	T1	QL (60 GM per 30 days)
LIDOCORT EXTERNAL (***Lidocaine-Hydrocortisone Ace***)	T1	
Lidopin External Cream 3 %	T1	QL (85 GM per 30 days)
Phenazopyridine HCl Oral Tablet 100 MG, 200 MG	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (***Pramoxine-HC***)	T1	
PRAMOSONE EXTERNAL LOTION (***Pramoxine-HC***)	T1	PA
PROCTOFOAM HC EXTERNAL (***Hydrocortisone Ace-Pramoxine***)	T1	PA
REGENECARE (***Lidocaine-Collagen-Aloe Vera***)	T1	
Zionodil	T1	
Antivirals (Skin And Mucous Membrane)		
Acyclovir External	T1	PA
Acyclovir Oral Capsule	T1	
Acyclovir Oral Suspension 200 MG/5ML	T1	
Acyclovir Oral Tablet	T1	
Astringents (84:12)		
DRYSOL (***Aluminum Chloride***)	T1	
Glycopyrrolate Oral Tablet 1 MG, 2 MG	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XERAC AC (***Aluminum Chloride in Alcohol***)	T1	
Astringents, Anti-Infective		
Benzalkonium Chloride External Solution , 50 %	T1	
Chlorhexidine Gluconate Mouth/Throat	T1	
Hydrocortisone-Iodoquinol External Cream 1-1 %	T1	
Iodine Strong Oral	T1	
IODOFLEX (***Cadexomer Iodine***)	T1	
Chlorhexidine Gluconate (Periogard)	T1	
Selenium Sulfide External Lotion	T1	
Selenium Sulfide External Shampoo 2.25 %	T1	
Silver sulfADIAZINE External	T1	
Azoles (Skin And Mucous Membrane)		
Clotrimazole External Cream	T1	
Clotrimazole External Solution	T1	
Clotrimazole Mouth/Throat Troche	T1	
Clotrimazole-Betamethasone	T1	
Econazole Nitrate External Cream	T1	
GYNAZOLE-1 (***Butoconazole Nitrate (1 Dose)***)	T1	
Ketoconazole External Cream	T1	
Ketoconazole External Shampoo 2 %	T1	
Miconazole 3 Vaginal Suppository	T1	
Miconazole Nitrate External Cream	T1	
Terconazole Vaginal Cream	T1	
Terconazole Vaginal Suppository	T1	PA
Basic Ointments And Protectants		
Calcipotriene External	T1	PA
Calcipotriene-Betameth Diprop External Suspension	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Emollient Base	T1	
Hydrocortisone External Cream 1 %	T1	
REGENECARE (***Lidocaine-Collagen-Aloe Vera***)	T1	
SANTYL (***Collagenase***)	T1	
Cell Stimulants And Proliferants		
Finasteride Oral Tablet 5 MG	T1	
Minoxidil Oral	T1	
Tretinoin External Cream	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin External Gel 0.01 %, 0.025 %	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin Microsphere External Gel 0.04 %, 0.1 %	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin Microsphere Pump External Gel 0.04 %, 0.1 %	T1	QL (50 GM per 30 days); AL (Max 29 Years)
Tretinoin Oral	T1	PA
Corticosteroids (Skin, Mucous Membrane)		
Ala-Cort External Cream 1 %	T1	
Alclometasone Dipropionate	T1	PA
Anucort-HC	T1	
ANUSOL-HC EXTERNAL (***Hydrocortisone***)	T1	
Betamethasone Dipropionate Aug External Cream	T1	
Betamethasone Dipropionate Aug External Gel	T1	
Betamethasone Dipropionate Aug External Lotion	T1	PA
Betamethasone Dipropionate Aug External Ointment	T1	PA
Betamethasone Dipropionate External	T1	
Betamethasone Valerate External Cream	T1	
Betamethasone Valerate External Foam	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Betamethasone Valerate External Lotion	T1	
Betamethasone Valerate External Ointment	T1	
Budesonide Rectal Foam 2 MG	T1	PA
Calcipotriene-Betameth Diprop External Suspension	T1	PA
Clobetasol Prop Emollient Base	T1	
Clobetasol Propionate E	T1	
Clobetasol Propionate External Cream 0.05 %	T1	
Clobetasol Propionate External Foam	T1	
Clobetasol Propionate External Gel	T1	
Clobetasol Propionate External Lotion	T1	
Clobetasol Propionate External Ointment	T1	
Clobetasol Propionate External Shampoo	T1	PA
Clobetasol Propionate External Solution	T1	
Clocortolone Pivalate	T1	PA
Clobetasol Propionate (Clodan External Shampoo)	T1	PA
Clotrimazole-Betamethasone	T1	
CORDRAN EXTERNAL TAPE (***Flurandrenolide***)	T1	PA
CORTANE-B EXTERNAL (***HC-Pramoxine-Chloroxylenol***)	T1	
CORTIFOAM EXTERNAL (***Hydrocortisone Acetate***)	T1	PA
Desonide External Cream	T1	
Desonide External Lotion	T1	PA
Desonide External Ointment	T1	
Desoximetasone External Cream	T1	PA
Desoximetasone External Gel	T1	PA
Desoximetasone External Ointment 0.25 %	T1	PA
Diflorasone Diacetate External	T1	PA
EPIFOAM (***Pramoxine-HC***)	T1	PA
Fluocinolone Acetonide Body	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fluocinolone Acetonide External	T1	
Fluocinolone Acetonide Scalp	T1	
Fluocinonide Emulsified Base	T1	
Fluocinonide External	T1	
Flurandrenolide External Lotion	T1	PA
Fluticasone Propionate External Cream	T1	
Fluticasone Propionate External Ointment	T1	
Halcinonide External Cream	T1	PA
Halobetasol Propionate External Cream	T1	
Halobetasol Propionate External Ointment	T1	
HALOG EXTERNAL SOLUTION (***Halcinonide***)	T1	PA
Hydrocortisone (Perianal)	T1	
Hydrocortisone Ace-Pramoxine External Cream 1-1 %, 2.5-1 %	T1	
Hydrocortisone Acetate Rectal	T1	
Hydrocortisone Butyrate External Cream	T1	PA
Hydrocortisone Butyrate External Ointment	T1	PA
Hydrocortisone Butyrate External Solution	T1	PA
Hydrocortisone External Cream 1 %, 2.5 %	T1	
Hydrocortisone External Lotion 2.5 %	T1	
Hydrocortisone External Ointment 1 %, 2.5 %	T1	
Hydrocortisone Oral	T1	
Hydrocortisone Rectal Enema	T1	
Hydrocortisone Valerate	T1	PA
Hydrocortisone-Acetic Acid	T1	
Hydrocortisone-Iodoquinol External Cream 1-1 %	T1	
Hydrocort-Pramoxine (Perianal)	T1	
Lidocaine-Hydrocort (Perianal)	T1	

	Drug Tier	Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Lidocaine-Hydrocortisone Ace Rectal Kit 3-0.5 %	T1	
LIDOCORT EXTERNAL (***Lidocaine-Hydrocortisone Ace***)	T1	
Mometasone Furoate External	T1	
Nystatin-Triamcinolone	T1	
Triamcinolone Acetonide (Oralone)	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (***Pramoxine-HC***)	T1	
PRAMOSONE EXTERNAL LOTION (***Pramoxine-HC***)	T1	PA
PROCTOFOAM HC EXTERNAL (***Hydrocortisone Ace-Pramoxine***)	T1	PA
Hydrocortisone (Procto-Med Hc External)	T1	
Hydrocortisone (Proctosol Hc External)	T1	
Hydrocortisone (Proctozone-Hc External)	T1	
TEXACORT (***Hydrocortisone***)	T1	
Triamcinolone Acetonide External Aerosol Solution	T1	PA
Triamcinolone Acetonide External Cream	T1	
Triamcinolone Acetonide External Lotion	T1	
Triamcinolone Acetonide External Ointment 0.025 %, 0.1 %, 0.5 %	T1	
Triamcinolone Acetonide External Ointment 0.05 %	T1	PA
Triamcinolone Acetonide Mouth/Throat	T1	
Triamcinolone in Absorbase	T1	PA
Triamcinolone Acetonide (Triderm External Cream 0.5 %)	T1	
Detergents		
Polysorbate 80	T1	
Hydroxypyridones (Skin, Mucous Membrane)		
Ciclopirox (Ciclodan External Solution)	T1	
Ciclopirox External	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ciclopirox Olamine External	T1	
Immunomodulatory Agents (84:06)		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Dupilumab***)	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (***Dupilumab***)	T1	PA
Pimecrolimus	T1	PA
PROGRAF ORAL CAPSULE (***Tacrolimus***)	T1	
SILIQ (***Brodalumab***)	T1	PA
Sirolimus Oral	T1	
Tacrolimus External Ointment	T1	QL (30 GM per 30 days)
Tacrolimus Oral	T1	
Janus Kinase Inhibitors (84:06)		
JAKAFI (***Ruxolitinib Phosphate***)	T1	PA
Keratolytic Agents		
ISOtretinoin (Accutane Oral Capsule 40 Mg)	T1	PA
Acitretin Oral Capsule 10 MG, 25 MG	T1	
Adapalene External Gel 0.1 %	T1	
Adapalene External Pad	T1	
Adapalene External Solution	T1	
Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %	T1	QL (45 GM per 30 days); AL (Max 30 Years)
ISOtretinoin (Amnesteem)	T1	PA
AVAR-E EMOLLIENT (***Sulfacetamide Sodium-Sulfur***)	T1	
Benzoyl Peroxide External Gel 10 %	T1	
Benzoyl Peroxide Wash External Liquid 10 %	T1	
ISOtretinoin (Claravis)	T1	PA
Clindamycin Phos-Benzoyl Perox External Gel 1-5 %	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONDYLOX EXTERNAL GEL (***Podofilox***)	T1	QL (7 GM per 365 days)
EXODERM EXTERNAL LOTION (***Sod Thiosulfate-Salicylic Acd***)	T1	
ISOtretinoin Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG	T1	PA
Podofilox External Solution	T1	
Salicylic Acid External Shampoo	T1	
Selenium Sulfide External Shampoo 2.25 %	T1	
SSS 10-5 External Cream	T1	
Sulfacetamide Sodium-Sulfur External Cream 10-5 %	T1	
Sulfacetamide Sodium-Sulfur External Lotion 10-5 %	T1	
Sulfacetamide Sodium-Sulfur External Suspension 10-5 %	T1	
Sulfacetamide-Sulfur in Urea External Emulsion	T1	
Tazarotene External Cream	T1	
Tazarotene External Gel	T1	
ISOtretinoin (Zenatane)	T1	PA
Keratoplastic Agents		
Coal Tar External Solution	T1	
Coal Tar Solution	T1	
Local Anti-Infectives, Miscellaneous		
Acetic Acid Glacial Solution 99 %	T1	
Acetic Acid Solution 5 %	T1	
Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %	T1	QL (45 GM per 30 days); AL (Max 30 Years)
AVAR-E EMOLLIENT (***Sulfacetamide Sodium-Sulfur***)	T1	
Benzalkonium Chloride External Solution , 50 %	T1	
Benzoyl Peroxide External Gel 10 %	T1	
Benzoyl Peroxide Wash External Liquid 10 %	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Chlorhexidine Gluconate Mouth/Throat	T1	
Clindamycin Phos-Benzoyl Perox External Gel 1-5 %	T1	PA
CORTANE-B EXTERNAL (***HC-Pramoxine-Chloroxylenol***)	T1	
DEBACTEROL (***Sulfuric Acid-Sulf Phenolics***)	T1	
FEM PH (***Acetic Acid-Oxyquinoline***)	T1	
Hydrocortisone-Iodoquinol External Cream 1-1 %	T1	
Hydrogen Peroxide Solution 30 %	T1	
IODOFLEX (***Cadexomer Iodine***)	T1	
Chlorhexidine Gluconate (Periogard)	T1	
Selenium Sulfide External Lotion	T1	
Selenium Sulfide External Shampoo 2.25 %	T1	
Silver Nitrate External Solution 0.5 %	T1	
Silver sulfADIAZINE External	T1	
Sodium Sulfacetamide External Shampoo 10 %	T1	
SSS 10-5 External Cream	T1	
Sulfacetamide Sodium-Sulfur External Cream 10-5 %	T1	
Sulfacetamide Sodium-Sulfur External Lotion 10-5 %	T1	
Sulfacetamide Sodium-Sulfur External Suspension 10-5 %	T1	
Sulfacetamide-Sulfur in Urea External Emulsion	T1	
SULFAMYLON EXTERNAL CREAM (***Mafenide Acetate***)	T1	PA
Nonsteroidal Anti-Inflammat.Agents(Skin)		
Diclofenac Epolamine External	T1	PA
Diclofenac Sodium External Gel 1 %	T1	
Pigmenting Agents		
UVADEX EXTRACORPOREAL (***Methoxsalen (Photopheresis)***)	T1	
Polyenes (Skin And Mucous Membrane)		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nystatin External	T1	
Nystatin Mouth/Throat	T1	
Nystatin-Triamcinolone	T1	
Nystatin (Nystop)	T1	
Scabicides And Pediculicides		
Malathion External	T1	PA
Permethrin External Cream	T1	
Spinosad	T1	PA
Skin And Mucous Membrane Agents, Misc.		
ISOtretinoin (Accutane Oral Capsule 40 Mg)	T1	PA
Acitretin Oral Capsule 10 MG, 25 MG	T1	
Adapalene External Gel 0.1 %	T1	
Adapalene External Pad	T1	
Adapalene External Solution	T1	
Adapalene-Benzoyl Peroxide External Gel 0.1-2.5 %	T1	QL (45 GM per 30 days); AL (Max 30 Years)
ISOtretinoin (Amnesteem)	T1	PA
AVSOLA (***inFLIXimab-axxq***)	T1	PA
Azelaic Acid External	T1	PA
Calcipotriene External	T1	PA
Calcipotriene-Betameth Diprop External Suspension	T1	PA
Calcitriol External	T1	PA
ISOtretinoin (Claravis)	T1	PA
CONDYLOX EXTERNAL GEL (***Podofilox***)	T1	QL (7 GM per 365 days)
Dapsone Oral	T1	
DEBACTEROL (***Sulfuric Acid-Sulf Phenolics***)	T1	
Diclofenac Epolamine External	T1	PA
Diclofenac Sodium External Gel 1 %	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Dupilumab***)	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (***Dupilumab***)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (***Etanercept***)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (***Etanercept***)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR (***Etanercept***)	T1	PA
FEM PH (***Acetic Acid-Oxyquinoline***)	T1	
FINACEA EXTERNAL FOAM (***Azelaic Acid***)	T1	PA
Fluorouracil External Cream 5 %	T1	
Fluorouracil External Solution	T1	
GELCLAIR (***Povidone-NaHyaluron-Glycyrrhet***)	T1	
Imiquimod External Cream 5 %	T1	
INFLECTRA (***InFLIXimab-dyyb***)	T1	PA
inFLIXimab	T1	PA
ISOtretinoin Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG	T1	PA
ORAMAGICRX (***Oral Wound Care Products***)	T1	
OTEZLA ORAL TABLET (***Apremilast***)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK (***Apremilast***)	T1	PA
Pimecrolimus	T1	PA
Podofilox External Solution	T1	
RADIAPLEXRX (***Wound Dressings***)	T1	
REGENECARE (***Lidocaine-Collagen-Aloe Vera***)	T1	
RENFLEXIS (***InFLIXimab-abda***)	T1	PA
SANTYL (***Collagenase***)	T1	
SILIQ (***Brodalumab***)	T1	PA

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tacrolimus External Ointment	T1	QL (30 GM per 30 days)
Tazarotene External Cream	T1	
Tazarotene External Gel	T1	
ISOtretinoin (Zenatane)	T1	PA
Smooth Muscle Relaxants		
Antimuscarinics		
Darifenacin Hydrobromide ER	T1	PA
Fesoterodine Fumarate ER	T1	PA
FlavoxATE HCl	T1	PA
Oxybutynin Chloride ER	T1	
oxyBUTYnin Chloride Oral Solution	T1	
Oxybutynin Chloride Oral Tablet 5 MG	T1	
OXYTROL (***Oxybutynin***)	T1	PA
Solifenacin Succinate	T1	
Tolterodine Tartrate	T1	
Tolterodine Tartrate ER	T1	QL (30 EA per 30 days)
Trospium Chloride	T1	PA
Trospium Chloride ER	T1	PA
Genitourinary Smooth Muscle Relaxants		
FlavoxATE HCl	T1	PA
Oxybutynin Chloride ER	T1	
Oxybutynin Chloride Oral Tablet 5 MG	T1	
OXYTROL (***Oxybutynin***)	T1	PA
Tolterodine Tartrate	T1	
Trospium Chloride	T1	PA
Trospium Chloride ER	T1	PA
Respiratory Smooth Muscle Relaxants		

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sildenafil Citrate Oral Tablet 20 MG	T1	PA
THEO-24 (***Theophylline***)	T1	
Theophylline ER	T1	
Theophylline Oral Elixir	T1	
Selective Beta-3-Adrenergic Agonists		
GEMTESA (***Vibegron***)	T1	PA
Mirabegron ER	T1	PA
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER (***Mirabegron***)	T1	PA
Vitamins		
Multivitamin Preparations		
Actical	T1	
B Complex Formula 1 (Lipotrop)	T1	
B Complex-C Oral Tablet	T1	
B Complex-C-Biotin-E-FA	T1	
B Complex-C-Folic Acid	T1	
Balance B-50	T1	
B-Complex (Folic Acid)	T1	
B-Complex/Vitamin C	T1	
B-Complex-C Oral Tablet	T1	
Centravites 50 Plus	T1	
Childrens Chew Multivitamin	T1	
Childrens Chewable Vitamins	T1	
Classic Prenatal	T1	
Complete Natal DHA Oral 29-1-200 & 200 MG	T1	
CVS B Complex Plus C	T1	
CVS One Daily Essential	T1	
CVS Super B Complex/C	T1	

	Drug Tier	Coverage Requirements and Limits
bold italics = Generic drugs UPPERCASE = Brand name drugs	**SCO** = State Carve Out **T1** = Preferred Medication **T2** = Preferred Medication with Restriction **T3** = Non-Preferred Medication - Prior Authorization is Required	**AL** = Age Limit **PA** = Prior Authorization **QL** = Quantity Limit **SCO** = State Carve Out **ST** = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Daily Value Multivitamin	T1	
Daily Vite	T1	
Daily Vites	T1	
Daily-Vite	T1	
Daily-Vite Multivitamin	T1	
DIALYVITE 3000 (***B Complex-C-Biotin-E-Min-FA***)	T1	
DIALYVITE 800 ORAL TABLET (***B Complex-C-Folic Acid***)	T1	
DIALYVITE/ZINC (***B Complex-C-Zn-Folic Acid***)	T1	
ELITE-OB (***Prenatal Vit-Iron Carbonyl-FA***)	T1	
EQL Prenatal Formula	T1	
Essential One Daily Multivit	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (***Pediatric Multiple Vitamins***)	T1	
Folbee Plus	T1	
Full Spectrum B/Vitamin C	T1	
GERITOL ENERGY SUPPORT (***Iron-Vitamins***)	T1	
GERITOL TONIC (***Iron-Vitamins***)	T1	
GNP Essential One Daily	T1	
GNP PreNatal	T1	
GUMMI BEAR MULTIVITAMIN/MIN (***Pediatric Multivit-Minerals***)	T1	
Hylavite	T1	
Kobee	T1	
LYSIPLEX PLUS ORAL LIQUID (***Multiple Vitamins-Minerals***)	T1	
M-Natal Plus	T1	
Multiple Vitamins Oral Tablet	T1	
Multiple Vitamins-Iron Oral Tablet Chewable	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Multi-Vitamin	T1	
Multivitamin Adult Oral Tablet	T1	
Multivitamin Childrens	T1	
Multivitamin Childrens (w/ FA)	T1	
Multivitamin Oral Tablet	T1	
Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG	T1	
Nephro Vitamins	T1	
NEPHRO-VITE (***B Complex-C-Folic Acid***)	T1	
NUTRIVIT (***B Complex-Lysine-Min-Fe-FA***)	T1	
One-Daily Multi-Vitamin Oral Tablet	T1	
PC Pediatric Tri-Vitamin Drops	T1	
Prenatal Gummies/DHA & FA	T1	
PRENATAL MULTIVITAMIN + DHA (***Prenatal MV-Min-Fe Fum-FA-DHA***)	T1	
Prenatal One Daily	T1	
Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG	T1	
Prenatal Plus	T1	
Prenatal Vitamin and Mineral	T1	
Prenatal Vitamins Oral Tablet 28-0.8 MG	T1	
Prenatal/Iron	T1	
QC Prenatal	T1	
Quintabs	T1	
RENAL ORAL CAPSULE (***B Complex-C-Folic Acid***)	T1	
Renal Vitamin	T1	
Rena-Vite	T1	
Rena-Vite Rx	T1	
Reno Caps	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Stress Formula	T1	
Super B Complex/FA/Vit C	T1	
Super B/C	T1	
Super B-Complex + Vitamin C	T1	
Super B-Complex/Vit C/FA	T1	
Support	T1	
SUPPORT-500 (***Multiple Vitamins-Minerals***)	T1	
THERA (***Multiple Vitamin***)	T1	
Thrivite Rx	T1	
Triphrocaps	T1	
Tri-Vite Pediatric	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	
V-C Forte	T1	
VIC-FORTE (***Multiple Vitamins-Minerals***)	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (***Pediatric Multivit-Minerals***)	T1	
WesCaps	T1	
WesTab Plus	T1	
Vitamin A		
AQUASOL A INTRAMUSCULAR SOLUTION 50000 UNIT/ML (***Vitamin A***)	T1	
PC Pediatric Tri-Vitamin Drops	T1	
Tri-Vite Pediatric	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	
Vitamin B Complex		
B Complex-C Oral Tablet	T1	
B Complex-C-Biotin-E-FA	T1	
B Complex-C-Folic Acid	T1	

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Drug Tier
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Coverage Requirements and Limits
AL = Age Limit
PA = Prior Authorization
QL = Quantity Limit
SCO = State Carve Out
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
B1	T1	
B-1 Oral Tablet 100 MG	T1	
B-12 DOTS (***Cyanocobalamin***)	T1	
B-12 Oral Tablet 100 MCG, 50 MCG, 500 MCG	T1	
B-12 TR Oral Tablet Extended Release 2000 MCG	T1	
Balance B-50	T1	
B-Complex (Folic Acid)	T1	
B-Complex/B-12 Oral	T1	PA
B-Complex/Vitamin C	T1	
B-Complex-C Oral Tablet	T1	
BP Vit 3	T1	
Centravites 50 Plus	T1	
Childrens Chew Multivitamin	T1	
Childrens Chewable Vitamins	T1	
Classic Prenatal	T1	
Complete Natal DHA Oral 29-1-200 & 200 MG	T1	
CVS B Complex Plus C	T1	
CVS B-1	T1	
CVS B-12 Oral Tablet	T1	
CVS One Daily Essential	T1	
CVS Super B Complex/C	T1	
CVS Vitamin B-12 Oral Tablet Extended Release	T1	
Cyanocobalamin Injection Solution 1000 MCG/ML	T1	
DIALYVITE 3000 (***B Complex-C-Biotin-E-Min-FA***)	T1	
DIALYVITE 800 ORAL TABLET (***B Complex-C-Folic Acid***)	T1	
DIALYVITE/ZINC (***B Complex-C-Zn-Folic Acid***)	T1	
Drospiren-Eth Estrad-Levomefol	T1	
ELITE-OB (***Prenatal Vit-Iron Carbonyl-FA***)	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 500 MG (***Niacin***)	T1	
EQL Prenatal Formula	T1	
EQL Vitamin B-12	T1	
Essential One Daily Multivit	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (***Pediatric Multiple Vitamins***)	T1	
Folbee Plus	T1	
Folic Acid Injection	T1	
Folic Acid Oral Tablet 1 MG, 400 MCG	T1	
Folplex 2.2	T1	
Full Spectrum B/Vitamin C	T1	
GERITOL TONIC (***Iron-Vitamins***)	T1	
GNP Essential One Daily	T1	
GNP PreNatal	T1	
GNP Vitamin B-1	T1	
GNP Vitamin B-12 Oral Tablet	T1	
Hematinic Plus Vit/Minerals	T1	
Hematinic/Folic Acid	T1	
HEMATOGEN FA (***Fe Fum-Vit C-Vit B12-FA***)	T1	
Hydroxocobalamin Acetate	T1	
Hylavite	T1	
Kobee	T1	
KP Folic Acid Oral Tablet 1 MG	T1	
LEDERLE LEUCOVORIN (***Leucovorin Calcium***)	T1	
Leucovorin Calcium Oral Tablet 5 MG	T1	
METAFOLBIC (***L-Methylfolate-B12-B6-B2***)	T1	
M-Natal Plus	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Multivitamin Adult Oral Tablet	T1	
Multivitamin Childrens	T1	
Multivitamin Childrens (w/ FA)	T1	
Multivitamin/Fluoride Oral Tablet Chewable 0.25 MG, 0.5 MG, 1 MG	T1	
Nephro Vitamins	T1	
NEPHRO-VITE (***B Complex-C-Folic Acid***)	T1	
Neurin-SL	T1	
Niacin (Antihyperlipidemic)	T1	
Niacin ER (Antihyperlipidemic)	T1	PA
NIAVASC (***Niacin***)	T1	
NUTRIVIT (***B Complex-Lysine-Min-Fe-FA***)	T1	
Poly-Iron 150 Forte	T1	
Prenatal Gummies/DHA & FA	T1	
PRENATAL MULTIVITAMIN + DHA (***Prenatal MV-Min-Fe Fum-FA-DHA***)	T1	
Prenatal One Daily	T1	
Prenatal Oral Tablet 27-0.8 MG, 27-1 MG, 28-0.8 MG	T1	
Prenatal Plus	T1	
Prenatal Vitamin and Mineral	T1	
Prenatal Vitamins Oral Tablet 28-0.8 MG	T1	
Prenatal/Iron	T1	
Pyridoxine HCl Injection	T1	
QC Prenatal	T1	
Quintabs	T1	
RENAL ORAL CAPSULE (***B Complex-C-Folic Acid***)	T1	
Renal Vitamin	T1	
Rena-Vite	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Rena-Vite Rx	T1	
Reno Caps	T1	
Stress Formula	T1	
Super B Complex/FA/Vit C	T1	
Super B/C	T1	
Super B-Complex + Vitamin C	T1	
Super B-Complex/Vit C/FA	T1	
SUPPORT-500 (***Multiple Vitamins-Minerals***)	T1	
Thiamine HCl Injection	T1	
Thiamine HCl Oral	T1	
Thiamine Mononitrate Oral	T1	
Thrivite Rx	T1	
Trigels-F Forte	T1	
Triphrocaps	T1	
V-C Forte	T1	
VIC-FORTE (***Multiple Vitamins-Minerals***)	T1	
Vitamin B 12 Oral Tablet	T1	
Vitamin B Complex Oral Tablet	T1	PA
Vitamin B1 Oral Tablet 100 MG	T1	
Vitamin B-1 Oral Tablet 100 MG	T1	
Vitamin B-12 ER Oral Tablet Extended Release 2000 MCG	T1	
Vitamin B12 TR Oral Tablet Extended Release 2000 MCG	T1	
WesCaps	T1	
WesTab Plus	T1	
Vitamin C		
Ascorbic Acid Injection	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
B Complex-C Oral Tablet	T1	
B Complex-C-Biotin-E-FA	T1	
B Complex-C-Folic Acid	T1	
B-Complex/Vitamin C	T1	
B-Complex-C Oral Tablet	T1	
Childrens Chew Multivitamin	T1	
Childrens Chewable Vitamins	T1	
CVS B Complex Plus C	T1	
CVS Super B Complex/C	T1	
DIALYVITE 3000 (***B Complex-C-Biotin-E-Min-FA***)	T1	
DIALYVITE 800 ORAL TABLET (***B Complex-C-Folic Acid***)	T1	
DIALYVITE/ZINC (***B Complex-C-Zn-Folic Acid***)	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (***Pediatric Multiple Vitamins***)	T1	
Folbee Plus	T1	
Full Spectrum B/Vitamin C	T1	
GUMMI BEAR MULTIVITAMIN/MIN (***Pediatric Multivit-Minerals***)	T1	
Hematinic Plus Vit/Minerals	T1	
HEMATOGEN FA (***Fe Fum-Vit C-Vit B12-FA***)	T1	
Hylavite	T1	
Multivitamin Childrens	T1	
Multivitamin Childrens (w/ FA)	T1	
Nephro Vitamins	T1	
NEPHRO-VITE (***B Complex-C-Folic Acid***)	T1	
PC Pediatric Tri-Vitamin Drops	T1	
RENAL ORAL CAPSULE (***B Complex-C-Folic Acid***)	T1	
Renal Vitamin	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Rena-Vite	T1	
Rena-Vite Rx	T1	
Reno Caps	T1	
Stress Formula	T1	
Super B Complex/FA/Vit C	T1	
Super B/C	T1	
Super B-Complex + Vitamin C	T1	
Super B-Complex/Vit C/FA	T1	
SUPPORT-500 (***Multiple Vitamins-Minerals***)	T1	
Trigels-F Forte	T1	
Triphrocaps	T1	
Tri-Vite Pediatric	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (***Pediatric Multivit-Minerals***)	T1	
Vitamin B Complex Oral Tablet	T1	PA
WesCaps	T1	
Vitamin D		
Actical	T1	
Calcitriol Oral	T1	
Doxercalciferol Oral Capsule 0.5 MCG, 2.5 MCG	T1	
Ergocalciferol Oral Capsule	T1	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT (***Alendronate-Cholecalciferol***)	T1	PA
PC Pediatric Tri-Vitamin Drops	T1	
Tri-Vite Pediatric	T1	
Tri-Vite/Fluoride Oral Solution 0.25 MG/ML	T1	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamin D (Ergocalciferol) Oral Capsule 1.25 MG (50000 UT)	T1	
Vitamin E		
B Complex-C-Biotin-E-FA	T1	
DIALYVITE 3000 (***B Complex-C-Biotin-E-Min-FA***)	T1	
Vitamin K Activity		
Multivitamin Adult Oral Tablet	T1	
Phytonadione Injection Solution 1 MG/0.5ML, 10 MG/ML	T1	
Phytonadione Oral	T1	
Vitamin K1 Injection Solution 1 MG/0.5ML, 10 MG/ML	T1	

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