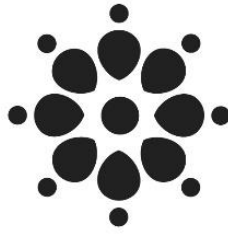


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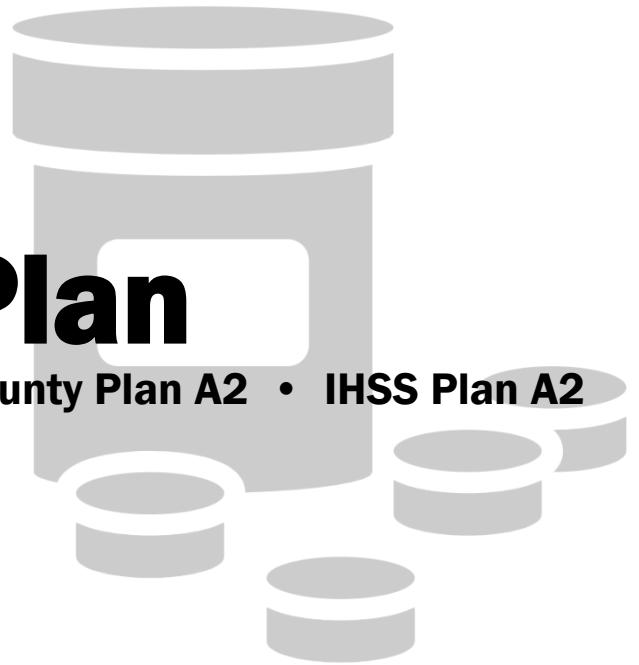


Commercial Plan

County Plan A • County Plan B • County Plan A2 • IHSS Plan A2

Formulary

Formulario



Contra Costa Health Plan (CCHP)

March **2026**

Marzo 2026



- The CCHP formulary is subject to change. For the most up-to-date formulary, use the interactive formulary search tool at cchealth.org/CCHPrx
- For plan-specific coverage information, including cost sharing information, review your Member Handbook / Evidence of Coverage (EOC) at cchealth.org/CCHPmaterials

- El formulario de CCHP está sujeto a cambios. Para obtener el formulario más actualizado, utilice la herramienta de búsqueda de formulario interactiva en cchealth.org/CCHPrx-es
- Para obtener información de cobertura específica del plan, incluida información de costos compartidos, revise su Manual para Miembros / Evidencia de Cobertura (EOC) en cchealth.org/CCHPmateriales

Table of Contents:

<u>Informational Section (ENGLISH)</u>	i-xi
<u>Sección Informativa (ESPAÑOL)</u>	a-m
<u>Antihistamine Drugs - Drugs For Allergy</u>	1
<u>Anti-Infective Agents - Drugs For Infections</u>	4
<u>Antineoplastic Agents - Drugs For Cancer</u>	15
<u>Antitoxins,Immune Glob,Toxoids,Vaccines - Drugs For The Immune System</u>	19
<u>Autonomic Drugs - Drugs For The Nervous System</u>	22
<u>Blood Formation, Coagulation, Thrombosis - Drugs For The Blood</u>	28
<u>Cardiovascular Drugs - Drugs For The Heart</u>	31
<u>Central Nervous System Agents - Drugs For The Nervous System</u>	49
<u>Contraceptives (E.G. Foams, Devices) - Drugs For Women</u>	65
<u>Devices - Medical Supplies And Durable Medical Equipment</u>	67
<u>Diagnostic Agents</u>	68
<u>Electrolytic, Caloric, And Water Balance</u>	68
<u>Enzymes</u>	73
<u>Eye, Ear, Nose And Throat (Eent) Preps</u>	73
<u>Gastrointestinal Drugs</u>	78
<u>Gastrointestinal Drugs - Drugs For The Stomach</u>	79
<u>Gold Compounds</u>	83
<u>Heavy Metal Antagonists - Drugs To Reduce Iron</u>	83
<u>Hormones And Synthetic Substitutes - Hormones</u>	84
<u>Local Anesthetics (Parenteral) - Drugs For Numbing</u>	95
<u>Miscellaneous Therapeutic Agents</u>	95
<u>Oxytocics - Drugs For Women</u>	100
<u>Pharmaceutical Aids</u>	101
<u>Respiratory Tract Agents - Drugs For The Lungs</u>	101
<u>Skin And Mucous Membrane Agents - Drugs For The Skin</u>	109
<u>Smooth Muscle Relaxants - Drugs To Relax Muscles</u>	119
<u>Vitamins</u>	120
<u>Index of Prescription Drugs</u>	125

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 on a monthly basis 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 of 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 (<i>insulin glargine</i>)		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 an approval through the plan for continuation of therapy.

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 make a decision to deny or approve all urgent prior authorization and exception requests within 24 hours of receiving the request and will make a decision to deny or approve all standard prior authorization and exception requests within 72 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 notify the member or the member's designee and the prescribing provider within 24 hours of CCHP's coverage determination.

CCHP will provide coverage pursuant to a prior authorization or exception request for the duration of the prescription, including refills. CCHP will not limit or exclude coverage for a medication if the health plan previously approved coverage for the medication for the member's medical condition.

If you would like to download the CCHP prior authorization form, it is available at: https://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf

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'm 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 Commercial 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 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.

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://cchealth.org/healthplan/>. Once you have navigated to the CCHP website, follow the directions below:

- (1) Scroll down and click on the "Search Doctors/Clinics/Pharmacies in My Area" button
- (2) Click on the red "Begin Your Search Here" button (a new window will pop up)
- (3) Click on the "Facility" tab, and choose "Pharmacy" as the facility type
- (4) Choose how you want to search (by zip code, distance, etc.)
- (5) 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. Additionally, CCHP has a contract with Walgreens for mail order prescriptions. If you have specific questions about how to obtain medications via mail order, please contact the CCHP pharmacy unit directly or visit the CCHP website at <https://cchealth.org/healthplan/member-pdl.php>.

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 this 10-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 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.

How Much I Will Pay for My Drugs?

CCHP commercial members (plans such as commercial plan A, plan B, IHSS, etc.) may have small copays for their medications. Please see your plan materials to determine if you have a 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. 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:

There are a number of 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 a 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.

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

Abbreviation	Term	What it means
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	What it means
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.



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Plan de Salud de Contra Costa CCHP) ORGANIZACIÓN DE ADMINISTRACIÓN DE SALUD (HMO) COMERCIAL Formulario

Última actualización: 1 de marzo 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://cchealth.org/healthplan/pdi/pdi.pdf>
- Para acceder a la herramienta de búsqueda del formulario interactivo del CCHP, visite la siguiente dirección web: <https://formularynavigator.com/Search.aspx?siteID=MMRREQ3QBC>
- 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:
<https://cchealth.org/healthplan/member-publications.php>

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 o 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 terapéutica		Nivel de medicamento	
↓		↓	
Insulins - Drugs For Diabetes			
LANTUS SOLOSTAR U-100 INSULIN (<i>insulin glargine</i>)		T2	QL (30mL per 30 days)
↑	↑	↑	
Marca	Nombre genérico	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.

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://cchealth.org/healthplan/pdf/performrx_medication_prior_auth_form.pdf

¿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?

El formulario de Medi-Cal del CCHP es muy similar a la Lista de Medicamentos con Contrato de Medi-Cal de California. Los siguientes tipos de medicamentos generalmente no son un beneficio cubierto para los miembros de Medi-Cal (tenga en cuenta que esta lista está sujeta a cambios):

- Medicamentos para la disfunción eréctil o sexual
- Medicamentos utilizados por razones estéticas o crecimiento del cabello
- Medicamentos que se consideran experimentales, o que se usan de manera experimental
- Medicamentos utilizados para tratar la infertilidad
- Medicamentos específicamente enumerados como "no cubiertos" en el formulario
- Medicamentos extranjeros o medicamentos no aprobados por la Administración de Alimentos y Medicamentos de los Estados Unidos (FDA)

Si se modifica la cobertura del CCHP 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.

Algunos medicamentos están excluidos por el Departamento de Servicios de Atención Médica. Esto significa que estos medicamentos están cubiertos por el programa de

pago por servicio de Medi-Cal para miembros de Medi-Cal, no por el CCHP. Los siguientes tipos de medicamentos están excluidos:

- Medicamentos antipsicóticos
- Medicamentos para el VIH/sida
- Medicamentos exclusivos para el tratamiento de desintoxicación y dependencia del alcohol y heroína
- Medicamentos exclusivos para tratar la hemofilia

¿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://cchealth.org/healthplan/>. Una vez que haya navegado al sitio web del CCHP, siga las instrucciones a continuación:

- (1) Desplácese hacia abajo y haga clic en el botón "Buscar médicos/clínicas/farmacias en mi área" (Search Doctors/Clinics/Pharmacies in My Area)
- (2) Haga clic en el botón rojo "Comenzar aquí" (Begin Your Search Here) (se abrirá una nueva ventana)
- (3) Haga clic en la pestaña "Instalaciones" (Facility) y elija "Farmacia" (Pharmacy) como tipo de instalación
- (4) Elija cómo desea buscar (por código postal, distancia, etc.)
- (5) 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:

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.

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 cubiertos para ciertas edades.
NF	No figura en el formulario	Estos medicamentos no están cubiertos en la Lista de medicamentos. Si su médico considera que necesita un medicamento que no está cubierto, puede solicitarnos que hagamos una excepción.
PA	Autorización previa	Su médico debe solicitar la aprobación del CCHP antes de que se cubran algunos medicamentos.
QL	Límite de cantidad	Algunos medicamentos solo están cubiertos para ciertas cantidades.
SCO	Exclusión estatal	Estos medicamentos están excluidos por el Departamento de Servicios de Atención Médica. Esto significa que estos medicamentos están cubiertos por el programa de tarifa por servicio de Medi-Cal y deben ser facturados al estado por la farmacia.
ST	Tratamiento escalonado	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	Nivel 1	Los medicamentos de nivel 1 se prefieren en el formulario del CCHP y están disponibles sin restricción o autorización previa.
T2	Nivel 2	Los medicamentos de nivel 2 se prefieren en el formulario del CCHP y están disponibles sin autorización previa, PERO pueden tener ciertas restricciones, como límites de cantidad, tratamiento escalonado, etc. (las restricciones específicas se enumeran en el formulario del CCHP).
T3	Nivel 3	Los medicamentos de nivel 3 no son preferidos. Estos medicamentos requieren autorización previa.

Contra Costa Health Plan Commercial Formulary

Informational Section	2
Antidote Therapeutics	1
Antihistamine Drugs	3
Anti-Infective Agents	6
Antineoplastic Agents	25
Antitoxins, Immune Glob, Toxoids, Vaccines	29
Autonomic Drugs	34
Blood Formation, Coagulation, Thrombosis	46
Cardiovascular Drugs	55
Central Nervous System Agents	83
Dental Agents	117
Devices	118
Diagnostic Agents	124
Electrolytic, Caloric, And Water Balance	125
Enzymes	133
Eye, Ear, Nose And Throat (Eent) Preps	134
Gastrointestinal Drugs	145
Heavy Metal Antagonists	153
Hormones And Synthetic Substitutes	154
Immunomodulatory Agents (90:00)	210
Local Anesthetics	216
Miscellaneous Therapeutic Agents	218
Nonhormonal Contraceptives	232
Oxytocics	235
Pharmaceutical Aids	236
Respiratory Tract Agents	236
Skin And Mucous Membrane Agents	247
Smooth Muscle Relaxants	268
Vitamins	269

Informational Section

CURRENT AS OF 3/01/2026

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidote Therapeutics		
Acetaminophen Antidote		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	T1	
Alcohol Deterrents (91:02)		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	T1	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	T1	
Antidote Therapeutics		
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	T1	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	T1	
CHEMET ORAL CAPSULE 100 MG (<i>succimer</i>)	T1	
<i>deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg</i>	T1	PA
<i>glucagon emergency injection solution reconstituted 1 mg, 1 mg/ml</i>	T1	
<i>gnp naloxone hcl nasal liquid 4 mg/0.1ml</i>	T1	
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	T1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	T1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	T1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	T1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	T1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	T1	
<i>hyosyne oral solution 0.125 mg/ml</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	T1	QL (4 EA per 180 days)
<i>magnesium sulfate injection solution 50 %</i>	T1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	T1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	T1	
<i>oscimin oral tablet 0.125 mg</i>	T1	
<i>oscimin sublingual tablet sublingual 0.125 mg</i>	T1	
<i>penicillamine oral capsule 250 mg</i>	T1	PA
<i>penicillamine oral tablet 250 mg</i>	T1	PA
<i>phytonadione injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<i>phytonadione oral tablet 5 mg</i>	T1	
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	T1	QL (4 EA per 180 days)
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	T1	QL (4 EA per 180 days)
<i>vitamin k1 injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
Antidotes (91:04)		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>sevelamer carbonate oral tablet 800 mg</i>	T1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	T1	PA
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	T1	
Chemotherapy Antidotes/Protectants		
LEDERLE LEUCOVORIN ORAL TABLET 5 MG (<i>leucovorin calcium</i>)	T1	
<i>leucovorin calcium oral tablet 5 mg</i>	T1	
Cyanide Antidotes		
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	T1	
Antihistamine Drugs		
Antihistamine Drugs		
<i>promethazine hcl oral tablet 25 mg</i>	T1	
Ethanalamine Derivatives		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	T1	
<i>clemastine fumarate oral syrup 0.67 mg/5ml</i>	T1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
First Gen. Antihist. Derivatives, Misc.		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	T1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
First Generation Antihistamines		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	T1	
<i>clemastine fumarate oral syrup 0.67 mg/5ml</i>	T1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	T1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	T1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	T1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	T1	
<i>meclizine hcl oral tablet chewable 25 mg</i>	T1	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	T1	PA
Other Antihistamines		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	T1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	T1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	T1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	T1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>nizatidine oral capsule 300 mg</i>	T1	PA
<i>olopatadine hcl ophthalmic solution 0.1 %, 0.2 %</i>	T1	
Phenothiazine Derivatives		
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	T1	
Piperazine Derivatives		
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	T1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	T1	
<i>meclizine hcl oral tablet chewable 25 mg</i>	T1	
Propylamine Derivatives		
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	T1	PA
Second Generation Antihistamines		
<i>desloratadine oral tablet 5 mg</i>	T1	PA
<i>desloratadine oral tablet dispersible 5 mg</i>	T1	PA
<i>epinastine hcl ophthalmic solution 0.05 %</i>	T1	PA
Anti-Infective Agents		
1St Generation Cephalosporin Antibiotics		
<i>cefadroxil oral capsule 500 mg</i>	T1	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	T1	
<i>cefadroxil oral tablet 1 gm</i>	T1	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	T1	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	T1	PA
2Nd Generation Cephalosporin Antibiotics		
<i>cefaclor er oral tablet extended release 12 hour 500 mg</i>	T1	PA
<i>cefaclor oral capsule 250 mg, 500 mg</i>	T1	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	T1	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	T1	
3Rd Generation Cephalosporin Antibiotics		
<i>cefdinir oral capsule 300 mg</i>	T1	QL (60 EA per 30 days)
<i>cefdinir oral suspension reconstituted 125 mg/5ml</i>	T1	QL (9000 ML per 30 days)
<i>cefdinir oral suspension reconstituted 250 mg/5ml</i>	T1	QL (6000 ML per 30 days)
<i>cefixime oral capsule 400 mg</i>	T1	QL (2 EA per 30 days)
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	T1	
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	T1	QL (112 EA per 180 days)
Adamantane Antivirals		
<i>amantadine hcl oral capsule 100 mg</i>	T1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	T1	
<i>amantadine hcl oral tablet 100 mg</i>	T1	
<i>rimantadine hcl oral tablet 100 mg</i>	T1	
Allylamine Antifungals		
<i>terbinafine hcl oral tablet 250 mg</i>	T1	
Amebicides		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>metronidazole external cream 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole vaginal gel 0.75 %</i>	T1	
NORITATE EXTERNAL CREAM 1 % (<i>metronidazole</i>)	T1	PA
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Aminoglycoside Antibiotics		
<i>gentamicin sulfate external cream 0.1 %</i>	T1	
<i>gentamicin sulfate external ointment 0.1 %</i>	T1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	T1	
<i>neomycin sulfate oral tablet 500 mg</i>	T1	
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	T1	QL (1 EA per 30 days)
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	T1	
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	T1	PA
<i>tobramycin ophthalmic solution 0.3 %</i>	T1	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	T1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (<i>tobramycin</i>)	T1	
Aminopenicillin Antibiotics		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg</i>	T1	PA
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	T1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	T1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	T1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	T1	
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	T1	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	T1	
<i>ampicillin oral capsule 500 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ampicillin sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg</i>	T1	
<i>ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	T1	
Anthelmintics		
<i>albendazole oral tablet 200 mg</i>	T1	PA
EMVERM ORAL TABLET CHEWABLE 100 MG (<i>mebendazole</i>)	T1	QL (60 EA per 30 days)
<i>ivermectin oral tablet 3 mg</i>	T1	QL (30 EA per 365 days)
<i>praziquantel oral tablet 600 mg</i>	T1	PA
Antifungals, Miscellaneous		
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	T1	
<i>griseofulvin microsize oral tablet 500 mg</i>	T1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
Antileprosy Agents		
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
Antimalarials		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg</i>	T1	QL (180 EA per 365 days)
<i>atovaquone-proguanil hcl oral tablet 62.5-25 mg</i>	T1	QL (540 EA per 365 days)
<i>avidoxy oral tablet 100 mg</i>	T1	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	T1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline hyclate oral tablet 100 mg</i>	T1	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	PA
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	T1	
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	T1	
<i>mefloquine hcl oral tablet 250 mg</i>	T1	
<i>minocycline hcl oral capsule 100 mg</i>	T1	QL (60 EA per 30 days)
<i>minocycline hcl oral capsule 50 mg</i>	T1	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg</i>	T1	
<i>pyrimethamine oral tablet 25 mg</i>	T1	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	T1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	T1	
<i>quinine sulfate oral capsule 324 mg</i>	T1	PA
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	T1	
Antimycobacterials, Miscellaneous		
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
Antiprotozoals, Cryptosporidiosis		
<i>nitazoxanide oral tablet 500 mg</i>	T1	
Antiprotozoals, Miscellaneous		
<i>atovaquone oral suspension 750 mg/5ml</i>	T1	PA
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>nitazoxanide oral tablet 500 mg</i>	T1	
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	T1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
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drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	T1	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	T1	
Antiprotozoals, Nitroimidazole-Derivative		
<i>tinidazole oral tablet 250 mg, 500 mg</i>	T1	
Antiretrovirals, Miscellaneous		
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG (<i>lenacapavir sodium</i>)	T1	
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (<i>lenacapavir sodium</i>)	T1	
YEZTUGO SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (<i>lenacapavir sodium</i>)	T1	
Antituberculosis Agents		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	T1	PA
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	PA
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	T1	
<i>cycloserine oral capsule 250 mg</i>	T1	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	T1	
<i>isoniazid oral syrup 50 mg/5ml</i>	T1	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	T1	
<i>levofloxacin oral solution 25 mg/ml</i>	T1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	T1	QL (30 EA per 30 days)
<i>moxifloxacin hcl oral tablet 400 mg</i>	T1	QL (21 EA per 21 days)
PRIFTIN ORAL TABLET 150 MG (<i>rifapentine</i>)	T1	
<i>pyrazinamide oral tablet 500 mg</i>	T1	
<i>rifabutin oral capsule 150 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>rifampin oral capsule 150 mg, 300 mg</i>	T1	
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	T1	QL (1 EA per 30 days)
Antivirals, Miscellaneous		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (<i>nirmatrelvir-ritonavir</i>)	T1	QL (11 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	T1	QL (30 EA per 180 days); AL (Min 12 Years)
Azole Antifungals		
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	T1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	T1	
<i>itraconazole oral capsule 100 mg</i>	T1	PA
<i>itraconazole oral solution 10 mg/ml</i>	T1	PA
<i>ketoconazole external cream 2 %</i>	T1	
<i>ketoconazole external shampoo 2 %</i>	T1	
<i>posaconazole oral tablet delayed release 100 mg</i>	T1	PA
<i>voriconazole intravenous solution reconstituted 200 mg</i>	T1	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	T1	PA
<i>voriconazole oral tablet 200 mg, 50 mg</i>	T1	PA
Bacitracin Antibiotics		
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	T1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	T1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	T1	
Coronavirus (Covid-19)		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	T1	QL (20 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG (<i>nirmatrelvir-ritonavir</i>)	T1	QL (11 EA per 180 days); AL (Min 12 Years)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	T1	QL (30 EA per 180 days); AL (Min 12 Years)
Erythromycin Antibiotics		
<i>ery external pad 2 %</i>	T1	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	T1	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	T1	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	T1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	T1	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	T1	
<i>erythromycin external gel 2 %</i>	T1	
<i>erythromycin external solution 2 %</i>	T1	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	T1	
Glycopeptide Antibiotics		
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	T1	
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml</i>	T1	
Hcv Polymerase Inhibitor Antivirals		
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	T1	PA
Hcv Protease Inhibitor Antivirals		
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	T1	PA
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	T1	PA
Hcv Replication Complex Inhibitors		
MAVYRET ORAL PACKET 50-20 MG (<i>glecaprevir-pibrentasvir</i>)	T1	PA
MAVYRET ORAL TABLET 100-40 MG (<i>glecaprevir-pibrentasvir</i>)	T1	PA
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	T1	PA
ZEPATIER ORAL TABLET 50-100 MG (<i>elbasvir-grazoprevir</i>)	T1	PA
Hiv Capsid Inhibitors		
SUNLENCA ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	T1	
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG (<i>lenacapavir sodium</i>)	T1	
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (<i>lenacapavir sodium</i>)	T1	
YEZTUGO ORAL TABLET 300 MG (<i>lenacapavir sodium</i>)	T1	
YEZTUGO SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (<i>lenacapavir sodium</i>)	T1	
Hiv Entry And Fusion Inhibitors		
<i>maraviroc oral tablet 150 mg, 300 mg</i>	T1	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	T1	
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	T1	
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML (<i>ibalizumab-uiyk</i>)	T1	
Hiv Integrase Inhibitor Antiretrovirals		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML (<i>cabotegravir</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofov</i>)	T1	
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML (<i>cabotegravir & rilpivirine</i>)	T1	
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	T1	
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	T1	
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	T1	
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	T1	
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	T1	
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (<i>raltegravir potassium</i>)	T1	
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	T1	
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	T1	
TIVICAY ORAL TABLET 50 MG (<i>dolutegravir sodium</i>)	T1	
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	T1	
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivud</i>)	T1	
<i>trumeq pd oral tablet soluble 60-5-30 mg</i>	T1	
VOCABRIA ORAL TABLET 30 MG (<i>cabotegravir sodium</i>)	T1	
Hiv Nonnucleoside Rev. Transcrip. Inhib.		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofov</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML (<i>cabotegravir & rilpivirine</i>)	T1	
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirine-lamivudine-tenofovir df</i>)	T1	
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	T1	
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG (<i>rilpivirine hcl</i>)	T1	
<i>efavirenz oral tablet 600 mg</i>	T1	
<i>efavirenz-emtricitabine-tenofovir df oral tablet 600-200-300 mg</i>	T1	
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	T1	
<i>emtricitabine-rilpivirine-tenofovir df oral tablet 200-25-300 mg</i>	T1	
<i>etravirine oral tablet 100 mg, 200 mg</i>	T1	
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	T1	
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	T1	
<i>methocarbamol oral tablet 500 mg</i>	T1	
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	T1	
<i>nevirapine oral suspension 50 mg/5ml</i>	T1	
<i>nevirapine oral tablet 200 mg</i>	T1	
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitabine-rilpivirine-tenofovir af</i>)	T1	
PIFELTRO ORAL TABLET 100 MG (<i>doravirine</i>)	T1	
Hiv Nucleoside, Nucleotide Rt Inhibitors		
<i>abacavir sulfate oral solution 20 mg/ml</i>	T1	
<i>abacavir sulfate oral tablet 300 mg</i>	T1	
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (<i>bictegravir-emtricitab-tenofo</i>)	T1	
CIMDUO ORAL TABLET 300-300 MG (<i>lamivudine-tenofovir</i>)	T1	
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofo</i> df)	T1	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG (<i>emtricitabine-tenofovir af</i>)	T1	
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	T1	
<i>efavirenz-emtricitab-tenofo</i> df oral tablet 600-200-300 mg	T1	
<i>efavirenz-lamivudine-tenofovir</i> oral tablet 400-300-300 mg, 600-300-300 mg	T1	
<i>emtricitabine</i> oral capsule 200 mg	T1	
<i>emtricitabine-tenofovir</i> df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	T1	
<i>emtricitab-rilpivir-tenofo</i> df oral tablet 200-25-300 mg	T1	
EMTRIVA ORAL SOLUTION 10 MG/ML (<i>emtricitabine</i>)	T1	
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	T1	
<i>lamivudine</i> oral solution 10 mg/ml	T1	
<i>lamivudine</i> oral tablet 100 mg	T1	PA
<i>lamivudine</i> oral tablet 150 mg, 300 mg	T1	
<i>lamivudine-zidovudine</i> oral tablet 150-300 mg	T1	
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofo</i> af)	T1	
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML (<i>zidovudine</i>)	T1	
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	T1	
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	T1	
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivud</i>)	T1	
<i>trimeq pd oral tablet soluble 60-5-30 mg</i>	T1	
VIREAD ORAL POWDER 40 MG/GM (<i>tenofovir disoproxil fumarate</i>)	T1	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	T1	
<i>zidovudine oral capsule 100 mg</i>	T1	
<i>zidovudine oral syrup 50 mg/5ml</i>	T1	
<i>zidovudine oral tablet 300 mg</i>	T1	
Hiv Protease Inhibitor Antiretrovirals		
APTIVUS ORAL CAPSULE 250 MG (<i>tipranavir</i>)	T1	
<i>atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg</i>	T1	
<i>darunavir oral tablet 600 mg, 800 mg</i>	T1	
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	T1	
<i>fosamprenavir calcium oral tablet 700 mg</i>	T1	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	T1	
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	T1	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (<i>darunavir-cobicistat</i>)	T1	
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	T1	
PREZISTA ORAL TABLET 150 MG, 75 MG (<i>darunavir</i>)	T1	
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	T1	
<i>ritonavir oral tablet 100 mg</i>	T1	
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRACEPT ORAL TABLET 250 MG, 625 MG (<i>nelfinavir mesylate</i>)	T1	
Interferon Antivirals		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	T1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	T1	PA
Lincomycin Antibiotics		
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	T1	ST
<i>clindamycin phosphate</i> (Clindacin Etz External Swab 1 %)	T1	
<i>clindamycin phosphate</i> (Clindacin-P External Swab 1 %)	T1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	T1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	T1	PA
<i>clindamycin phos (once-daily) external gel 1 %</i>	T1	
<i>clindamycin phos (twice-daily) external gel 1 %</i>	T1	
<i>clindamycin phos-benzoyl perox external gel 1-5 %</i>	T1	PA
<i>clindamycin phosphate external lotion 1 %</i>	T1	
<i>clindamycin phosphate external solution 1 %</i>	T1	
<i>clindamycin phosphate external swab 1 %</i>	T1	
<i>clindamycin phosphate vaginal cream 2 %</i>	T1	
Macrolide Antibiotics		
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	T1	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	T1	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	T1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	T1	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	T1	
Natural Penicillin Antibiotics		
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML (<i>penicillin g benzathine & proc</i>)	T1	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML (<i>penicillin g benzathine & proc</i>)	T1	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML (<i>penicillin g benzathine</i>)	T1	
<i>penicillin g potassium injection solution reconstituted 20000000 unit, 5000000 unit</i>	T1	
<i>penicillin g sodium injection solution reconstituted 5000000 unit</i>	T1	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	T1	
<i>penicillin g potassium</i> (Pfizerpen Injection Solution Reconstituted 20000000 Unit, 5000000 Unit)	T1	
Neuraminidase Inhibitor Antivirals		
<i>oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg</i>	T1	QL (10 EA per 180 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	T1	QL (120 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (<i>zanamivir</i>)	T1	QL (20 EA per 180 days)
Nitroimidazole Derivatives, Misc		
<i>metronidazole external cream 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	T1	QL (45 GM per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metronidazole external gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole vaginal gel 0.75 %</i>	T1	
NORITATE EXTERNAL CREAM 1 % (<i>metronidazole</i>)	T1	PA
Nucleoside And Nucleotide Antivirals		
<i>acyclovir external cream 5 %</i>	T1	PA
<i>acyclovir external ointment 5 %</i>	T1	PA
<i>acyclovir oral capsule 200 mg</i>	T1	
<i>acyclovir oral suspension 200 mg/5ml</i>	T1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	T1	
<i>adefovir dipivoxil oral tablet 10 mg</i>	T1	PA
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG (<i>emtricitabine-tenofovir af</i>)	T1	
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg</i>	T1	
<i>emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg</i>	T1	
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	T1	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	T1	PA
LAGEVRIO ORAL CAPSULE 200 MG (<i>molnupiravir</i>)	T1	QL (40 EA per 180 days); AL (Min 18 Years)
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofov af</i>)	T1	
<i>ribavirin inhalation solution reconstituted 6 gm</i>	T1	PA
<i>ribavirin oral capsule 200 mg</i>	T1	
<i>ribavirin oral tablet 200 mg</i>	T1	
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	T1	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>valganciclovir hcl oral tablet 450 mg</i>	T1	PA
VEMLIDY ORAL TABLET 25 MG (<i>tenofovir alafenamide fumarate</i>)	T1	PA
Other Macrolide Antibiotics		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg</i>	T1	PA
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	T1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	T1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	T1	PA
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	PA
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	T1	
Other Macrolides (8:12.12.92)		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg</i>	T1	PA
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	T1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	T1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	T1	PA
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	PA
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	T1	
Oxazolidinone Antibiotics		
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	T1	PA
<i>linezolid oral tablet 600 mg</i>	T1	PA
Penicillinase-Resistant Penicillins		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nafcillin sodium injection solution reconstituted 1 gm</i>	T1	
<i>oxacillin sodium injection solution reconstituted 1 gm, 2 gm</i>	T1	
Polyene Antifungals		
<i>nystatin</i> (Nyamyc External Powder 100000 Unit/Gm)	T1	
<i>nystatin external cream 100000 unit/gm</i>	T1	
<i>nystatin external ointment 100000 unit/gm</i>	T1	
<i>nystatin external powder 100000 unit/gm</i>	T1	
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	T1	
<i>nystatin oral tablet 500000 unit</i>	T1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	T1	
Polymyxin Antibiotics		
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	T1	
Quinolone Antibiotics		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	
<i>levofloxacin oral solution 25 mg/ml</i>	T1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	T1	QL (30 EA per 30 days)
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	T1	PA
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	T1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	T1	QL (21 EA per 21 days)
<i>ofloxacin ophthalmic solution 0.3 %</i>	T1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T1	PA
<i>ofloxacin otic solution 0.3 %</i>	T1	
Rifamycin Antibiotics		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRIFTIN ORAL TABLET 150 MG (<i>rifapentine</i>)	T1	
<i>rifabutin oral capsule 150 mg</i>	T1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	T1	
XIFAXAN ORAL TABLET 200 MG (<i>rifaximin</i>)	T1	PA
Sulfonamide Antibiotics (Systemic)		
<i>sulfadiazine oral tablet 500 mg</i>	T1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	T1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	T1	
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
Tetracycline Antibiotics		
<i>avidoxy oral tablet 100 mg</i>	T1	
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	T1	PA
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline hyclate oral tablet 100 mg</i>	T1	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	PA
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	T1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	T1	
<i>minocycline hcl oral capsule 100 mg</i>	T1	QL (60 EA per 30 days)
<i>minocycline hcl oral capsule 50 mg</i>	T1	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	T1	
Urinary Anti-Infectives		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fosfomycin tromethamine oral packet 3 gm</i>	T1	
<i>methenamine hippurate oral tablet 1 gm</i>	T1	
<i>methenamine mandelate oral tablet 0.5 gm, 1 gm</i>	T1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	T1	
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	T1	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	T1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	T1	
<i>trimethoprim oral tablet 100 mg</i>	T1	
Antineoplastic Agents		
Antineoplastic Agents		
ALECENSA ORAL CAPSULE 150 MG (<i>alectinib hcl</i>)	T1	PA
<i>anastrozole oral tablet 1 mg</i>	T1	QL (30 EA per 30 days)
<i>bexarotene oral capsule 75 mg</i>	T1	PA
<i>bicalutamide oral tablet 50 mg</i>	T1	
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (<i>cabozantinib s-malate</i>)	T1	PA
<i>capecitabine oral tablet 150 mg, 500 mg</i>	T1	PA
COTELLIC ORAL TABLET 20 MG (<i>cobimetinib fumarate</i>)	T1	PA
<i>cyclophosphamide oral tablet 50 mg</i>	T1	
<i>dasatinib oral tablet 100 mg, 20 mg, 50 mg, 70 mg</i>	T1	PA
<i>diclofenac sodium external gel 3 %</i>	T1	PA
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (<i>hydroxyurea</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 22.5 MG (<i>leuprolide acetate (3 month)</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELIGARD SUBCUTANEOUS KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 45 MG (<i>leuprolide acetate (6 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 7.5 MG (<i>leuprolide acetate</i>)	T1	
<i>erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg</i>	T1	PA
<i>etoposide oral capsule 50 mg</i>	T1	
<i>exemestane oral tablet 25 mg</i>	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	T1	QL (1 EA per 30 days)
<i>fluorouracil external cream 5 %</i>	T1	
<i>fluorouracil external solution 2 %, 5 %</i>	T1	
<i>gefitinib oral tablet 250 mg</i>	T1	PA
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (<i>lomustine</i>)	T1	
<i>hydroxyurea oral capsule 500 mg</i>	T1	
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	T1	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	T1	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG (<i>ponatinib hcl</i>)	T1	PA
<i>imatinib mesylate oral tablet 100 mg, 400 mg</i>	T1	PA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	T1	PA
<i>lapatinib ditosylate oral tablet 250 mg</i>	T1	PA
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	T1	PA
<i>letrozole oral tablet 2.5 mg</i>	T1	QL (30 EA per 30 days)
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG (<i>leuprolide acetate</i>)	T1	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG (<i>leuprolide acetate (3 month)</i>)	T1	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	T1	PA
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (<i>leuprolide acetate</i>)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>leuprolide acetate (3 month)</i>)	T1	PA
LYSODREN ORAL TABLET 500 MG (<i>mitotane</i>)	T1	
MATULANE ORAL CAPSULE 50 MG (<i>procarbazine hcl</i>)	T1	
<i>megestrol acetate oral suspension 40 mg/ml</i>	T1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	T1	
<i>mercaptopurine oral tablet 50 mg</i>	T1	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	T1	
MYLERAN ORAL TABLET 2 MG (<i>busulfan</i>)	T1	
<i>nilutamide oral tablet 150 mg</i>	T1	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	T1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	T1	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (<i>pomalidomide</i>)	T1	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG (<i>lenalidomide</i>)	T1	PA
SIKLOS ORAL TABLET 100 MG, 1000 MG (<i>hydroxyurea</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sorafenib tosylate oral tablet 200 mg</i>	T1	PA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 50 mg</i>	T1	PA
TABLOID ORAL TABLET 40 MG (<i>thioguanine</i>)	T1	
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (<i>talazoparib tosylate</i>)	T1	PA
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	T1	
TASIGNA ORAL CAPSULE 200 MG (<i>nilotinib hcl</i>)	T1	PA
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	T1	PA
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	T1	PA
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG (<i>bcg live</i>)	T1	
<i>toremifene citrate oral tablet 60 mg</i>	T1	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>triptorelin pamoate</i>)	T1	QL (1 EA per 30 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>triptorelin pamoate</i>)	T1	
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin external gel 0.01 %, 0.025 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin oral capsule 10 mg</i>	T1	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>abemaciclib</i>)	T1	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG (<i>crizotinib</i>)	T1	PA
XTANDI ORAL CAPSULE 40 MG (<i>enzalutamide</i>)	T1	PA

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XTANDI ORAL TABLET 40 MG, 80 MG (<i>enzalutamide</i>)	T1	PA
ZELBORAF ORAL TABLET 240 MG (<i>vemurafenib</i>)	T1	PA
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG (<i>goserelin acetate</i>)	T1	
ZOLINZA ORAL CAPSULE 100 MG (<i>vorinostat</i>)	T1	PA
Antitoxins, Immune Glob, Toxoids, Vaccines		
Antitoxins And Immune Globulins		
HYPERRHO INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (<i>rho d immune globulin</i>)	T1	
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT (<i>rho d immune globulin</i>)	T1	
Toxoids		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
TENIVAC INTRAMUSCULAR SUSPENSION 5-2 LF/0.5ML (<i>tetanus-diphtheria toxoids td</i>)	T1	QL (0.5 ML per 1 FILL)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recmb</i>)	T1	QL (0.5 ML per 1 Fill)
Vaccines		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (<i>rsv pre-fusion f a&b vac rcmb</i>)	T1	QL (0.5 ml per 1 Dose)
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>haemophilus b polysac conj vac</i>)	T1	QL (1 ML per 1 Fill)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
AFLURIA INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (<i>rsvpref3 vac recomb adjuvanted</i>)	T1	QL (0.5 ml per 1 Dose); AL (Min 50 Years)
<i>bcg vaccine injection solution reconstituted 50 mg</i>	T1	PA
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b recomb omv adj</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5 (<i>tetanus-diphth-acell pertussis</i>)	T1	QL (0.5 ML per 1 FILL)
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 21-valent conjuga</i>)	T1	QL (0.5 dose per 1 lifetime); AL (Min 18 Years)
COMIRNATY 5-11 YEARS INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	T1	
COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML (<i>covid-19 mrna virus vaccine</i>)	T1	
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	T1	QL (2 ML per 1 Fill)
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (<i>hepatitis b vac recombinant</i>)	T1	QL (2 ML per 1 Fill)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac a&b surf ant adj</i>)	T1	QL (1 ML per 270 days); AL (Min 65 Years)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (<i>influenza vac recombinant ha</i>)	T1	QL (1 ML per 270 days); AL (Min 9 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION (<i>influenza vac tiss-cult subunt</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac tiss-cult subunt</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUMIST NASAL LIQUID (<i>influenza virus vaccine live</i>)	T1	QL (1 EA per 270 days); AL (Min 3 Years and Max 49 Years)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza vac split high-dose</i>)	T1	QL (1 ML per 270 days); AL (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION (<i>influenza virus vaccine split</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>influenza virus vacc split pf</i>)	T1	QL (1 ML per 270 days); AL (Min 3 Years)
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 45 Years)
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>hpv 9-valent recomb vaccine</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 45 Years)
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML, 720 EL U/0.5ML (<i>hepatitis a vaccine</i>)	T1	QL (1 ML per 1 Fill)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (<i>hepatitis b vac recomb adj</i>)	T1	QL (0.5 ML per 1 Fill); AL (Min 18 Years)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG (<i>haemophilus b polysac conj vac</i>)	T1	QL (1 ML per 1 Fill)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML (<i>rabies virus vaccine, hdc</i>)	T1	QL (1 ML per 1 Fill)
IPOL INJECTION SUSPENSION (<i>poliovirus vaccine inactivated</i>)	T1	QL (0.5 ML per 1 Fill)
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML (<i>mening acy&w-135 tetanus conj</i>)	T1	QL (0.5 ML per 1 Fill)
MENVEO INTRAMUSCULAR SOLUTION (<i>meningococcal a c y&w-135 olig</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 55 Years)
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED (<i>meningococcal a c y&w-135 olig</i>)	T1	QL (1 ml per 1 Fill); AL (Max 55 Years)
M-M-R II INJECTION SOLUTION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	T1	QL (1 EA per 1 Fill)
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML (<i>covid-19 mrna virus vaccine</i>)	T1	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>rsv mrna pre-f virus vaccine</i>)	T1	QL (0.5 ML per 1 lifetime); AL (Min 18 Years)
<i>nuvaxovid covid-19 vaccine intramuscular suspension prefilled syringe 5 mcg/0.5ml</i>	T1	
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML (<i>haemophilus b polysac conj vac</i>)	T1	QL (0.5 ML per 1 Fill)
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>mening acyw(tet conj)-b(rcmb)</i>)	T1	QL (1 vial per 1 Fill); AL (Max 25 Years)
<i>penmenvy intramuscular suspension reconstituted</i>	T1	QL (1 vial per 1 Fill); AL (Min 10 Years and Max 25 Years)
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (<i>pneumococcal vac polyvalent</i>)	T1	QL (0.5 ML per 1 Dose)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 20-val conj vacc</i>)	T1	QL (0.5 ML per 1 Fill)
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles, mumps & rubella vac</i>)	T1	QL (1 EA per 1 Fill)
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED (<i>measles-mumps-rubella-varicell</i>)	T1	QL (1 EA per 1 Fill)
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED (<i>rabies vaccine, pcec</i>)	T1	
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	T1	QL (1 ML per 1 Fill)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (<i>hepatitis b vac recombinant</i>)	T1	QL (1 ML per 1 Fill)
SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>zoster vac recomb adjuvanted</i>)	T1	QL (1 syringe per 1 Fill); AL (Min 18 Years)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (<i>zoster vac recomb adjuvanted</i>)	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)
SPIKEVAX 6M-11Y INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 MCG/0.25ML (<i>covid-19 mrna virus vaccine</i>)	T1	
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (<i>covid-19 mrna virus vaccine</i>)	T1	
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG (<i>bcg live</i>)	T1	
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>meningococcal b vac (recomb)</i>)	T1	QL (0.5 ML per 1 Fill); AL (Max 25 Years)
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (<i>hepatitis a-hep b recomb vac</i>)	T1	QL (1 ML per 1 Fill); AL (Min 18 Years)

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (<i>typhoid vi polysaccharide vacc</i>)	T1	QL (0.5 ML per 270 days)
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML (<i>hepatitis a vaccine</i>)	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION 50 UNIT/ML (<i>hepatitis a vaccine</i>)	T1	QL (1 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML (<i>hepatitis a vaccine</i>)	T1	QL (0.5 ML per 1 Fill)
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 UNIT/ML (<i>hepatitis a vaccine</i>)	T1	QL (1 ML per 1 Fill)
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML (<i>varicella virus vaccine live</i>)	T1	QL (1 EA per 1 Dose)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (<i>dtap-ipv-hib-hepatitis b recmb</i>)	T1	QL (0.5 ML per 1 Fill)
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (<i>pneumococcal 15-val conj vacc</i>)	T1	QL (0.5 ML per 1 Fill)
VIVOTIF ORAL CAPSULE DELAYED RELEASE (<i>typhoid vaccine</i>)	T1	QL (4 EA per 5 years)
Autonomic Drugs		
Alpha- And Beta-Adrenergic Agonists		
<i>bupivacaine-epinephrine (pf) injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>bupivacaine-epinephrine injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>epinephrine (anaphylaxis) injection solution 1 mg/ml, 30 mg/30ml</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	T1	QL (4 EA per 180 days)
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine-epinephrine injection solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000</i>	T1	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	T1	PA
<i>bupivacaine-epinephrine</i> (Sensorcaine/Epinephrine Injection Solution 0.25% -1:200000, 0.5% -1:200000)	T1	
<i>bupivacaine-epinephrine</i> (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (<i>bupivacaine-epinephrine</i>)	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 (<i>lidocaine-epinephrine</i>)	T1	
Alpha-Adrenergic Agonists (12:12)		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	T1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	T1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	T1	
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	T1	
Antimuscarinics/Antispasmodics		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	T1	PA
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	T1	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	T1	
<i>dicyclomine hcl oral capsule 10 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dicyclomine hcl oral tablet 20 mg</i>	T1	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	T1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	T1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T1	
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	T1	QL (45 EA per 30 days); AL (Min 18 Years)
<i>hydromet oral solution 5-1.5 mg/5ml</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	T1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	T1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	T1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	T1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	T1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	T1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	T1	
<i>hyosyne oral solution 0.125 mg/ml</i>	T1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (<i>umeclidinium bromide</i>)	T1	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	T1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	T1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
<i>methscopolamine bromide oral tablet 2.5 mg</i>	T1	PA
MOTOFEN ORAL TABLET 1-0.025 MG (<i>difenoxin-atropine</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NULEV ORAL TABLET DISPERSIBLE 0.125 MG <i>(hyoscyamine sulfate)</i>	T1	
<i>oscimin oral tablet 0.125 mg</i>	T1	
<i>oscimin sublingual tablet sublingual 0.125 mg</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral elixir 16.2 mg/5ml</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral tablet 16.2 mg</i>	T1	
<i>phenobarbital-belladonna alk oral elixir 16.2 mg/5ml</i>	T1	
PHENOHYTRO ORAL TABLET 16.2 MG (<i>pb-hyoscy-atropine-scopolamine</i>)	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (<i>tiotropium bromide</i>)	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	T1	
<i>tiotropium bromide inhalation capsule 18 mcg</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	T1	PA
<i>umeclidinium-vilanterol inhalation aerosol powder breath activated 62.5-25 mcg/act</i>	T1	
Antiparkinsonian Agents		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	QL (120 EA per 30 days)
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	T1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	T1	
Autonomic Drugs, Miscellaneous		
<i>cvs nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>cvs nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>gnp nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>gnp nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>goodsense nicotine mouth/throat lozenge 2 mg</i>	T1	
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
KLS QUIT2 MOUTH/THROAT LOZENGE 2 MG (<i>nicotine polacrilex</i>)	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE 4 MG (<i>nicotine polacrilex</i>)	T1	QL (324 EA per 30 days)
<i>nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	T1	
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	T1	PA
<i>qc nicotine transdermal system transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>sm nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>sm nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	T1	QL (180 EA per 365 days)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	T1	QL (180 EA per 365 days)
Botulinum Toxins		
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT (<i>abobotulinumtoxinA</i>)	T1	PA
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT (<i>incobotulinumtoxinA</i>)	T1	PA
Centrally Acting Skeletal Muscle Relaxant		
<i>chlorzoxazone oral tablet 250 mg, 500 mg</i>	T1	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	T1	
<i>metaxalone oral tablet 800 mg</i>	T1	PA
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	T1	
<i>tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg</i>	T1	PA
<i>tizanidine hcl oral tablet 2 mg</i>	T1	QL (540 EA per 30 days)
<i>tizanidine hcl oral tablet 4 mg</i>	T1	QL (270 EA per 30 days)
Direct-Acting Skeletal Muscle Relaxants		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
Gaba-Derivative Skeletal Muscle Relaxant		
<i>baclofen oral tablet 10 mg, 20 mg</i>	T1	
<i>baclofen oral tablet 5 mg</i>	T1	QL (90 EA per 30 days)
Indirect-Acting Skeletal Muscle Relaxant		
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	T1	PA
<i>orphenadrine citrate injection solution 30 mg/ml</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (<i>orphenadrine-aspirin-caffeine</i>)	T1	
Non-Sel. Beta-Adrenergic Blocking Agents		
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	T1	

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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>timolol maleate</i> (Timolol Maleate OcuDose Ophthalmic Solution 0.5 %)	T1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	T1	
Non-Sel.Alpha-1-Adrenergic Blocking Agts		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Non-Sel.Alpha-Adrenergic Blocking Agents		
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	T1	PA
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	T1	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (<i>ergotamine-caffeine</i>)	T1	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	T1	
Parasympathomimetic (Cholinergic Agents)		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg</i>	T1	
<i>bethanechol chloride oral tablet 50 mg</i>	T1	PA
<i>cevimeline hcl oral capsule 30 mg</i>	T1	
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	T1	
<i>donepezil hcl oral tablet 23 mg</i>	T1	PA
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	T1	
<i>neostigmine methylsulfate intravenous solution prefilled syringe 3 mg/3ml</i>	T1	PA
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	T1	
<i>pilocarpine hcl oral tablet 5 mg</i>	T1	
<i>pilocarpine hcl oral tablet 7.5 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	T1	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	T1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	T1	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	T1	
Selective Alpha-1-Adrenergic Block.Agent		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	T1	
<i>tamsulosin hcl oral capsule 0.4 mg</i>	T1	
Selective Beta-2-Adrenergic Agonists		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	T1	QL (2 GM per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 2.5 mg/0.5ml</i>	T1	
<i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml</i>	T1	PA
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	T1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	T1	PA
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	T1	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	T1	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT (<i>mometasone furo-formoterol fum</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	T1	
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	T1	PA
<i>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</i>	T1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>salmeterol xinafoate</i>)	T1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	T1	
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	T1	PA
<i>umeclidinium-vilanterol inhalation aerosol powder breath activated 62.5-25 mcg/act</i>	T1	
<i>fluticasone-salmeterol</i> (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		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	T1	PA
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % <i>(betaxolol hcl)</i>	T1	PA
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
Skeletal Muscle Relaxants, Miscellaneous		
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT <i>(abobotulinumtoxina)</i>	T1	PA
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	T1	PA
<i>orphenadrine citrate injection solution 30 mg/ml</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG <i>(orphenadrine-aspirin-caffeine)</i>	T1	
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT <i>(incobotulinumtoxina)</i>	T1	PA
Smoking Cessation Agents		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	T1	QL (60 EA per 30 days)
<i>cvs nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>cvs nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>cvs nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>eq nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>eq nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>eq nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>gnp nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>gnp nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>goodsense nicotine mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)
<i>goodsense nicotine mouth/throat lozenge 2 mg</i>	T1	
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
KLS QUIT2 MOUTH/THROAT LOZENGE 2 MG (<i>nicotine polacrilex</i>)	T1	QL (324 EA per 30 days)
KLS QUIT4 MOUTH/THROAT LOZENGE 4 MG (<i>nicotine polacrilex</i>)	T1	QL (324 EA per 30 days)
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>nicotine mini mouth/throat lozenge 2 mg</i>	T1	
<i>nicotine mini mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
<i>nicotine polacrilex mini mouth/throat lozenge 2 mg</i>	T1	
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	T1	QL (340 EA per 30 days)

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg</i>	T1	QL (324 EA per 30 days)
<i>nicotine step 1 transdermal patch 24 hour 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine step 2 transdermal patch 24 hour 14 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	T1	QL (30 EA per 30 days)
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	T1	PA
<i>qc nicotine transdermal system transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr</i>	T1	QL (30 EA per 30 days)
<i>sm nicotine mouth/throat gum 4 mg</i>	T1	QL (340 EA per 30 days)
<i>sm nicotine mouth/throat lozenge 2 mg</i>	T1	QL (324 EA per 30 days)
<i>sm nicotine polacrilex mouth/throat lozenge 4 mg</i>	T1	QL (324 EA per 30 days)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	T1	PA
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	T1	QL (180 EA per 365 days)
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	T1	QL (180 EA per 365 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	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 (<i>epoetin alfa</i>)	T1	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa</i>)	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	T1	PA

Anticoagulants, Miscellaneous

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACD-A NOCLOT-50 IN VITRO SOLUTION 0.73-2.45-2.2 GM/100ML (<i>anticoagulant cit dext soln a</i>)	T1	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	T1	
Antithrombotic Agents, Miscellaneous		
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	T1	PA
Coumarin Derivatives		
<i>warfarin sodium</i> (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	T1	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	T1	
Direct Factor Xa Inhibitors		
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG (<i>apixaban</i>)	T1	
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG (<i>apixaban</i>)	T1	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (<i>apixaban</i>)	T1	QL (74 EA per 30 days)
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG (<i>apixaban</i>)	T1	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (<i>apixaban</i>)	T1	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG (<i>apixaban</i>)	T1	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	T1	
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (<i>rivaroxaban</i>)	T1	QL (600 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG (<i>rivaroxaban</i>)	T1	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG (<i>rivaroxaban</i>)	T1	QL (42 EA per 21 days)
XARELTO ORAL TABLET 2.5 MG (<i>rivaroxaban</i>)	T1	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (<i>rivaroxaban</i>)	T1	QL (51 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Direct Thrombin Inhibitors		
<i>dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg</i>	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 (<i>epoetin alfa</i>)	T1	PA
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-jmdb</i>)	T1	PA
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-pbbk</i>)	T1	PA
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>tbo-filgrastim</i>)	T1	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim</i>)	T1	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim</i>)	T1	PA
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim</i>)	T1	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim-aafi</i>)	T1	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-aafi</i>)	T1	PA
NYPOZI INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-txid</i>)	T1	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-apgf</i>)	T1	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>releuko subcutaneous solution prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml</i>	T1	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	T1	PA
STIMUFEND SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-fpgk</i>)	T1	PA
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	T1	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	T1	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-cbqv</i>)	T1	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	T1	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-bmez</i>)	T1	PA
Hemorrhologic Agents		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	T1	
Hemostatics		
<i>aminocaproic acid oral solution 0.25 gm/ml</i>	T1	PA
<i>aminocaproic acid oral tablet 1000 mg</i>	T1	
<i>aminocaproic acid oral tablet 500 mg</i>	T1	PA
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	T1	PA
<i>desmopressin acetate injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate nasal solution 1.5 mg/ml</i>	T1	PA
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	T1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate spray nasal solution 0.01 %</i>	T1	PA
GELFILM OPHTHALMIC FILM (<i>gelatin adsorbable</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Heparins		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	T1	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml</i>	T1	QL (40 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml</i>	T1	QL (32 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml</i>	T1	QL (12 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml</i>	T1	QL (16 ML per 180 days)
<i>enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml</i>	T1	QL (24 ML per 180 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML (<i>dalteparin sodium</i>)	T1	
<i>heparin na (pork) lock flsh pf intravenous solution 10 unit/ml</i>	T1	
<i>heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	T1	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	T1	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml</i>	T1	
Indirect Factor Xa Inhibitors		
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	T1	
Iron Preparations		
<i>classic prenatal oral tablet 28-0.8 mg</i>	T1	
<i>complete natal dha oral 29-1-200 & 200 mg</i>	T1	
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	T1	
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GERITOL TONIC ORAL LIQUID (<i>iron-vitamins</i>)	T1	
<i>gnp prenatal oral tablet 28-0.8 mg</i>	T1	
<i>hematinic plus vit/minerals oral tablet 106-1 mg</i>	T1	
<i>hematinic/folic acid oral tablet 324-1 mg</i>	T1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG (<i>fe fum-vit c-vit b12-fa</i>)	T1	
INFED INJECTION SOLUTION 50 MG/ML (<i>iron dextran</i>)	T1	
<i>m-natal plus oral tablet 27-1 mg</i>	T1	
<i>multiple vitamins-iron oral tablet chewable 15 mg</i>	T1	
<i>multivitamin adult oral tablet</i>	T1	
<i>multivitamin oral tablet</i>	T1	
NUTRIVIT ORAL LIQUID (<i>b complex-lysine-min-fe-fa</i>)	T1	
<i>poly-iron 150 forte oral capsule 150-25-1 mg-mcg-mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	T1	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	T1	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i>	T1	
<i>prenatal plus oral tablet 27-1 mg</i>	T1	
<i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i>	T1	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	T1	
<i>prenatal/iron oral tablet , 28-0.8 mg</i>	T1	
<i>qc prenatal oral tablet 28-0.8 mg</i>	T1	
TAB-A-VITE ORAL TABLET (<i>multiple vitamin</i>)	T1	
<i>thrivite rx oral tablet 29-1 mg</i>	T1	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>pediatric multivit-minerals</i>)	T1	
<i>westab plus oral tablet 27-1 mg</i>	T1	
Liver And Stomach Preparations		

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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	T1	
<i>hydroxocobalamin acetate intramuscular solution 1000 mcg/ml</i>	T1	
<i>neurin-sl sublingual tablet sublingual 600-600 mcg</i>	T1	
Platelet-Aggregation Inhibitors		
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 81 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cilostazol oral tablet 100 mg, 50 mg</i>	T1	
<i>clopidogrel bisulfate oral tablet 300 mg</i>	T1	QL (2 EA per 30 days)
<i>clopidogrel bisulfate oral tablet 75 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>ticagrelor oral tablet 60 mg, 90 mg</i>	T1	QL (60 EA per 30 days)
Platelet-Reducing Agents		

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lowercase bold italics =
Generic drugs
UPPERCASE = Brand name drugs

Drug Tier
T1 = Formulary Medication

Coverage Requirements and Limits
AL = Age Limit
PA = Prior Authorization
QL = Quantity Limit
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>anagrelide hcl oral capsule 0.5 mg</i>	T1	
Thrombolytic Agents		
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 81 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
Cardiovascular Drugs		
Acl Inhibitors		
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	T1	PA
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	T1	PA
Alpha-Adrenergic Blocking Agents (24:16)		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Alpha-Adrenergic Blocking Agt.(Hypoten)		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Angiotensin li Recep Antagonist/Neprollys		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG (<i>sacubitril-valsartan</i>)	T1	QL (240 EA per 30 days)
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	T1	QL (60 EA per 30 days)
Angiotensin li Receptor Antagon.(Hypotn)		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	T1	PA
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg</i>	T1	PA
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	T1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	T1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	T1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	T1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	T1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	T1	PA
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	T1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	T1	
Angiotensin li Receptor Antagonists		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	T1	PA
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg</i>	T1	PA
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG (<i>sacubitril-valsartan</i>)	T1	QL (240 EA per 30 days)
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	T1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	T1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	T1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	T1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	T1	
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	T1	QL (60 EA per 30 days)
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	T1	PA
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	T1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	T1	
Angiotensin-Convert.Enzyme Inhib(Hypotn)		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	T1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	T1	PA
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	T1	PA
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	T1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	T1	PA
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	T1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	T1	PA
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
Angiotensin-Converting Enzyme Inhibitors		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	T1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	T1	PA
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	T1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	T1	PA
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	T1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	T1	PA
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
Antiarrhythmics, Miscellaneous		
<i>digoxin</i> (Digox Oral Tablet 125 Mcg, 250 Mcg)	T1	
<i>digoxin oral solution 0.05 mg/ml</i>	T1	
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	T1	
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>digoxin</i>)	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
Antilipemic Agents, Miscellaneous		
<i>bp vit 3 oral capsule 1 mg</i>	T1	
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	T1	PA
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	T1	PA
<i>niacin (antihyperlipidemic) oral tablet 500 mg</i>	T1	
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	T1	PA
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	T1	ST
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	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

lowercase bold italics =
Generic drugs
UPPERCASE = Brand name drugs

Drug Tier
T1 = Formulary Medication

Coverage Requirements and Limits
AL = Age Limit
PA = Prior Authorization
QL = Quantity Limit
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	T1	PA
Beta-Adrenergic Blocking Agents (24:20)		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	T1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	T1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	T1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	T1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	T1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	T1	
timolol maleate (Timolol Maleate OcuDose Ophthalmic Solution 0.5 %)	T1	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	T1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	T1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	T1	PA
timolol maleate pf ophthalmic solution 0.25 %, 0.5 %	T1	
Bile Acid Sequestrants		
cholestyramine light oral packet 4 gm	T1	
cholestyramine light oral powder 4 gm/dose	T1	
cholestyramine oral packet 4 gm	T1	
cholestyramine oral powder 4 gm/dose	T1	
colestipol hcl oral granules 5 gm	T1	
colestipol hcl oral packet 5 gm	T1	
colestipol hcl oral tablet 1 gm	T1	
cholestyramine light (Prevalite Oral Packet 4 Gm)	T1	
cholestyramine light (Prevalite Oral Powder 4 Gm/Dose)	T1	
Calcium-Channel Block.Agt,Misc(Hypoten)		
diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 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

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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	T1	PA
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	T1	PA
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
Calcium-Channel Blocking Agents		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	T1	PA
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	T1	PA
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	T1	ST
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	T1	PA
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	T1	
<i>nimodipine oral capsule 30 mg</i>	T1	PA

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
Calcium-Channel Blocking Agents, Misc.		
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	T1	PA
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	T1	PA
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
Carbonic Anhydrase Inhibitors (24:36)		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	T1	PA
Carbonic Anhydrase Inhibitors(Hypoten)		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	T1	PA
Cardiotonic Agents		
<i>digoxin</i> (Digox Oral Tablet 125 Mcg, 250 Mcg)	T1	
<i>digoxin oral solution 0.05 mg/ml</i>	T1	
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LANOXIN ORAL TABLET 125 MCG, 250 MCG (<i>digoxin</i>)	T1	
Central Alpha-Agonists		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	T1	PA
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	T1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	T1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
Cgmp Synthesis Agent		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>vericiguat</i>)	T1	PA
Cholesterol Absorption Inhibitors		
<i>ezetimibe oral tablet 10 mg</i>	T1	
NEXLIZET ORAL TABLET 180-10 MG (<i>bempedoic acid-ezetimibe</i>)	T1	PA
Class Ia Antiarrhythmics		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	T1	
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (<i>disopyramide phosphate</i>)	T1	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	T1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	T1	
Class Ib Antiarrhythmics		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (<i>phenytoin</i>)	T1	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (<i>phenytoin sodium extended</i>)	T1	
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	T1	
<i>phenytoin</i> (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)	T1	
<i>phenytoin oral suspension 100 mg/4ml, 125 mg/5ml</i>	T1	
<i>phenytoin oral tablet chewable 50 mg</i>	T1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	T1	
Class Ic Antiarrhythmics		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	T1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	T1	
Class II Antiarrhythmics		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	T1	PA
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	T1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	T1	PA
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg, 400 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	T1	
<i>timolol maleate</i> (Timolol Maleate OcuDose Ophthalmic Solution 0.5 %)	T1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	T1	
Class Iii Antiarrhythmics		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	T1	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	T1	
MULTAQ ORAL TABLET 400 MG (<i>dronedarone hcl</i>)	T1	PA
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
Class Iv Antiarrhythmics		
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	

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lowercase bold italics = Generic drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits
UPPERCASE = Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	T1	PA
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	T1	PA
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
Dihydropyridines		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	T1	ST

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	T1	PA
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	T1	
<i>nimodipine oral capsule 30 mg</i>	T1	PA
Dihydropyridines (Antihypertensive)		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	T1	ST
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	T1	PA
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	T1	
<i>nimodipine oral capsule 30 mg</i>	T1	PA
Direct Vasodilators		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (<i>alprostadil (vasodilator)</i>)	T1	PA
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	T1	PA
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	T1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	T1	
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	T1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	T1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	T1	
Diuretics, Miscellaneous (Hypotensive)		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
Fibric Acid Derivatives		
<i>fenofibrate micronized oral capsule 130 mg, 43 mg</i>	T1	PA
<i>fenofibrate micronized oral capsule 134 mg</i>	T1	
<i>fenofibrate micronized oral capsule 200 mg, 67 mg</i>	T1	QL (30 EA per 30 days)
<i>fenofibrate oral capsule 134 mg</i>	T1	
<i>fenofibrate oral capsule 200 mg, 67 mg</i>	T1	QL (30 EA per 30 days)
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	T1	
<i>gemfibrozil oral tablet 600 mg</i>	T1	
Hmg-Coa Reductase Inhibitors		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	T1	
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	T1	PA
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	T1	PA
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	T1	QL (30 EA per 30 days)
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	T1	
Kallikrein Inhibitors (24:48:08)		
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (<i>berotralstat hcl</i>)	T1	PA
Loop Diuretics (24:36)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>ethacrynic acid oral tablet 25 mg</i>	T1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	T1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	T1	
Loop Diuretics (Hypotensive Agents)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>ethacrynic acid oral tablet 25 mg</i>	T1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	T1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	T1	
Mineralocorticoid (Aldosterone) Antagnts		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG (<i>finerenone</i>)	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
Mineralocorticoid(Aldoster.)Antag(Hypot)		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
Nitrates And Nitrites		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	T1	PA
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	T1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	T1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	T1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	T1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
NITRO-BID TRANSDERMAL OINTMENT 2 % (<i>nitroglycerin</i>)	T1	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	T1	
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	T1	PA
NITRO-TIME ORAL CAPSULE EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (<i>nitroglycerin</i>)	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
Omega-3-Mediated Antilipemics		
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	T1	ST
Pcsk9 Inhibitors		
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML (<i>alirocumab</i>)	T1	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	T1	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	T1	PA
Phosphodiesterase Type 5 Inhibitors		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	T1	PA
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	QL (15 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
<i>tadalafil (pah) oral tablet 20 mg</i>	T1	PA
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	PA
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
Potassium-Sparing Diuretics (24:36)		
<i>amiloride hcl oral tablet 5 mg</i>	T1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	T1	PA
Potassium-Sparing Diuretics (Hypoten)		
<i>amiloride hcl oral tablet 5 mg</i>	T1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	T1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	T1	PA
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	T1	
Renin-Angioten.-Aldost. Sys. Inhib, Misc		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG (<i>sacubitril-valsartan</i>)	T1	QL (240 EA per 30 days)
<i>sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg</i>	T1	QL (60 EA per 30 days)
Steroidal Mineralocorticoid Receptor Ant		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
Thiazide Diuretics (24:36)		

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lowercase bold italics =

Generic drugs

UPPERCASE = Brand name drugs

Drug Tier

T1 = Formulary Medication

Coverage Requirements and Limits

AL = Age Limit

PA = Prior Authorization

QL = Quantity Limit

ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIURIL ORAL SUSPENSION 250 MG/5ML <i>(chlorothiazide)</i>	T1	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	T1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
Thiazide Diuretics(Hypotensive Agents)		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	T1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg</i>	T1	PA
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	T1	PA
DIURIL ORAL SUSPENSION 250 MG/5ML <i>(chlorothiazide)</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	T1	PA
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	T1	PA
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	T1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	T1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	T1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	T1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	T1	PA
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	T1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	T1	
Thiazide-Like Diuretics (24:36)		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	T1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
THALITONE ORAL TABLET 15 MG (<i>chlorthalidone</i>)	T1	
Thiazide-Like Diuretics(Hypotensive Agt)		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	T1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
THALITONE ORAL TABLET 15 MG (<i>chlorthalidone</i>)	T1	
Vasodilating Agents, Misc (24:08)		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	T1	
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	T1	PA
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	T1	ST
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	T1	PA
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	T1	
<i>nimodipine oral capsule 30 mg</i>	T1	PA
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	T1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	T1	PA
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	T1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	T1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
VECAMYL ORAL TABLET 2.5 MG (<i>mecamylamine hcl</i>)	T1	PA
Vasodilating Agents, Miscellaneous		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	T1	PA
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	T1	
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	T1	PA
<i>diltiazem hcl coated beads</i> (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	T1	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG (<i>alprostadil (vasodilator)</i>)	T1	PA
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 20 MCG, 40 MCG (<i>alprostadil (vasodilator)</i>)	T1	PA
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	T1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 420 mg</i>	T1	PA
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 360 mg</i>	T1	PA
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	T1	ST
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	T1	PA
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	T1	ST
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	T1	PA
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	T1	PA
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	T1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	T1	
<i>nimodipine oral capsule 30 mg</i>	T1	PA
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	T1	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	T1	PA
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	T1	
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour 420 Mg)	T1	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	T1	PA
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	T1	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	T1	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg</i>	T1	PA
<i>verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	T1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	T1	
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (<i>vericiguat</i>)	T1	PA
Central Nervous System Agents		
Adamantanes (Cns)		
<i>amantadine hcl oral capsule 100 mg</i>	T1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	T1	
<i>amantadine hcl oral tablet 100 mg</i>	T1	
Amphetamines		
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg</i>	T1	PA

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	T1	PA
<i>methamphetamine hcl oral tablet 5 mg</i>	T1	PA
Amyotrophic Lateral Sclerosis(Als) Agent		
<i>riluzole oral tablet 50 mg</i>	T1	
Analgesics And Antipyretics, Misc.		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml</i>	T1	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	T1	QL (400 EA per 30 days)
<i>butalbital-apap-caffeine</i> (Bac (Butalbital-Acetamin-Caff) Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T1	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	T1	
<i>gabapentin oral solution 250 mg/5ml</i>	T1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	T1	
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	T1	QL (5400 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	T1	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	T1	
<i>pregabalin oral solution 20 mg/ml</i>	T1	ST
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 500 MCG/20ML, 500 MCG/5ML (<i>ziconotide acetate</i>)	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
Anorexigenic Agents		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (<i>naltrexone-bupropion hcl</i>)	T1	PA
Anorexigenic Agents And Stimulants, Misc		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 30 mg, 40 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	T1	QL (450 ML per 30 days); AL (Max 18 Years)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	T1	QL (900 ML per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>modafinil oral tablet 100 mg, 200 mg</i>	T1	PA
Anorexigenic Agents, Miscellaneous		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (<i>naltrexone-bupropion hcl</i>)	T1	PA
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide</i>)	T1	ST; QL (9 ML per 28 days)
Anticholinergic Agents (Cns)		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	QL (120 EA per 30 days)
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	T1	PA
<i>orphenadrine citrate injection solution 30 mg/ml</i>	T1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	T1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	T1	
Anticonvulsants, Miscellaneous		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	T1	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	T1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	T1	
<i>carbamazepine oral tablet 200 mg</i>	T1	
<i>carbamazepine oral tablet chewable 100 mg, 200 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine</i>)	T1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	T1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (<i>cannabidiol</i>)	T1	PA
<i>felbamate oral suspension 600 mg/5ml</i>	T1	PA
<i>felbamate oral tablet 400 mg, 600 mg</i>	T1	PA
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	T1	
<i>gabapentin oral solution 250 mg/5ml</i>	T1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	T1	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	T1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	T1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	T1	
<i>levetiracetam oral solution 100 mg/ml, 500 mg/5ml</i>	T1	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	T1	
<i>magnesium chloride injection solution 200 mg/ml</i>	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	T1	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	T1	
<i>pregabalin oral solution 20 mg/ml</i>	T1	ST
<i>rufinamide oral tablet 200 mg, 400 mg</i>	T1	PA
<i>lamotrigine</i> (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	T1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (<i>carbamazepine</i>)	T1	
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	T1	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (<i>carbamazepine</i>)	T1	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	T1	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg</i>	T1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>valproic acid oral capsule 250 mg</i>	T1	
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
Antidepressants, Miscellaneous		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	T1	QL (60 EA per 30 days)
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	T1	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	T1	
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	T1	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	T1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg</i>	T1	
<i>mirtazapine oral tablet dispersible 45 mg</i>	T1	PA
Antimanic Agents		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	T1	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	T1	PA
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	T1	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	T1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	T1	
<i>carbamazepine oral tablet 200 mg</i>	T1	
<i>carbamazepine oral tablet chewable 100 mg, 200 mg</i>	T1	
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (<i>carbamazepine</i>)	T1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	T1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	T1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	T1	
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	T1	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	T1	
<i>lithium carbonate oral tablet 300 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (<i>lithium carbonate</i>)	T1	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	T1	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	T1	
<i>risperidone oral solution 1 mg/ml</i>	T1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>risperidone oral tablet dispersible 0.25 mg</i>	T1	QL (60 EA per 30 days)
<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>lamotrigine</i> (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	T1	
TEGRETOL ORAL SUSPENSION 100 MG/5ML (<i>carbamazepine</i>)	T1	
TEGRETOL ORAL TABLET 200 MG (<i>carbamazepine</i>)	T1	
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (<i>carbamazepine</i>)	T1	
<i>valproic acid oral capsule 250 mg</i>	T1	
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	T1	PA
Antimigraine Agents, Miscellaneous		

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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (<i>erenumab-aooe</i>)	T1	PA
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	T1	PA
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	T1	
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 81 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (<i>divalproex sodium</i>)	T1	
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	T1	PA
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 500 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (<i>propranolol hcl sr beads</i>)	T1	
<i>ketoprofen er oral capsule extended release 24 hour 200 mg</i>	T1	
<i>ketoprofen oral capsule 50 mg</i>	T1	PA
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (<i>ergotamine-caffeine</i>)	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	T1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	T1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	PA
<i>topiramate oral capsule sprinkle 15 mg, 25 mg, 50 mg</i>	T1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
<i>valproic acid oral capsule 250 mg</i>	T1	
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
Antipsychotics, Miscellaneous		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	T1	
<i>pimozide oral tablet 1 mg, 2 mg</i>	T1	
Anxiolytics, Sedatives, And Hypnotics, Misc		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	T1	PA
<i>bupirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T1	
DAYVIGO ORAL TABLET 10 MG, 5 MG (<i>lemborexant</i>)	T1	PA
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	T1	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	T1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	T1	PA
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROMETHEGAN RECTAL SUPPOSITORY 50 MG <i>(promethazine hcl)</i>	T1	
<i>zaleplon oral capsule 10 mg</i>	T1	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
Atypical Antipsychotics		
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	T1	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	T1	PA
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	PA
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	T1	QL (30 EA per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	T1	QL (60 EA per 30 days)
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	T1	
<i>risperidone oral solution 1 mg/ml</i>	T1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>risperidone oral tablet dispersible 0.25 mg</i>	T1	QL (60 EA per 30 days)
<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	T1	PA
Barbiturates (Anticonvulsants)		
<i>pb-hyoscy-atropine-scopolamine oral elixir 16.2 mg/5ml</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral tablet 16.2 mg</i>	T1	
<i>phenobarbital oral elixir 20 mg/5ml, 30 mg/7.5ml, 60 mg/15ml</i>	T1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	T1	
<i>phenobarbital-belladonna alk oral elixir 16.2 mg/5ml</i>	T1	
PHENOHYTRO ORAL TABLET 16.2 MG (<i>pb-hyoscy-atropine-scopolamine</i>)	T1	
<i>primidone oral tablet 250 mg, 50 mg</i>	T1	
Barbiturates (Anxiolytic, Sedative/Hyp)		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>butalbital-apap-caffeine</i> (Bac (Butalbital-Acetamin-Caff) Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T1	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral elixir 16.2 mg/5ml</i>	T1	
<i>pb-hyoscy-atropine-scopolamine oral tablet 16.2 mg</i>	T1	
<i>phenobarbital oral elixir 20 mg/5ml, 30 mg/7.5ml, 60 mg/15ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	T1	
<i>phenobarbital-belladonna alk oral elixir 16.2 mg/5ml</i>	T1	
PHENOHYTRO ORAL TABLET 16.2 MG (<i>pb-hyoscy-atropine-scopolamine</i>)	T1	
Benzodiazepines (Anticonvulsants)		
<i>clobazam oral tablet 10 mg, 20 mg</i>	T1	QL (60 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	T1	
<i>diazepam</i> (Diazepam Intensol Oral Concentrate 5 Mg/ML)	T1	
<i>diazepam oral concentrate 5 mg/ml</i>	T1	
<i>diazepam oral solution 5 mg/5ml</i>	T1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	T1	
<i>lorazepam</i> (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	T1	
<i>lorazepam oral concentrate 2 mg/ml</i>	T1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
Benzodiazepines (Anxiolytic, Sedativ/Hyp)		
<i>alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	T1	
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (<i>alprazolam</i>)	T1	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	PA
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg, 3 mg</i>	T1	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	T1	
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	T1	
<i>clobazam oral tablet 10 mg, 20 mg</i>	T1	QL (60 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	T1	
<i>diazepam (Diazepam Intensol Oral Concentrate 5 Mg/MI)</i>	T1	
<i>diazepam oral concentrate 5 mg/ml</i>	T1	
<i>diazepam oral solution 5 mg/5ml</i>	T1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	T1	
<i>estazolam oral tablet 1 mg, 2 mg</i>	T1	
<i>flurazepam hcl oral capsule 15 mg, 30 mg</i>	T1	
<i>lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/MI)</i>	T1	
<i>lorazepam oral concentrate 2 mg/ml</i>	T1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	T1	PA
<i>quazepam oral tablet 15 mg</i>	T1	PA
<i>temazepam oral capsule 15 mg, 30 mg</i>	T1	
<i>temazepam oral capsule 22.5 mg, 7.5 mg</i>	T1	PA
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	T1	
Butyrophenones		
<i>haloperidol decanoate intramuscular solution 50 mg/ml</i>	T1	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	T1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	T1	
Calcitonin Gene-Related Peptide Antag.		

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (<i>erenumab-aooe</i>)	T1	PA
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	T1	PA
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	T1	PA
NURTEC ORAL TABLET DISPERSIBLE 75 MG (<i>rimegepant sulfate</i>)	T1	PA
UBRELVY ORAL TABLET 100 MG, 50 MG (<i>ubrogepant</i>)	T1	PA
Catechol-O-Methyltransferase(Comt)Inhib.		
<i>entacapone oral tablet 200 mg</i>	T1	
<i>tolcapone oral tablet 100 mg</i>	T1	
Central Nervous System Agents, Misc.		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	T1	
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 80 mg</i>	T1	
<i>atomoxetine hcl oral capsule 60 mg</i>	T1	PA
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (<i>deutetrabenazine</i>)	T1	PA
<i>carbidopa oral tablet 25 mg</i>	T1	
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	T1	
INGREZZA ORAL CAPSULE 40 MG, 80 MG (<i>valbenazine tosylate</i>)	T1	PA
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg</i>	T1	
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (<i>viloxazine hcl</i>)	T1	PA
<i>riluzole oral tablet 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	T1	PA
Cyclooxygenase-2 (Cox-2) Inhibitors		
<i>celecoxib oral capsule 100 mg, 200 mg</i>	T1	
<i>celecoxib oral capsule 400 mg, 50 mg</i>	T1	PA
Dibenzoxapines		
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	T1	
Diphenylbutylperidines		
<i>pimozide oral tablet 1 mg, 2 mg</i>	T1	
Dopamine Precursors		
<i>carbidopa oral tablet 25 mg</i>	T1	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	T1	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	T1	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	T1	
VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML (<i>foscarbidopa-foslevodopa</i>)	T1	PA
Ergot-Deriv. Dopamine Receptor Agonists		
<i>bromocriptine mesylate oral capsule 5 mg</i>	T1	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	T1	
<i>cabergoline oral tablet 0.5 mg</i>	T1	
Fibromyalgia Agents		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	T1	QL (60 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	T1	PA
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral solution 20 mg/ml</i>	T1	ST
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	T1	QL (60 EA per 30 days)
Gaba-Mediated Anticonvulsants		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (<i>divalproex sodium</i>)	T1	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	T1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	T1	
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	T1	
<i>gabapentin oral solution 250 mg/5ml</i>	T1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	T1	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	T1	
<i>pregabalin oral solution 20 mg/ml</i>	T1	ST
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	T1	
<i>valproic acid oral solution 250 mg/5ml</i>	T1	
Hydantoins		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (<i>phenytoin</i>)	T1	
DILANTIN ORAL CAPSULE 100 MG, 30 MG (<i>phenytoin sodium extended</i>)	T1	
<i>phenytoin</i> (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)	T1	
<i>phenytoin oral suspension 100 mg/4ml, 125 mg/5ml</i>	T1	
<i>phenytoin oral tablet chewable 50 mg</i>	T1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ion Channel Inhibition Agents		
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	T1	
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	T1	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	T1	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	T1	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
Monoamine Oxidase B Inhibitors		
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	T1	PA
<i>selegiline hcl oral capsule 5 mg</i>	T1	
<i>selegiline hcl oral tablet 5 mg</i>	T1	
Monoamine Oxidase Inhibitors		
<i>phenelzine sulfate oral tablet 15 mg</i>	T1	PA
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	T1	PA
<i>selegiline hcl oral capsule 5 mg</i>	T1	
<i>selegiline hcl oral tablet 5 mg</i>	T1	
<i>tranylcypromine sulfate oral tablet 10 mg</i>	T1	PA
Non-Benzodiazepine Anxiolytics		
<i>bupirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	T1	
<i>meprobamate oral tablet 200 mg, 400 mg</i>	T1	PA
Non-Benzodiazepine Hypnotics		
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	T1	
<i>zaleplon oral capsule 10 mg</i>	T1	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	T1	QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	T1	QL (30 EA per 30 days)
Nonergot-Deriv.Dopamine Receptor Agonist		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	T1	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	T1	
Non-Opioid Analgesics		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml</i>	T1	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	T1	QL (400 EA per 30 days)
<i>butalbital-apap-caffeine</i> (Bac (Butalbital-Acetamin-Caff) Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T1	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	T1	QL (5400 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	T1	PA
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 500 MCG/20ML, 500 MCG/5ML (<i>ziconotide acetate</i>)	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
Nonsteroidal Anti-Inflamm. Agents, Misc		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diclofenac epolamine external patch 1.3 %</i>	T1	PA
<i>diclofenac potassium oral tablet 50 mg</i>	T1	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	T1	
<i>diclofenac sodium external gel 1 %</i>	T1	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	T1	
<i>diflunisal oral tablet 500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 500 mg</i>	T1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	T1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	T1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	T1	
<i>flurbiprofen oral tablet 100 mg</i>	T1	PA
<i>hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg</i>	T1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>indomethacin er oral capsule extended release 75 mg</i>	T1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	T1	
<i>indomethacin oral suspension 25 mg/5ml</i>	T1	
<i>ketoprofen er oral capsule extended release 24 hour 200 mg</i>	T1	
<i>ketoprofen oral capsule 50 mg</i>	T1	PA
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	T1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	T1	PA
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	T1	PA
<i>mefenamic acid oral capsule 250 mg</i>	T1	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	T1	

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lowercase bold italics =
Generic drugs
UPPERCASE = Brand name drugs

Drug Tier
T1 = Formulary Medication

Coverage Requirements and Limits
AL = Age Limit
PA = Prior Authorization
QL = Quantity Limit
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nabumetone oral tablet 500 mg, 750 mg</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>oxaprozin oral tablet 600 mg</i>	T1	QL (90 EA per 30 days)
<i>piroxicam oral capsule 10 mg, 20 mg</i>	T1	
<i>sulindac oral tablet 150 mg, 200 mg</i>	T1	
Opioid Agonists (28:08)		
<i>acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml</i>	T1	QL (5000 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	T1	QL (400 EA per 30 days)
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	T1	
DISKETS ORAL TABLET SOLUBLE 40 MG (<i>methadone hcl</i>)	T1	
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg, 5-325 Mg, 7.5-325 Mg)	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg)	T1	PA
<i>fentanyl cit-ropivacaine-nacl epidural solution 0.2-0.2-0.9 mg/100ml-%, 0.5-0.2-0.9 mg/250ml-%</i>	T1	
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>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-%</i>	T1	
<i>hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml</i>	T1	QL (5400 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg</i>	T1	
<i>hydromorphone hcl oral liquid 1 mg/ml</i>	T1	
<i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i>	T1	
<i>hydromorphone hcl rectal suppository 3 mg</i>	T1	
<i>levorphanol tartrate oral tablet 2 mg</i>	T1	PA
<i>meperidine hcl oral solution 50 mg/5ml</i>	T1	PA
<i>meperidine hcl oral tablet 50 mg</i>	T1	PA
<i>methadone hcl</i> (Methadone Hcl Intensol Oral Concentrate 10 Mg/ML)	T1	
<i>methadone hcl oral concentrate 10 mg/ml</i>	T1	
<i>methadone hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	T1	
<i>methadone hcl oral tablet 10 mg, 5 mg</i>	T1	
<i>methadone hcl oral tablet soluble 40 mg</i>	T1	
<i>morphine sulfate (concentrate) oral solution 10 mg/0.5ml, 100 mg/5ml, 20 mg/ml</i>	T1	
<i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 30 mg, 60 mg, 90 mg</i>	T1	PA
<i>morphine sulfate er oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	T1	PA
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T1	
<i>morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml</i>	T1	
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>morphine sulfate rectal suppository 10 mg, 20 mg, 30 mg, 5 mg</i>	T1	
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG (<i>tapentadol hcl</i>)	T1	PA
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (<i>tapentadol hcl</i>)	T1	PA
<i>opium oral tincture 10 mg/ml (1%)</i>	T1	PA
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	T1	PA
<i>oxycodone hcl oral solution 5 mg/5ml</i>	T1	PA
<i>oxycodone hcl oral tablet 15 mg, 20 mg, 30 mg</i>	T1	PA
<i>oxycodone hcl oral tablet 5 mg</i>	T1	
<i>oxycodone hcl oral tablet abuse-deterrent 15 mg, 5 mg</i>	T1	PA
<i>oxycodone-acetaminophen oral solution 5-325 mg/5ml</i>	T1	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T1	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	T1	PA
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>tramadol hcl oral tablet 50 mg</i>	T1	
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	T1	QL (240 EA per 30 days)
Opioid Antagonists (28:10)		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	T1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	T1	
<i>gnp naloxone hcl nasal liquid 4 mg/0.1ml</i>	T1	
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	T1	QL (4 EA per 180 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	T1	PA
RELISTOR ORAL TABLET 150 MG (<i>methylnaltrexone bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML, 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	T1	PA
REXTOVY NASAL LIQUID 4 MG/0.25ML (<i>naloxone hcl</i>)	T1	QL (4 EA per 180 days)
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	T1	QL (4 EA per 180 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	T1	
Opioid Partial Agonists		
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	T1	
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	T1	
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	T1	
<i>pentazocine-naloxone hcl oral tablet 50-0.5 mg</i>	T1	PA
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (<i>buprenorphine</i>)	T1	
Orexin Receptor Antagonists		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAYVIGO ORAL TABLET 10 MG, 5 MG (<i>lemborexant</i>)	T1	PA
QUVIVIQ ORAL TABLET 25 MG, 50 MG (<i>daridorexant hcl</i>)	T1	PA
Phenothiazines		
<i>chlorpromazine hcl oral concentrate 100 mg/ml</i>	T1	
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	T1	
<i>prochlorperazine</i> (Compro Rectal Suppository 25 Mg)	T1	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	T1	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	T1	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	T1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	T1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	T1	
<i>prochlorperazine rectal suppository 25 mg</i>	T1	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	T1	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Respiratory And Cns Stimulants		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 80 mg</i>	T1	
<i>atomoxetine hcl oral capsule 60 mg</i>	T1	PA
<i>butalbital-apap-caffeine</i> (Bac (Butalbital-Acetamin-Caff) Oral Tablet 50-325-40 Mg)	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-apap-caffeine oral capsule 50-325-40 mg</i>	T1	QL (360 EA per 30 days)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	T1	QL (360 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 15 mg, 20 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	T1	
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 50 mg, 60 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg, 72 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl er oral tablet extended release 24 hour 36 mg</i>	T1	QL (60 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	T1	QL (450 ML per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	T1	QL (900 ML per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	T1	QL (90 EA per 30 days); AL (Max 18 Years)
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	T1	QL (30 EA per 30 days); AL (Max 18 Years)

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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIGERGOT RECTAL SUPPOSITORY 2-100 MG <i>(ergotamine-caffeine)</i>	T1	
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG <i>(orphenadrine-aspirin-caffeine)</i>	T1	
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG <i>(viloxazine hcl)</i>	T1	PA
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG <i>(theophylline)</i>	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
Reversible Cox-1/Cox-2 Inhibitors		
<i>diclofenac sodium external gel 3 %</i>	T1	PA
<i>diflunisal oral tablet 500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 500 mg</i>	T1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	T1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	T1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	T1	
<i>flurbiprofen oral tablet 100 mg</i>	T1	PA
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	T1	
<i>hydrocodone-ibuprofen oral tablet 5-200 mg, 7.5-200 mg</i>	T1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>indomethacin er oral capsule extended release 75 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>indomethacin oral capsule 25 mg, 50 mg</i>	T1	
<i>indomethacin oral suspension 25 mg/5ml</i>	T1	
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	T1	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	T1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	T1	PA
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	T1	PA
<i>mefenamic acid oral capsule 250 mg</i>	T1	PA
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	T1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>oxaprozin oral tablet 600 mg</i>	T1	QL (90 EA per 30 days)
<i>piroxicam oral capsule 10 mg, 20 mg</i>	T1	
<i>sulindac oral tablet 150 mg, 200 mg</i>	T1	
Salicylates		
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	T1	PA
<i>aspirin 81 oral tablet chewable 81 mg</i>	T1	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin childrens oral tablet chewable 81 mg</i>	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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aspirin ec adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet chewable 81 mg</i>	T1	
<i>aspirin oral tablet delayed release 81 mg</i>	T1	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	T1	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	T1	PA
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	T1	
<i>childrens aspirin oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	T1	
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	T1	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	T1	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	T1	
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	T1	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	T1	
<i>mm aspirin oral tablet delayed release 81 mg</i>	T1	
<i>norgesic forte oral tablet 50-770-60 mg</i>	T1	
<i>orphenadrine-aspirin-caffeine oral tablet 25-385-30 mg</i>	T1	
ORPHENGESIC FORTE ORAL TABLET 50-770-60 MG (<i>orphenadrine-aspirin-caffeine</i>)	T1	
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	T1	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	T1	
<i>salsalate oral tablet 500 mg, 750 mg</i>	T1	
Sel.Serotonin,Norepi Reuptake Inhibitor		
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	T1	QL (60 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	T1	PA
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	T1	QL (60 EA per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	T1	
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	T1	
Selective Serotonin Agonists		
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	T1	ST; QL (12 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	T1	QL (12 EA per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	T1	QL (12 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 50 mg</i>	T1	QL (18 EA per 30 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T1	QL (12 EA per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	T1	PA
Selective-Serotonin Reuptake Inhibitors		
<i>citalopram hydrobromide oral solution 10 mg/5ml, 20 mg/10ml</i>	T1	QL (900 ML per 30 days)
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg</i>	T1	QL (90 EA per 30 days)
<i>citalopram hydrobromide oral tablet 40 mg</i>	T1	QL (45 EA per 30 days)
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	T1	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>fluoxetine hcl (pmdd) oral tablet 10 mg</i>	T1	PA
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	T1	
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	T1	PA
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	T1	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	T1	PA
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	T1	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	T1	
<i>sertraline hcl oral concentrate 20 mg/ml</i>	T1	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
Serotonin Modulators		
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	T1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg</i>	T1	
<i>mirtazapine oral tablet dispersible 45 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	T1	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	T1	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (<i>vortioxetine hbr</i>)	T1	PA
Succinimides		
<i>ethosuximide oral capsule 250 mg</i>	T1	
<i>ethosuximide oral solution 250 mg/5ml</i>	T1	
Thioxanthenes		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
Tricyclics, Other Norepi-Ru Inhibitors		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	T1	
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	T1	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	T1	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>doxepin hcl external cream 5 %</i>	T1	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	T1	
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	T1	PA
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	T1	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	T1	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	T1	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	T1	
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	T1	PA
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
Vesicular Monoamine Transport2 Inhibitor		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (<i>deutetrabenazine</i>)	T1	PA
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (<i>deutetrabenazine</i>)	T1	PA
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG (<i>deutetrabenazine</i>)	T1	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (<i>valbenazine tosylate</i>)	T1	PA
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (<i>valbenazine tosylate</i>)	T1	PA
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	T1	PA
Wakefulness-Promoting Agents		
<i>diclofenac sodium oral tablet delayed release 75 mg</i>	T1	
<i>modafinil oral tablet 100 mg, 200 mg</i>	T1	PA
Dental Agents		
Dental Agents		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	T1	
<i>sf 5000 plus dental cream 1.1 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sf dental gel 1.1 %</i>	T1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental gel 1.1 %</i>	T1	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	T1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	T1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
Nutritional Supplements		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	T1	
<i>sf 5000 plus dental cream 1.1 %</i>	T1	
<i>sf dental gel 1.1 %</i>	T1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental gel 1.1 %</i>	T1	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	T1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	T1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
Devices		
Devices		
ACCU-CHEK SOFTCLIX LANCETS (<i>lancets</i>)	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACE AEROSOL CLOUD ENHANCER (<i>respiratory therapy supplies</i>)	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU LARGE (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
AEROCHAMBER PLUS FLO-VU SMALL (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
AQUALANCE LANCETS 30G (<i>lancets</i>)	T1	
BD DISP NEEDLE 23G X 1" (<i>needle (disp)</i>)	T1	
BD DISP NEEDLES 18G X 1-1/2" , 25G X 5/8" (<i>needle (disp)</i>)	T1	
BD INSULIN SYRINGE 29G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	T1	
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	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 (<i>insulin syringe-needle u-100</i>)	T1	
BD INTEGRA SYRINGE 21G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	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 (<i>syringe/needle (disp)</i>)	T1	
BD PEN NEEDLE MINI U/F 31G X 5 MM (<i>insulin pen needle</i>)	T1	
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM (<i>insulin pen needle</i>)	T1	
BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM (<i>insulin pen needle</i>)	T1	
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM (<i>insulin pen needle</i>)	T1	
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM (<i>insulin pen needle</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM (<i>insulin pen needle</i>)	T1	
BD PLASTIPAK SYRINGE 21G X 1" 3 ML (<i>syringe/needle disp</i>)	T1	
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML (<i>syringe/needle disp</i>)	T1	
BD TB SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	T1	
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML (<i>insulin syringe-needle u-100</i>)	T1	
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
COMFORT EZ PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	T1	
COMPACT SPACE CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	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 (<i>insulin syringe-needle u-100</i>)	T1	
DROPLET MICRON 34G X 3.5 MM (<i>insulin pen needle</i>)	T1	
DROPLET PEN NEEDLES 31G X 5 MM , 31G X 8 MM , 32G X 4 MM , 32G X 5 MM , 32G X 6 MM (<i>insulin pen needle</i>)	T1	
EASIVENT (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
<i>easy comfort lancets</i>	T1	
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	T1	
EASY TOUCH PEN NEEDLES 31G X 5 MM , 31G X 8 MM (<i>insulin pen needle</i>)	T1	
EMBECTA AUTOSHIELD DUO 30G X 5 MM (<i>insulin pen needle</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML, 31G X 5/16" 0.3 ML (<i>insulin syringe-needle u-100</i>)	T1	
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	T1	
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	T1	
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	T1	
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM (<i>insulin pen needle</i>)	T1	
EMBECTA PEN NEEDLE NANO 32G X 4 MM (<i>insulin pen needle</i>)	T1	
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM , 31G X 5 MM , 31G X 8 MM , 32G X 6 MM (<i>insulin pen needle</i>)	T1	
EMBRACE LANCETS ULTRA THIN 30G (<i>lancets</i>)	T1	
<i>eq space chamber anti-static device</i>	T1	QL (2 EA per 365 days)
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (<i>cervical caps</i>)	T1	
FREESTYLE LANCETS (<i>lancets</i>)	T1	
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous glucose receiver</i>)	T1	PA
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous glucose sensor</i>)	T1	PA
FREESTYLE LIBRE 2 PLUS SENSOR (<i>continuous glucose sensor</i>)	T1	PA
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous glucose receiver</i>)	T1	PA
FREESTYLE LIBRE 2 SENSOR (<i>continuous glucose sensor</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 3 PLUS SENSOR (<i>continuous glucose sensor</i>)	T1	PA
FREESTYLE LIBRE 3 READER DEVICE (<i>continuous glucose receiver</i>)	T1	PA
FREESTYLE LIBRE 3 SENSOR (<i>continuous glucose sensor</i>)	T1	PA
GEBAUERS PAIN EASE EXTERNAL AEROSOL (<i>pentafluoroprop-tetrafluoroeth</i>)	T1	
GEBAUERS SPRAY AND STRETCH EXTERNAL AEROSOL (<i>pentafluoroprop-tetrafluoroeth</i>)	T1	
GELCLAIR MOUTH/THROAT GEL (<i>povidone-nahyaluron-glycyrrhet</i>)	T1	
<i>heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml</i>	T1	
<i>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</i>	T1	
<i>lancets 28g thin</i>	T1	
<i>lancets micro thin 33g</i>	T1	
<i>lancets super thin 28g</i>	T1	
<i>lancets ultra thin 30g</i>	T1	
<i>lancing device</i>	T1	
MICROCHAMBER (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
MICROLET LANCETS (<i>lancets</i>)	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (<i>sodium chloride</i>)	T1	
NOVOFINE PEN NEEDLE 32G X 6 MM (<i>insulin pen needle</i>)	T1	
ONETOUCH DELICA PLUS LANCET30G (<i>lancets</i>)	T1	
ONETOUCH DELICA PLUS LANCET33G (<i>lancets</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTICHAMBER DIAMOND (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-LG MASK DEVICE (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-MD MASK (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
OPTICHAMBER DIAMOND-SM MASK (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
ORAMAGICRX MOUTH/THROAT SUSPENSION RECONSTITUTED (<i>oral wound care products</i>)	T1	
POCKET CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
<i>prochamber vhc device</i>	T1	QL (2 EA per 365 days)
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
RADIAPLEXRX EXTERNAL GEL (<i>wound dressings</i>)	T1	
REGENECARE EXTERNAL GEL 2 % (<i>lidocaine-collagen-aloe vera</i>)	T1	
RELION TRUE MET AIR GLUC METER KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	T1	QL (100 EA per 90 days)
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %</i>	T1	
<i>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</i>	T1	
<i>sure comfort lancets 30g</i>	T1	
<i>sure comfort pen needles 31g x 8 mm</i>	T1	
<i>techlite insulin syringe 31g x 5/16" 0.3 ml</i>	T1	
TECHLITE PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	T1	
TRUE METRIX AIR GLUCOSE METER KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	T1	QL (1 EA per 365 days)

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE METRIX METER KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	T1	QL (1 EA per 365 days)
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	T1	
TRUEPLUS LANCETS 28G (<i>lancets</i>)	T1	
TRUEPLUS LANCETS 30G (<i>lancets</i>)	T1	
TRUEPLUS LANCETS 33G (<i>lancets</i>)	T1	
TRUEPLUS SAFETY LANCETS 28G (<i>lancets</i>)	T1	
TRUETRACK BLOOD GLUCOSE KIT W/DEVICE (<i>blood glucose monitoring suppl</i>)	T1	QL (1 EA per 365 days)
ULTICARE MICRO PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	T1	
UNIFINE PENTIPS PLUS 31G X 8 MM (<i>insulin pen needle</i>)	T1	
VORTEX VALVED HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	T1	QL (2 EA per 365 days)
Diagnostic Agents		
Adrenocortical Insufficiency		
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (<i>corticotropin</i>)	T1	PA
CORTROPHIN INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	T1	PA
Cardiac Function		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	T1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	T1	
Diabetes Mellitus		
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP (<i>glucose blood</i>)	T1	QL (100 EA per 90 days)
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (<i>glucose blood</i>)	T1	QL (100 EA per 90 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE METRIX PRO BLOOD GLUCOSE IN VITRO STRIP (<i>glucose blood</i>)	T1	QL (100 EA per 90 days)
TRUETRACK TEST IN VITRO STRIP (<i>glucose blood</i>)	T1	QL (100 EA per 90 days)
Diagnostic Agents		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
CARESTART COVID-19 HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
<i>ellume covid-19 home test in vitro kit</i>	T1	QL (8 EA per 30 days)
<i>fastep covid-19 antigen test in vitro kit</i>	T1	QL (8 EA per 30 days)
FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
IHEALTH COVID-19 RAPID TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
INTELISWAB COVID-19 RAPID TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
LUCIRA CHECK IT COVID-19 TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
QUICKVUE AT-HOME COVID-19 TEST IN VITRO KIT (<i>covid-19 at home test</i>)	T1	QL (8 EA per 30 days)
Myasthenia Gravis		
<i>neostigmine methylsulfate intravenous solution prefilled syringe 3 mg/3ml</i>	T1	PA
Pheochromocytoma		
<i>metyrosine oral capsule 250 mg</i>	T1	
Electrolytic, Caloric, And Water Balance		
Acidifying Agents		
K-PHOS NO 2 ORAL TABLET 305-700 MG (<i>pot & sod ac phosphates</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
K-PHOS ORAL TABLET 500 MG (<i>potassium phosphate monobasic</i>)	T1	
PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG (<i>k phos mono-sod phos di & mono</i>)	T1	
<i>phosphorous oral tablet 155-852-130 mg</i>	T1	
Alkalinizing Agents		
ORACIT ORAL SOLUTION 490-640 MG/5ML (<i>sod citrate-citric acid</i>)	T1	
<i>pot & sod cit-cit ac oral solution 550-500-334 mg/5ml</i>	T1	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 5 meq (540 mg)</i>	T1	
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	T1	
<i>sod citrate-citric acid oral solution 500-334 mg/5ml</i>	T1	
<i>tricitrates oral solution 550-500-334 mg/5ml</i>	T1	
Ammonia Detoxicants		
<i>constulose oral solution 10 gm/15ml</i>	T1	
<i>enulose oral solution 10 gm/15ml</i>	T1	
<i>generlac oral solution 10 gm/15ml</i>	T1	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	T1	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	T1	
LITHOSTAT ORAL TABLET 250 MG (<i>acetohydroxamic acid</i>)	T1	PA
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	T1	
<i>sodium phenylbutyrate oral tablet 500 mg</i>	T1	
Caloric Agents		
<i>bupivacaine in dextrose intrathecal solution 0.75-8.25 %</i>	T1	
<i>bupivacaine spinal intrathecal solution 0.75-8.25 %</i>	T1	
ELLIOTTS B INTRATHECAL SOLUTION (<i>intrathecal elec-dextrose</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUTRIVIT ORAL LIQUID (<i>b complex-lysine-min-fe-fa</i>)	T1	
Carbonic Anhydrase Inhibitors (40:28)		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	
Diuretics, Miscellaneous		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
Irrigating Solutions		
<i>acetic acid glacial solution 99 %</i>	T1	
<i>acetic acid irrigation solution 0.25 %</i>	T1	
<i>acetic acid solution 5 %</i>	T1	
ARGYLE STERILE SALINE IRRIGATION SOLUTION 0.9 % (<i>sodium chloride (gu irrigant)</i>)	T1	
<i>glycine irrigation solution 1.5 %</i>	T1	
<i>glycine urologic irrigation solution 1.5 %</i>	T1	
<i>lactated ringers irrigation solution</i>	T1	
PHYSIOLYTE IRRIGATION SOLUTION (<i>irrigation solns physiological</i>)	T1	
<i>ringers irrigation irrigation solution</i>	T1	
<i>sodium chloride irrigation solution 0.9 %</i>	T1	
<i>sorbitol-mannitol irrigation solution 2.7-0.54 gm/100ml</i>	T1	
<i>sterile water for irrigation irrigation solution</i>	T1	
<i>water for irrigation, sterile irrigation solution</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Loop Diuretics (40:28)		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>ethacrynic acid oral tablet 25 mg</i>	T1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	T1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	T1	
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	T1	
Osmotic Diuretics (40:28)		
<i>sorbitol-mannitol irrigation solution 2.7-0.54 gm/100ml</i>	T1	
Phosphate-Removing Agents		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	T1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	T1	
<i>calcium acetate oral tablet 667 mg</i>	T1	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	T1	PA
<i>sevelamer carbonate oral tablet 800 mg</i>	T1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	T1	PA
Potassium-Removing Agents		
LOKELMA ORAL PACKET 10 GM, 5 GM (<i>sodium zirconium cyclosilicate</i>)	T1	QL (30 EA per 30 days)
VELTASSA ORAL PACKET 1 GM (<i>patiromer sorbitex calcium</i>)	T1	ST; QL (60 EA per 30 days)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM (<i>patiromer sorbitex calcium</i>)	T1	ST; QL (30 EA per 30 days)
Potassium-Sparing Diuretics (40:28)		
<i>amiloride hcl oral tablet 5 mg</i>	T1	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	T1	
<i>eplerenone oral tablet 25 mg, 50 mg</i>	T1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>triamterene oral capsule 100 mg, 50 mg</i>	T1	PA
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	T1	
Replacement Preparations		
<i>actical oral capsule</i>	T1	
<i>b-complex/vitamin c oral tablet</i>	T1	
<i>bupivacaine hcl-nacl epidural solution 0.125-0.9 %</i>	T1	
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	T1	
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	T1	
<i>calcium acetate oral tablet 667 mg</i>	T1	
<i>centravites 50 plus oral tablet</i>	T1	
<i>classic prenatal oral tablet 28-0.8 mg</i>	T1	
<i>complete natal dha oral 29-1-200 & 200 mg</i>	T1	
<i>cvs one daily essential oral tablet</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG (<i>b complex-c-biotin-e-min-fa</i>)	T1	
DIALYVITE/ZINC ORAL TABLET (<i>b complex-c-zn-folic acid</i>)	T1	
EFFER-K ORAL TABLET EFFERVESCENT 25 MEQ (<i>potassium bicarbonate</i>)	T1	
ELLIOTTS B INTRATHECAL SOLUTION (<i>intrathecal elec-dextrose</i>)	T1	
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	T1	
<i>essential one daily multivit oral tablet</i>	T1	
<i>fentanyl cit-ropivacaine-nacl epidural solution 0.2-0.2-0.9 mg/100ml-%, 0.5-0.2-0.9 mg/250ml-%</i>	T1	
<i>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-%</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GALZIN ORAL CAPSULE 25 MG, 50 MG (<i>zinc acetate (oral)</i>)	T1	PA
<i>gnp prenatal oral tablet 28-0.8 mg</i>	T1	
GUMMI BEAR MULTIVITAMIN/MIN ORAL TABLET CHEWABLE (<i>pediatric multivit-minerals</i>)	T1	
<i>hematinic plus vit/minerals oral tablet 106-1 mg</i>	T1	
INFASURF INTRATRACHEAL SUSPENSION 35-0.9 MG/ML-% (<i>calfactant in nacl</i>)	T1	
<i>potassium chloride crys er</i> (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	T1	
<i>potassium chloride crys er</i> (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	T1	
<i>potassium chloride</i> (Klor-Con Oral Packet 20 Meq)	T1	PA
K-PHOS ORAL TABLET 500 MG (<i>potassium phosphate monobasic</i>)	T1	
<i>lactated ringers irrigation solution</i>	T1	
<i>magnesium chloride injection solution 200 mg/ml</i>	T1	
<i>m-natal plus oral tablet 27-1 mg</i>	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (<i>sodium chloride</i>)	T1	
NUTRIVIT ORAL LIQUID (<i>b complex-lysine-min-fe-fa</i>)	T1	
PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG (<i>k phos mono-sod phos di & mono</i>)	T1	
<i>phosphorous oral tablet 155-852-130 mg</i>	T1	
PHOSPHO-TRIN K500 ORAL TABLET 500 MG (<i>potassium phosphate monobasic</i>)	T1	
<i>potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq</i>	T1	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq</i>	T1	
<i>potassium chloride oral packet 20 meq</i>	T1	PA
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	T1	
<i>prenatal gummies/dha & fa oral tablet chewable 0.4-32.5 mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	T1	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	T1	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i>	T1	
<i>prenatal plus oral tablet 27-1 mg</i>	T1	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	T1	
<i>prenatal/iron oral tablet</i>	T1	
<i>ropivacaine hcl-nacl injection solution 0.2-0.9 %</i>	T1	
<i>saline bacteriostatic injection solution 0.9 %</i>	T1	
<i>sodium chloride (pf) injection solution 0.9 %</i>	T1	
<i>sodium chloride bacteriostatic injection solution 0.9 %</i>	T1	
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %</i>	T1	
<i>sodium chloride injection solution 2.5 meq/ml</i>	T1	
<i>stress formula oral tablet</i>	T1	
<i>support oral liquid</i>	T1	
SUPPORT-500 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	
TAB-A-VITE ORAL TABLET (<i>multiple vitamin</i>)	T1	
<i>v-c forte oral capsule</i>	T1	
VIC-FORTE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>pediatric multivit-minerals</i>)	T1	
<i>wes-phos 250 neutral oral tablet 155-852-130 mg</i>	T1	
<i>westab plus oral tablet 27-1 mg</i>	T1	
Salt And Sugar Substitutes		
<i>aspartame (for compounding) powder</i>	T1	
Thiazide Diuretics (40:28)		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	T1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	T1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	T1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg</i>	T1	PA
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	T1	PA
DIURIL ORAL SUSPENSION 250 MG/5ML (<i>chlorothiazide</i>)	T1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg</i>	T1	
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	T1	PA
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	T1	PA
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	T1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	T1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	T1	PA
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	T1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	T1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	T1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	T1	PA
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	T1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	T1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	T1	
Thiazide-Like Diuretics (40:28)		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	T1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	T1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
THALITONE ORAL TABLET 15 MG (<i>chlorthalidone</i>)	T1	
Uricosuric Agents		
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	T1	
<i>probenecid oral tablet 500 mg</i>	T1	
Enzymes		
Enzyme Inhibitors		
<i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i>	T1	
Enzymes		
AMPHADASE INJECTION SOLUTION 150 UNIT/ML (<i>hyaluronidase bovine</i>)	T1	

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		Coverage Requirements and Limits
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Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	T1	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	T1	
SUCRAID ORAL SOLUTION 8500 UNIT/ML (<i>sacrosidase</i>)	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 (<i>pancrelipase (lip-prot-amyl)</i>)	T1	
Eye, Ear, Nose And Throat (Eent) Preps.		
Alpha-Adrenergic Agonists (52:40)		
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	T1	
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	T1	PA
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	T1	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	T1	PA
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	T1	
Antiallergic Agents		
ALOCRIAL OPHTHALMIC SOLUTION 2 % (<i>nedocromil sodium</i>)	T1	
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	T1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	T1	QL (6 ML per 30 days)
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	T1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	T1	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	T1	PA
<i>olopatadine hcl ophthalmic solution 0.1 %, 0.2 %</i>	T1	
Antibacterials (52:04)		
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	T1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	T1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	T1	
CILOXAN OPHTHALMIC OINTMENT 0.3 % (<i>ciprofloxacin hcl</i>)	T1	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	T1	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	T1	
<i>ciprofloxacin-hydrocortisone otic suspension 0.2-1 %</i>	T1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (<i>neomycin-colist-hc-thonzonium</i>)	T1	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	PA
<i>ery external pad 2 %</i>	T1	
<i>erythromycin external gel 2 %</i>	T1	
<i>erythromycin external solution 2 %</i>	T1	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	T1	
<i>gentamicin sulfate external cream 0.1 %</i>	T1	
<i>gentamicin sulfate external ointment 0.1 %</i>	T1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	T1	
<i>minocycline hcl oral capsule 100 mg</i>	T1	QL (60 EA per 30 days)
<i>minocycline hcl oral capsule 50 mg</i>	T1	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	T1	PA
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	T1	
<i>neomycin sulfate oral tablet 500 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	T1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	T1	
<i>ofloxacin ophthalmic solution 0.3 %</i>	T1	
<i>ofloxacin otic solution 0.3 %</i>	T1	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	T1	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	T1	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	T1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	T1	
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	T1	PA
<i>tobramycin ophthalmic solution 0.3 %</i>	T1	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	T1	
TOBREX OPHTHALMIC OINTMENT 0.3 % (<i>tobramycin</i>)	T1	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (<i>loteprednol-tobramycin</i>)	T1	
Antifungals (Eent)		
NATACYN OPHTHALMIC SUSPENSION 5 % (<i>natamycin</i>)	T1	
Antiglaucoma Agents, Miscellaneous		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>epinephrine (anaphylaxis) injection solution 30 mg/30ml</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % <i>(netarsudil-latanoprost)</i>	T1	PA
Anti-Infectives, Miscellaneous (52:04)		
<i>acetic acid otic solution 2 %</i>	T1	
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 % <i>(povidone-iodine)</i>	T1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<i>silver nitrate external solution 0.5 %</i>	T1	
Anti-Inflammatory Agents (Eent)		
CEQUA OPHTHALMIC SOLUTION 0.09 % <i>(cyclosporine)</i>	T1	PA
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	T1	
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	T1	PA
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	T1	
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG <i>(cyclosporine modified)</i>	T1	
NEORAL ORAL SOLUTION 100 MG/ML <i>(cyclosporine modified)</i>	T1	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG <i>(cyclosporine)</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XIIDRA OPHTHALMIC SOLUTION 5 % (<i>lifitegrast</i>)	T1	PA
Antivirals (Eent)		
<i>trifluridine ophthalmic solution 1 %</i>	T1	
Astringents (52:04)		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
Beta-Adrenergic Blocking Agents (52:40)		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	T1	PA
BETIMOL OPHTHALMIC SOLUTION 0.5 % (<i>timolol hemihydrate</i>)	T1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	T1	PA
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	T1	PA
<i>carteolol hcl ophthalmic solution 1 %</i>	T1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	T1	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	T1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	T1	
<i>timolol maleate</i> (Timolol Maleate OcuDose Ophthalmic Solution 0.5 %)	T1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	T1	
<i>timolol maleate pf ophthalmic solution 0.25 %, 0.5 %</i>	T1	
Carbonic Anhydrase Inhibitors (52:40)		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	T1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>brinzolamide ophthalmic suspension 1 %</i>	T1	PA
<i>dorzolamide hcl ophthalmic solution 2 %</i>	T1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	T1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	T1	PA
Corticosteroids (Eent)		
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	T1	PA
<i>ala-cort external cream 1 %</i>	T1	
ALREX OPHTHALMIC SUSPENSION 0.2 % (<i>loteprednol etabonate</i>)	T1	
<i>anucort-hc rectal suppository 25 mg</i>	T1	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	T1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	T1	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	T1	
<i>ciprofloxacin-hydrocortisone otic suspension 0.2-1 %</i>	T1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	T1	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	T1	PA
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (<i>neomycin-colist-hc-thonzonium</i>)	T1	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML (<i>dexamethasone</i>)	T1	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	T1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	T1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	T1	
<i>dexamethasone oral tablet therapy pack 1.5 mg (51)</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	T1	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	T1	ST; QL (5 ML per 30 days)
FLAREX OPHTHALMIC SUSPENSION 0.1 % (<i>fluorometholone acetate</i>)	T1	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA
<i>fluocinolone acetonide body external oil 0.01 %</i>	T1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	T1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	T1	
<i>fluocinolone acetonide external solution 0.01 %</i>	T1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	T1	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	T1	
<i>fluticasone furoate ellipta inhalation aerosol powder breath activated 100 mcg/act, 200 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	T1	
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	T1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	T1	PA
<i>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</i>	T1	
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (<i>fluorometholone</i>)	T1	
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	T1	

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lowercase bold italics =

Generic drugs

UPPERCASE = Brand name drugs

Drug Tier

T1 = Formulary Medication

Coverage Requirements and Limits

AL = Age Limit

PA = Prior Authorization

QL = Quantity Limit

ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 2.5 %</i>	T1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	T1	
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (<i>dexamethasone</i>)	T1	
<i>mometasone furoate external cream 0.1 %</i>	T1	
<i>mometasone furoate external ointment 0.1 %</i>	T1	
<i>mometasone furoate external solution 0.1 %</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 0.1 %, 3.5-10000-0.1</i>	T1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	T1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	T1	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (<i>prednisolone acetate</i>)	T1	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisolone oral solution 15 mg/5ml</i>	T1	
<i>prednisolone oral tablet 5 mg</i>	T1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	T1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 5 mg/5ml</i>	T1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % <i>(hydrocortisone ace-pramoxine)</i>	T1	PA
<i>hydrocortisone</i> (Procto-Med Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctosol Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctozone-Hc External Cream 2.5 %)	T1	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	T1	
TEXACORT EXTERNAL SOLUTION 2.5 % <i>(hydrocortisone)</i>	T1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % <i>(tobramycin-dexamethasone)</i>	T1	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT <i>(fluticasone-umeclidin-vilant)</i>	T1	PA
<i>fluticasone-salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % <i>(loteprednol-tobramycin)</i>	T1	
Eent Anti-Inflammatory Agents, Misc.		
CEQUA OPHTHALMIC SOLUTION 0.09 % <i>(cyclosporine)</i>	T1	PA
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	T1	PA
XIIDRA OPHTHALMIC SOLUTION 5 % <i>(lifitegrast)</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Eent Drugs, Miscellaneous		
<i>acetic acid otic solution 2 %</i>	T1	
AMVISC INTRAOCULAR SOLUTION PREFILLED SYRINGE 9.6 MG/0.8ML (<i>sodium hyaluronate</i>)	T1	
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	T1	
<i>carteolol hcl ophthalmic solution 1 %</i>	T1	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	T1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	T1	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	T1	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	T1	
GELFILM OPHTHALMIC FILM (<i>gelatin adsorbable</i>)	T1	PA
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	T1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	T1	
<i>polysorbate 80 oral liquid</i>	T1	
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (<i>varenicline tartrate</i>)	T1	PA
Eent Nonsteroidal Anti-Inflam. Agents		
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	T1	
<i>flurbiprofen oral tablet 100 mg</i>	T1	PA
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	T1	
<i>ketorolac tromethamine intramuscular solution 60 mg/2ml</i>	T1	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	T1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	T1	PA
Local Anesthetics (Eent)		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine hcl</i> (Glydo External Prefilled Syringe 2 %)	T1	
<i>lidocaine hcl external solution 4 %</i>	T1	PA
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	T1	
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	T1	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	T1	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	T1	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	T1	
Miotics		
MIOCHOL-E INTRAOCULAR SOLUTION RECONSTITUTED 20 MG (<i>acetylcholine chloride</i>)	T1	PA
MIOSTAT INTRAOCULAR SOLUTION 0.01 % (<i>carbachol</i>)	T1	PA
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (<i>echothiophate iodide</i>)	T1	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	T1	
<i>pilocarpine hcl oral tablet 5 mg</i>	T1	
<i>pilocarpine hcl oral tablet 7.5 mg</i>	T1	PA
Mydriatics		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (<i>cyclopentolate-phenylephrine</i>)	T1	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	T1	
<i>epinephrine (anaphylaxis) injection solution 30 mg/30ml</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
HOMATROPAIRE OPHTHALMIC SOLUTION 5 % (<i>homatropine hbr</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	T1	
<i>tropicamide ophthalmic solution 0.5 %, 1 %</i>	T1	
Prostaglandin Analogs		
<i>bimatoprost ophthalmic solution 0.03 %</i>	T1	PA
<i>latanoprost ophthalmic solution 0.005 %</i>	T1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (<i>bimatoprost</i>)	T1	PA
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	T1	PA
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	T1	PA
Rho Kinase Inhibitors		
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (<i>netarsudil-latanoprost</i>)	T1	PA
Vasoconstrictors		
CYCLOMYDRIL OPHTHALMIC SOLUTION 0.2-1 % (<i>cyclopentolate-phenylephrine</i>)	T1	
<i>epinephrine (anaphylaxis) injection solution 30 mg/30ml</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	T1	
Gastrointestinal Drugs		
5-Ht3 Receptor Antagonists		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	T1	PA
<i>granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml</i>	T1	PA
<i>granisetron hcl oral tablet 1 mg</i>	T1	ST; QL (12 EA per 30 days)
<i>ondansetron hcl oral solution 4 mg/5ml</i>	T1	
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T1	
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antacids And Adsorbents		
<i>omeprazole-sodium bicarbonate oral capsule 20-1100 mg</i>	T1	
Antidiarrhea Agents		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	T1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	T1	
<i>loperamide hcl oral capsule 2 mg</i>	T1	
MOTOFEN ORAL TABLET 1-0.025 MG (<i>difenoxin-atropine</i>)	T1	
<i>opium oral tincture 10 mg/ml (1%)</i>	T1	PA
Antiemetics, Miscellaneous		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	T1	PA
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	T1	PA
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	T1	QL (30 EA per 30 days)
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	T1	
Antihistamines (Gi Drugs)		
<i>prochlorperazine</i> (Compro Rectal Suppository 25 Mg)	T1	
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	T1	
<i>meclizine hcl oral tablet chewable 25 mg</i>	T1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	T1	
<i>prochlorperazine rectal suppository 25 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIGAN INTRAMUSCULAR SOLUTION 100 MG/ML (<i>trimethobenzamide hcl</i>)	T1	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	T1	
Anti-Inflammatory Agents (Gi Drugs)		
<i>alosetron hcl oral tablet 0.5 mg, 1 mg</i>	T1	PA
<i>balsalazide disodium oral capsule 750 mg</i>	T1	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	T1	
<i>mesalamine oral capsule delayed release 400 mg</i>	T1	
<i>mesalamine oral tablet delayed release 1.2 gm, 800 mg</i>	T1	
<i>mesalamine rectal enema 4 gm</i>	T1	
<i>mesalamine rectal suppository 1000 mg</i>	T1	
SFROWASA RECTAL ENEMA 4 GM/60ML (<i>mesalamine</i>)	T1	
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
Antiulcer Agents And Acid Suppressants		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	T1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	T1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	T1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	T1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	T1	PA
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	T1	PA
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cathartics And Laxatives		
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	T1	
<i>peg 3350-kcl-nabcb-nacl-nasulf</i> (Gavilyte-G Oral Solution Reconstituted 236 Gm)	T1	
<i>peg 3350-kcl-na bicarb-nacl</i> (Gavilyte-N With Flavor Pack Oral Solution Reconstituted 420 Gm)	T1	
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	T1	PA
<i>na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml</i>	T1	
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	T1	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	T1	
PLURONIC F127 POWDER (<i>poloxamer</i>)	T1	
<i>sorbitol solution 70 %</i>	T1	
SUTAB ORAL TABLET 1479-225-188 MG (<i>sodium sulfate-mag sulfate-kcl</i>)	T1	
Chloride Channel Activators		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	T1	PA
Cholelitholytic Agents		
<i>ursodiol oral capsule 300 mg</i>	T1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	T1	
Digestants		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
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 (<i>pancrelipase (lip-prot-amyl)</i>)	T1	
Dopamine Receptor Antagonists		
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	T1	
Gi Drugs, Miscellaneous		
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty cd/uc/hs start subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	T1	PA
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	T1	PA
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (<i>vedolizumab</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
IBSRELA ORAL TABLET 50 MG (<i>tenapanor hcl</i>)	T1	PA
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (<i>linaclotide</i>)	T1	PA
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	T1	PA
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (<i>naloxegol oxalate</i>)	T1	PA
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	T1	
<i>prucalopride succinate oral tablet 1 mg, 2 mg</i>	T1	PA
RELISTOR ORAL TABLET 150 MG (<i>methylnaltrexone bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML, 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	T1	PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
SYMPROIC ORAL TABLET 0.2 MG (<i>naldemedine tosylate</i>)	T1	PA
TRULANCE ORAL TABLET 3 MG (<i>plecanatide</i>)	T1	PA
Guanylate Cyclase C (Gcc) Recept Agonist		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (<i>linaclotide</i>)	T1	PA
TRULANCE ORAL TABLET 3 MG (<i>plecanatide</i>)	T1	PA
Histamine H2-Antagonists		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	T1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	T1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	T1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
<i>nizatidine oral capsule 300 mg</i>	T1	PA
Immunomodulatory Agents (56:44)		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (<i>vedolizumab</i>)	T1	PA
Lipotropic Agents		
<i>b complex formula 1 (lipotrop) oral tablet</i>	T1	
<i>b complex-c oral tablet</i>	T1	
<i>balance b-100 oral tablet</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Neurokinin-1 Receptor Antagonists		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	T1	PA
<i>aprepitant oral capsule 125 mg, 80 & 125 mg, 80 mg</i>	T1	QL (30 EA per 30 days)
<i>aprepitant oral capsule 40 mg</i>	T1	QL (1 EA per 30 days)
Opioid Antagonists (56:18)		
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (<i>naloxegol oxalate</i>)	T1	PA
RELISTOR ORAL TABLET 150 MG (<i>methylnaltrexone bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML (<i>methylnaltrexone bromide</i>)	T1	PA
RELISTOR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 12 MG/0.6ML, 8 MG/0.4ML (<i>methylnaltrexone bromide</i>)	T1	PA
SYMPROIC ORAL TABLET 0.2 MG (<i>naldemedine tosylate</i>)	T1	PA
Prokinetic Agents		
<i>metoclopramide hcl +rfid injection solution 5 mg/ml</i>	T1	
<i>metoclopramide hcl injection solution 5 mg/ml</i>	T1	
<i>metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml</i>	T1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	T1	
Prostaglandins		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	T1	
Protectants		
<i>sucralfate oral suspension 1 gm/10ml</i>	T1	
<i>sucralfate oral tablet 1 gm</i>	T1	
Proton-Pump Inhibitors		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</i>	T1	
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	T1	
<i>lansoprazole oral tablet delayed release dispersible 15 mg</i>	T1	
<i>lansoprazole oral tablet delayed release dispersible 30 mg</i>	T1	QL (30 EA per 30 days)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg</i>	T1	
<i>omeprazole oral capsule delayed release 40 mg</i>	T1	QL (60 EA per 30 days)
<i>omeprazole-sodium bicarbonate oral capsule 20-1100 mg</i>	T1	
<i>pantoprazole sodium intravenous solution reconstituted 40 mg</i>	T1	PA
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	T1	
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	T1	
Heavy Metal Antagonists		
Heavy Metal Antagonists		
CHEMET ORAL CAPSULE 100 MG (<i>succimer</i>)	T1	
<i>deferasirox granules oral packet 180 mg, 360 mg, 90 mg</i>	T1	PA
<i>deferasirox oral packet 180 mg, 360 mg, 90 mg</i>	T1	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	T1	PA
<i>deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg</i>	T1	PA
<i>deferiprone oral tablet 1000 mg, 500 mg</i>	T1	PA
<i>deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg</i>	T1	PA
FERRIPROX ORAL SOLUTION 100 MG/ML (<i>deferiprone</i>)	T1	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (<i>deferiprone</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GALZIN ORAL CAPSULE 25 MG, 50 MG (<i>zinc acetate (oral)</i>)	T1	PA
<i>penicillamine oral capsule 250 mg</i>	T1	PA
<i>penicillamine oral tablet 250 mg</i>	T1	PA
<i>pentetate calcium trisodium combination solution 200 mg/ml</i>	T1	
<i>pentetate zinc trisodium combination solution 200 mg/ml</i>	T1	
<i>trientine hcl oral capsule 250 mg</i>	T1	PA
Hormones And Synthetic Substitutes		
Adrenals		
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	T1	PA
<i>ala-cort external cream 1 %</i>	T1	
<i>anucort-hc rectal suppository 25 mg</i>	T1	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	T1	
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>mometasone furoate</i>)	T1	
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>mometasone furoate</i>)	T1	
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT (<i>mometasone furoate</i>)	T1	
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (<i>mometasone furoate</i>)	T1	
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (<i>mometasone furoate</i>)	T1	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	T1	PA
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	T1	PA
<i>betamethasone dipropionate external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	T1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	T1	
<i>betamethasone valerate external cream 0.1 %</i>	T1	
<i>betamethasone valerate external foam 0.12 %</i>	T1	PA
<i>betamethasone valerate external lotion 0.1 %</i>	T1	
<i>betamethasone valerate external ointment 0.1 %</i>	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	T1	PA
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	T1	PA
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	T1	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	T1	QL (60 ML per 30 days)
<i>budesonide oral capsule delayed release particles 3 mg</i>	T1	QL (90 EA per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	T1	QL (20.4 GM per 30 days)
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	T1	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	T1	PA
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML (<i>dexamethasone</i>)	T1	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	T1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	T1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	T1	
<i>dexamethasone oral tablet therapy pack 1.5 mg (51)</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT (<i>mometasone furo-formoterol fum</i>)	T1	
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	T1	
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA
<i>fluticasone furoate ellipta inhalation aerosol powder breath activated 100 mcg/act, 200 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	T1	
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone propionate external cream 0.05 %</i>	T1	
<i>fluticasone propionate external ointment 0.005 %</i>	T1	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	T1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	T1	PA
<i>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</i>	T1	
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %</i>	T1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 2.5 %</i>	T1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
MEDROL ORAL TABLET 2 MG (<i>methylprednisolone</i>)	T1	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	T1	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	T1	
<i>mometasone furoate external cream 0.1 %</i>	T1	
<i>mometasone furoate external ointment 0.1 %</i>	T1	
<i>mometasone furoate external solution 0.1 %</i>	T1	
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (<i>prednisolone acetate</i>)	T1	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	T1	
<i>prednisolone oral solution 15 mg/5ml</i>	T1	
<i>prednisolone oral tablet 5 mg</i>	T1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	T1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 5 mg/5ml</i>	T1	
PREDNISON INTENSOL ORAL CONCENTRATE 5 MG/ML (<i>prednisone</i>)	T1	
<i>prednisone oral solution 5 mg/5ml</i>	T1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	T1	
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCTOFOAM HC EXTERNAL FOAM 1-1 % (<i>hydrocortisone ace-pramoxine</i>)	T1	PA
<i>hydrocortisone</i> (Procto-Med Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctosol Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctozone-Hc External Cream 2.5 %)	T1	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (<i>budesonide</i>)	T1	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	T1	
TEXACORT EXTERNAL SOLUTION 2.5 % (<i>hydrocortisone</i>)	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	T1	PA
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	T1	PA
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.05 %</i>	T1	PA
<i>triamcinolone in absorbase external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide</i> (Triderm External Cream 0.5 %)	T1	
<i>fluticasone-salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	T1	
Alpha-Glucosidase Inhibitors		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	T1	ST
Androgens		
COVARYX HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	T1	
COVARYX ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	T1	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	T1	PA
EEMT HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	T1	
EEMT ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	T1	
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	T1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	T1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	T1	
<i>methyltestosterone oral capsule 10 mg</i>	T1	PA
<i>testosterone cypionate injection solution 200 mg/ml</i>	T1	QL (4 ML per 28 days)
<i>testosterone cypionate intramuscular solution 200 mg/ml</i>	T1	QL (4 ML per 28 days)
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	T1	
<i>testosterone transdermal gel 12.5 mg/act (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)</i>	T1	PA
Antiestrogens		
<i>anastrozole oral tablet 1 mg</i>	T1	QL (30 EA per 30 days)
<i>exemestane oral tablet 25 mg</i>	T1	
<i>letrozole oral tablet 2.5 mg</i>	T1	QL (30 EA per 30 days)
Antigonadotropins		
AFTERA ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
AFTERPILL ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>cetorelix acetate subcutaneous kit 0.25 mg</i>	T1	PA

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lowercase bold italics = Generic drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits
UPPERCASE = Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	T1	QL (1 EA per 30 days)
<i>ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml</i>	T1	PA
HER STYLE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel oral tablet 1.5 mg</i>	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)	T1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>levonorgestrel</i>)	T1	
MY CHOICE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
MY WAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
NEW DAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (<i>etonogestrel</i>)	T1	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
ORILISSA ORAL TABLET 150 MG, 200 MG (<i>elagolix sodium</i>)	T1	PA
PLAN B ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (<i>levonorgestrel</i>)	T1	
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	T1	
TAKE ACTION ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>testosterone cypionate injection solution 200 mg/ml</i>	T1	QL (4 ML per 28 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>testosterone cypionate intramuscular solution 200 mg/ml</i>	T1	QL (4 ML per 28 days)
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	T1	
<i>testosterone transdermal gel 12.5 mg/act (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)</i>	T1	PA
Antihypoglycemic Agents, Miscellaneous		
<i>diazoxide oral suspension 50 mg/ml</i>	T1	PA
Antiparathyroid Agents		
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	T1	
Antithyroid Agents		
<i>iodine strong oral solution 5 %</i>	T1	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T1	
<i>propylthiouracil oral tablet 50 mg</i>	T1	
Biguanides		
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	T1	ST
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	T1	
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	T1	PA
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	T1	
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (<i>canagliflozin-metformin hcl</i>)	T1	QL (60 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (<i>sitagliptin phos-metformin hcl</i>)	T1	ST
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (<i>sitagliptin phos-metformin hcl</i>)	T1	ST
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	T1	
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	T1	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	T1	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG (<i>dapagliflozin prop-metformin</i>)	T1	QL (30 EA per 30 days)
Contraceptives		
<i>levonorgestrel-ethinyl estrad</i> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	T1	
AFTERA ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
AFTERPILL ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	T1	
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet 90-20 Mcg)	T1	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	T1	
<i>desogestrel-ethinyl estradiol</i> (Apri Oral Tablet 0.15-30 Mg-Mcg)	T1	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG (<i>norethin-eth estrad triphasic</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	T1	
<i>norethindrone</i> (Camila Oral Tablet 0.35 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgestrel-ethinyl estrad (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
norgestrel-ethinyl estradiol (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	T1	
desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
norethindrone-eth estradiol (Dasetta 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
norethin-eth estrad triphasic (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
levonorgest-eth estrad 91-day (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
norethindrone (Deblitane Oral Tablet 0.35 Mg)	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (medroxyprogesterone acetate)	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (medroxyprogesterone acetate)	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (medroxyprogesterone acetate)	T1	PA
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	T1	
levonorgestrel-ethinyl estrad (Dolishale Oral Tablet 90-20 Mcg)	T1	
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	T1	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	T1	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	T1	
norgestrel-ethinyl estradiol (Elinest Oral Tablet 0.3-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	T1	
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone</i> (Errin Oral Tablet 0.35 Mg)	T1	
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	T1	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Feirza 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Feirza 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	T1	
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethin-eth estradiol-fe</i> (Galbriela Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Gem mily Oral Capsule 1-20 Mg-Mcg(24))	T1	
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>norethindrone</i> (Heather Oral Tablet 0.35 Mg)	T1	
HER STYLE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Iclevia Oral Tablet 0.15-0.03 Mg)	T1	
<i>norethindrone</i> (Incassia Oral Tablet 0.35 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet 3-0.02 Mg)	T1	
<i>norethindrone</i> (Jencycla Oral Tablet 0.35 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	T1	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (<i>levonorgestrel</i>)	T1	
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>levonorgest-eth est & eth est oral tablet 42-21-21-7 days</i>	T1	
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	T1	
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	T1	
<i>levonorgestrel oral tablet 1.5 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	T1	
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/125-30 mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)	T1	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphas</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	T1	
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone</i> (Lyleq Oral Tablet 0.35 Mg)	T1	
<i>norethindrone</i> (Lyza Oral Tablet 0.35 Mg)	T1	
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	T1	
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	T1	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	T1	
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	T1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>levonorgestrel</i>)	T1	
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	T1	
MY CHOICE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
MY WAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	T1	
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
NEW DAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (<i>etonogestrel</i>)	T1	
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	T1	
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	T1	
<i>norethindrone</i> (Nora-Be Oral Tablet 0.35 Mg)	T1	
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	T1	
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	T1	
<i>norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg</i>	T1	
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	T1	
<i>norethindrone oral tablet 0.35 mg</i>	T1	
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg</i>	T1	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	T1	
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	T1	
<i>norethindrone</i> (Norlyda Oral Tablet 0.35 Mg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
OPILL ORAL TABLET 0.075 MG (<i>norgestrel</i>)	T1	
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
PLAN B ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet 42-21-21-7 Days)	T1	
<i>levonorgest-eth estrad 91-day</i> (Rosyrah Oral Tablet 42-21-21-7 Days)	T1	
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	T1	
<i>norethindrone</i> (Sharobel Oral Tablet 0.35 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg)	T1	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (<i>levonorgestrel</i>)	T1	
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	T1	
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet 3-0.03 Mg)	T1	
TAKE ACTION ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>norethin ace-eth estrad-fe</i> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	T1	
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
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		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	T1	
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	T1	
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
<i>ethynodiol diac-eth estradiol</i> (Valtya 1/50 Oral Tablet 1-50 Mg-Mcg)	T1	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	T1	
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Vienva Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	T1	
<i>desogestrel-ethinyl estradiol</i> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	T1	
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<i>norethin-eth estradiol-fe</i> (Xelria Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	T1	
Dipeptidyl Peptidase-4(Dpp-4) Inhibitors		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	T1	ST
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	T1	ST
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	T1	ST
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (<i>sitagliptin phos-metformin hcl</i>)	T1	ST
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (<i>sitagliptin phos-metformin hcl</i>)	T1	ST
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (<i>sitagliptin phosphate</i>)	T1	ST
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (<i>ertugliflozin-sitagliptin</i>)	T1	ST
Estrogen Agonist-Antagonists		
<i>clomiphene citrate oral tablet 50 mg</i>	T1	PA
<i>raloxifene hcl oral tablet 60 mg</i>	T1	
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	T1	
<i>toremifene citrate oral tablet 60 mg</i>	T1	
Estrogens		
<i>levonorgestrel-ethinyl estrad</i> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	T1	
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet 90-20 Mcg)	T1	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desogestrel-ethinyl estradiol</i> (Apris Oral Tablet 0.15-30 Mg-Mcg)	T1	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG (<i>norethin-eth estrad triphasic</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	T1	
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (<i>estradiol-levonorgestrel</i>)	T1	PA
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (<i>estradiol-norethindrone acet</i>)	T1	ST
COVARYX HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	T1	
COVARYX ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	T1	
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (<i>estradiol cypionate</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Dolishale Oral Tablet 90-20 Mcg)	T1	
<i>estradiol</i> (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	T1	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	T1	
EEMT HS ORAL TABLET 0.625-1.25 MG (<i>est estrogens-methyltest</i>)	T1	
EEMT ORAL TABLET 1.25-2.5 MG (<i>est estrogens-methyltest</i>)	T1	
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>est estrogens-methyltest ds oral tablet 1.25-2.5 mg</i>	T1	
<i>est estrogens-methyltest hs oral tablet 0.625-1.25 mg</i>	T1	
<i>est estrogens-methyltest oral tablet 1.25-2.5 mg</i>	T1	
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i>	T1	
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	T1	QL (8 EA per 28 days)

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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	T1	
<i>estradiol vaginal cream 0.01 %</i>	T1	
<i>estradiol vaginal tablet 10 mcg</i>	T1	
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	T1	PA
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	T1	PA
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	T1	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Feirza 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Feirza 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	T1	
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (<i>estradiol acetate</i>)	T1	PA
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethindrone-eth estradiol</i> (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
<i>norethin-eth estradiol-fe</i> (Galbriela Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Gem mily Oral Capsule 1-20 Mg-Mcg(24))	T1	
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>levonorgest-eth estrad 91-day</i> (Iclevia Oral Tablet 0.15-0.03 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet 3-0.02 Mg)	T1	
<i>norethindrone-eth estradiol</i> (Jinteli Oral Tablet 1-5 Mg-Mcg)	T1	PA
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>levonorgest-eth est & eth est oral tablet 42-21-21-7 days</i>	T1	
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	T1	
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	T1	
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/125-30 mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	T1	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphase</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	T1	
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>estradiol</i> (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	T1	
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>estradiol-norethindrone acet</i> (Mimvey Oral Tablet 1-0.5 Mg)	T1	PA
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	T1	
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	T1	
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	T1	
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	T1	
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	T1	
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	T1	
<i>norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg</i>	T1	
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	T1	
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	T1	
<i>norethindrone-eth estradiol oral tablet 1-5 mg-mcg</i>	T1	PA
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg</i>	T1	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	T1	
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	T1	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (<i>estrogens conjugated</i>)	T1	
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	T1	
PREMPHASE ORAL TABLET 0.625-5 MG (<i>conj estrog-medroxyprogest ace</i>)	T1	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (<i>conj estrog-medroxyprogest ace</i>)	T1	
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet 42-21-21-7 Days)	T1	
<i>levonorgest-eth estrad 91-day</i> (Rosyrah Oral Tablet 42-21-21-7 Days)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet 3-0.03 Mg)	T1	
<i>norethin ace-eth estrad-fe</i> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	T1	
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	T1	
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	T1	
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
<i>ethynodiol diac-eth estradiol</i> (Valtya 1/50 Oral Tablet 1-50 Mg-Mcg)	T1	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	T1	
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Vienva Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	T1	
<i>desogestrel-ethinyl estradiol</i> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	T1	
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<i>norethin-eth estradiol-fe</i> (Xelria Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<i>estradiol</i> (Yuvaferm Vaginal Tablet 10 Mcg)	T1	
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	T1	
Glycogenolytic Agents		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	T1	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	T1	
<i>glucagon emergency injection solution reconstituted 1 mg, 1 mg/ml</i>	T1	
Gonadotropins		
<i>chorionic gonadotropin intramuscular solution reconstituted 10000 unit</i>	T1	PA
ELIGARD SUBCUTANEOUS KIT 22.5 MG (<i>leuprolide acetate (3 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 45 MG (<i>leuprolide acetate (6 month)</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs UPPERCASE = Brand name drugs		AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELIGARD SUBCUTANEOUS KIT 7.5 MG (<i>leuprolide acetate</i>)	T1	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML, 600 UNT/0.72ML, 900 UNT/1.08ML (<i>follitropin beta</i>)	T1	PA
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (<i>follitropin alfa</i>)	T1	PA
GONAL-F RFF REDIJECT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNT/0.48ML, 450 UNT/0.72ML, 900 UNT/1.44ML (<i>follitropin alfa</i>)	T1	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG (<i>leuprolide acetate</i>)	T1	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG (<i>leuprolide acetate (3 month)</i>)	T1	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	T1	PA
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (<i>leuprolide acetate</i>)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>leuprolide acetate (3 month)</i>)	T1	PA
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT 45 MG (<i>leuprolide acetate (6 month)</i>)	T1	PA
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (<i>menotropins</i>)	T1	PA
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>chorionic gonadotropin</i>)	T1	PA
OVIDREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 250 MCG/0.5ML (<i>choriogonadotropin alfa</i>)	T1	PA
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	T1	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG (<i>triptorelin pamoate</i>)	T1	QL (1 EA per 30 days)

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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs UPPERCASE = Brand name drugs		AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG (<i>triptorelin pamoate</i>)	T1	
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG (<i>goserelin acetate</i>)	T1	
Gonadotropins And Antigonadotropins		
<i>chorionic gonadotropin intramuscular solution reconstituted 10000 unit</i>	T1	PA
ELIGARD SUBCUTANEOUS KIT 22.5 MG (<i>leuprolide acetate (3 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 45 MG (<i>leuprolide acetate (6 month)</i>)	T1	
ELIGARD SUBCUTANEOUS KIT 7.5 MG (<i>leuprolide acetate</i>)	T1	
FOLLISTIM AQ SUBCUTANEOUS SOLUTION 300 UNT/0.36ML, 600 UNT/0.72ML, 900 UNT/1.08ML (<i>follitropin beta</i>)	T1	PA
GONAL-F INJECTION SOLUTION RECONSTITUTED 450 UNIT (<i>follitropin alfa</i>)	T1	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG (<i>leuprolide acetate</i>)	T1	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG (<i>leuprolide acetate (3 month)</i>)	T1	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	T1	PA
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG (<i>leuprolide acetate</i>)	T1	PA
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (<i>leuprolide acetate (3 month)</i>)	T1	PA
MENOPUR SUBCUTANEOUS SOLUTION RECONSTITUTED 75 UNIT (<i>menotropins</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs UPPERCASE = Brand name drugs		AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT (<i>chorionic gonadotropin</i>)	T1	PA
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	T1	
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG (<i>goserelin acetate</i>)	T1	
Incretin Mimetics		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (<i>tirzepatide</i>)	T1	PA
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (<i>semaglutide</i>)	T1	ST; QL (3 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (<i>semaglutide</i>)	T1	ST; QL (3 ML per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (<i>semaglutide</i>)	T1	ST; QL (3 ML per 28 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (<i>semaglutide</i>)	T1	ST; QL (30 EA per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	T1	ST; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide</i>)	T1	ST; QL (9 ML per 28 days)
Insulins		
APIDRA INJECTION SOLUTION 100 UNIT/ML (<i>insulin glulisine</i>)	T1	QL (30 ML per 30 days)
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glulisine</i>)	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	T1	QL (30 ML per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs UPPERCASE = Brand name drugs		AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Drug Tier T1 = Formulary Medication		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	T1	QL (30 ML per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human isophane</i>)	T1	QL (30 ML per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human isophane</i>)	T1	QL (30 ML per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (30 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	T1	QL (12 ML per 30 days)
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	T1	QL (30 ML per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs UPPERCASE = Brand name drugs		AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine</i>)	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human isophane</i>)	T1	QL (30 ML per 30 days)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human isophane</i>)	T1	QL (30 ML per 30 days)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (30 ML per 30 days)
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (120 ML per 30 days)
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (30 ML per 30 days)
Intermediate-Acting Insulins		
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	T1	QL (30 ML per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human isophane</i>)	T1	QL (30 ML per 30 days)

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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	T1	QL (30 ML per 30 days)
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	T1	QL (30 ML per 30 days)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	T1	QL (30 ML per 30 days)
Long-Acting Insulins		
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	T1	QL (30 ML per 30 days)
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin glargine</i>)	T1	QL (30 ML per 30 days)
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine-aglr</i>)	T1	QL (30 ML per 30 days)
Meglitinides		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	T1	PA
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Parathyroid Agents		
<i>teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml</i>	T1	PA
Parathyroid And Antiparathyroid Agents		
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	T1	
Pituitary		
CORTROPHIN GEL SUBCUTANEOUS PREFILLED SYRINGE 40 UNIT/0.5ML, 80 UNIT/ML (<i>corticotropin</i>)	T1	PA
CORTROPHIN INJECTION GEL 80 UNIT/ML (<i>corticotropin</i>)	T1	PA
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	T1	PA
<i>desmopressin acetate injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate nasal solution 1.5 mg/ml</i>	T1	PA
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	T1	
<i>desmopressin acetate pf injection solution 4 mcg/ml</i>	T1	PA
<i>desmopressin acetate spray nasal solution 0.01 %</i>	T1	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (<i>somatropin</i>)	T1	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (<i>somatropin</i>)	T1	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG (<i>somatropin</i>)	T1	PA
NORDITROPIN FLEXPPO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML (<i>somatropin</i>)	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (<i>somatropin</i>)	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>somatropin</i>)	T1	PA

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lowercase bold italics = Generic drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits
UPPERCASE = Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	T1	PA
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (<i>somatropin</i>)	T1	PA
Progestins		
<i>levonorgestrel-ethinyl estrad</i> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	T1	
AFTERA ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
AFTERPILL ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	T1	
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet 90-20 Mcg)	T1	
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	T1	
<i>desogestrel-ethinyl estradiol</i> (Apri Oral Tablet 0.15-30 Mg-Mcg)	T1	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG (<i>norethin-eth estrad triphasic</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Ashlyna Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
AVERI ORAL TABLET 0.15-0.03 MG (<i>desogestrel-eth estrad-fe</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	T1	
<i>norethindrone</i> (Camila Oral Tablet 0.35 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (<i>estradiol-levonorgestrel</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY (<i>estradiol-norethindrone acet</i>)	T1	ST
CRINONE VAGINAL GEL 4 %, 8 % (<i>progesterone</i>)	T1	PA
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>norethindrone</i> (Deblitane Oral Tablet 0.35 Mg)	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (<i>medroxyprogesterone acetate</i>)	T1	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (<i>medroxyprogesterone acetate</i>)	T1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	T1	PA
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Dolishale Oral Tablet 90-20 Mcg)	T1	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	T1	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	T1	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	T1	
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	T1	
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone</i> (Errin Oral Tablet 0.35 Mg)	T1	
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	T1	PA
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	T1	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Feirza 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Feirza 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	T1	
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethindrone-eth estradiol</i> (Fyavolv Oral Tablet 1-5 Mg-Mcg)	T1	PA
<i>norethin-eth estradiol-fe</i> (Galbriela Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Gem mily Oral Capsule 1-20 Mg-Mcg(24))	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	T1	
<i>norethindrone</i> (Heather Oral Tablet 0.35 Mg)	T1	
HER STYLE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Iclevia Oral Tablet 0.15-0.03 Mg)	T1	
<i>norethindrone</i> (Incassia Oral Tablet 0.35 Mg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet 3-0.02 Mg)	T1	
<i>norethindrone</i> (Jencycla Oral Tablet 0.35 Mg)	T1	
<i>norethindrone-eth estradiol</i> (Jinteli Oral Tablet 1-5 Mg-Mcg)	T1	PA
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet 0.15-0.03 Mg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	T1	
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (<i>levonorgestrel</i>)	T1	
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>levonorgest-eth est & eth est oral tablet 42-21-21-7 days</i>	T1	
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	T1	
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	T1	
<i>levonorgestrel oral tablet 1.5 mg</i>	T1	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	T1	
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	T1	
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	T1	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)	T1	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphas</i>)	T1	
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	T1	
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone</i> (Lyleq Oral Tablet 0.35 Mg)	T1	
<i>norethindrone</i> (Lyza Oral Tablet 0.35 Mg)	T1	
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	T1	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	T1	
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>megestrol acetate oral suspension 40 mg/ml</i>	T1	
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	T1	
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	T1	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	T1	
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>estradiol-norethindrone acet</i> (Mimvey Oral Tablet 1-0.5 Mg)	T1	PA
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>levonorgestrel</i>)	T1	
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	T1	
MY CHOICE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
MY WAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	T1	
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEW DAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (<i>etonogestrel</i>)	T1	
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	T1	
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	T1	
<i>norethindrone</i> (Nora-Be Oral Tablet 0.35 Mg)	T1	
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	T1	
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	T1	
<i>norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg</i>	T1	
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	T1	
<i>norethindrone acetate oral tablet 5 mg</i>	T1	
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	T1	
<i>norethindrone oral tablet 0.35 mg</i>	T1	
<i>norethindrone-eth estradiol oral tablet 1-5 mg-mcg</i>	T1	PA
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg</i>	T1	
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	T1	
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	T1	
<i>norethindrone</i> (Norlyda Oral Tablet 0.35 Mg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	T1	
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
OPILL ORAL TABLET 0.075 MG (<i>norgestrel</i>)	T1	
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	T1	
PLAN B ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	T1	
PREMPHASE ORAL TABLET 0.625-5 MG (<i>conj estrogen-medroxyprogesterone</i>)	T1	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (<i>conj estrogen-medroxyprogesterone</i>)	T1	
<i>progesterone oral capsule 100 mg, 200 mg</i>	T1	QL (30 EA per 30 days)
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	T1	
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet 42-21-21-7 Days)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgest-eth estrad 91-day (Rosyrach Oral Tablet 42-21-21-7 Days)	T1	
levonorgest-eth estrad 91-day (Setlakin Oral Tablet 0.15-0.03 Mg)	T1	
norethindrone (Sharobel Oral Tablet 0.35 Mg)	T1	
desogestrel-ethinyl estradiol (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
levonorgest-eth estrad 91-day (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg)	T1	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (levonorgestrel)	T1	
SLYND ORAL TABLET 4 MG (drospirenone)	T1	
norgestimate-eth estradiol (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	T1	
levonorgestrel-ethinyl estrad (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	T1	
drospirenone-ethinyl estradiol (Syeda Oral Tablet 3-0.03 Mg)	T1	
TAKE ACTION ORAL TABLET 1.5 MG (levonorgestrel)	T1	
norethin ace-eth estrad-fe (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	T1	
norethin ace-eth estrad-fe (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	T1	
norethin ace-eth estrad-fe (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	T1	
norethindron-ethinyl estrad-fe (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
norgestim-eth estrad triphasic (Tri Femynor Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
norgestim-eth estrad triphasic (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	T1	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	T1	
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	T1	
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	T1	
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
<i>ethynodiol diac-eth estradiol</i> (Valtya 1/50 Oral Tablet 1-50 Mg-Mcg)	T1	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	T1	
<i>levonorgestrel-ethinyl estrad</i> (Vienna Oral Tablet 0.1-20 Mg-Mcg)	T1	
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	T1	
<i>desogestrel-ethinyl estradiol</i> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	T1	
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	T1	
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	T1	
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	T1	
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<i>norethin-eth estradiol-fe</i> (Xelria Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	T1	
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	T1	
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	T1	
Rapid-Acting Insulins		
APIDRA INJECTION SOLUTION 100 UNIT/ML (<i>insulin glulisine</i>)	T1	QL (30 ML per 30 days)
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glulisine</i>)	T1	QL (30 ML per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	T1	QL (30 ML per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (<i>insulin lispro prot & lispro</i>)	T1	QL (30 ML per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin lispro</i>)	T1	QL (30 ML per 30 days)
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart injection solution 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin lispro injection solution 100 unit/ml</i>	T1	QL (30 ML per 30 days)
<i>insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i>	T1	QL (30 ML per 30 days)
Short-Acting Insulins		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (30 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	T1	QL (12 ML per 30 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	T1	QL (30 ML per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (30 ML per 30 days)
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (120 ML per 30 days)
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	T1	QL (30 ML per 30 days)
Sodium-Gluc Cotransport 2 (Sglt2) Inhib		
FARXIGA ORAL TABLET 10 MG, 5 MG (<i>dapagliflozin propanediol</i>)	T1	QL (30 EA per 30 days)
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (<i>canagliflozin-metformin hcl</i>)	T1	QL (60 EA per 30 days)
INVOKANA ORAL TABLET 100 MG, 300 MG (<i>canagliflozin</i>)	T1	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG (<i>empagliflozin</i>)	T1	QL (30 EA per 30 days)
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (<i>ertugliflozin-sitagliptin</i>)	T1	ST
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	T1	QL (60 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	T1	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG (<i>dapagliflozin prop-metformin</i>)	T1	QL (30 EA per 30 days)
Somatostatin Agonists		
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	T1	
Somatotropin Agonists		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (<i>somatropin</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (<i>somatropin</i>)	T1	PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG (<i>somatropin</i>)	T1	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 15 MG/1.5ML, 5 MG/1.5ML (<i>somatropin</i>)	T1	PA
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (<i>somatropin</i>)	T1	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML (<i>somatropin</i>)	T1	PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (<i>somatropin (non-refrigerated)</i>)	T1	PA
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (<i>somatropin</i>)	T1	PA
Somatotropin Antagonists		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG (<i>pegvisomant</i>)	T1	
Sulfonylureas		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	T1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	T1	
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	T1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	T1	
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	T1	PA
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	T1	
Thiazolidinediones		
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	T1	ST

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	T1	
Thyroid Agents		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (<i>thyroid</i>)	T1	
<i>levothyroxine sodium</i> (Levo-T Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	T1	
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	T1	
<i>levothyroxine sodium</i> (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	T1	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	T1	
<i>niva thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	T1	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	T1	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG (<i>levothyroxine sodium</i>)	T1	
<i>thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	T1	
<i>levothyroxine sodium</i> (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	T1	
Immunomodulatory Agents (90:00)		
Amino Acid Polymers		
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i>	T1	
Antimetabolites, Immunosupp Therapy Misc		
<i>azathioprine oral tablet 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>azathioprine sodium injection solution reconstituted 100 mg</i>	T1	PA
<i>mycophenolate mofetil oral capsule 250 mg</i>	T1	
Calcineurin Inhibitors, Misc (90:28)		
CEQUA OPHTHALMIC SOLUTION 0.09 % (<i>cyclosporine</i>)	T1	PA
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	T1	
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	T1	PA
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	T1	
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine modified</i>)	T1	
NEORAL ORAL SOLUTION 100 MG/ML (<i>cyclosporine modified</i>)	T1	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	T1	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine</i>)	T1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	T1	QL (30 GM per 30 days)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	T1	
Disease-Modifying Antirheumat Drugs Misc		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (<i>vedolizumab</i>)	T1	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG (<i>abatacept</i>)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Disease-Modifying Antirheumatic Drugs		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	T1	PA
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	T1	
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	T1	PA
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
Fumarates		
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	T1	PA
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	T1	PA
Immunomodulatory Agents (90:00)		
<i>cyclophosphamide oral tablet 50 mg</i>	T1	
<i>mercaptopurine oral tablet 50 mg</i>	T1	
Interferons		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	T1	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	T1	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	T1	PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (<i>interferon beta-1a</i>)	T1	
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (<i>interferon beta-1a</i>)	T1	
Interleukin Inhibitor Agents, Misc		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (<i>omalizumab</i>)	T1	PA
Interleukin-Mediated Agents, Misc		
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-srlf</i>)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>sarilumab</i>)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	T1	PA
OTULFI SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab-aauz</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OTULFI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-aauz</i>)	T1	PA
SELARSDI SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab-aekn</i>)	T1	PA
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-aekn</i>)	T1	PA
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	T1	PA
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab-aazg</i>)	T1	PA
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab-kfce</i>)	T1	PA
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (<i>ustekinumab-kfce</i>)	T1	PA
Janus Kinase Inhibitors, Miscellaneous		
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (<i>baricitinib</i>)	T1	PA
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	T1	PA
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	T1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	T1	PA
Monocarboxylic Acid Amide Agents		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	T1	
Mtor Inhibitors, Miscellaneous		
<i>sirolimus oral solution 1 mg/ml</i>	T1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
Phosphodiesterase-4 Inhibitors, Misc		
OTEZLA ORAL TABLET 20 MG, 30 MG (<i>apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG (<i>apremilast</i>)	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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG (<i>apremilast</i>)	T1	PA
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG (<i>apremilast</i>)	T1	PA
Sphingosine 1-Phosphate (S1p) Agents		
<i> fingolimod hcl oral capsule 0.5 mg</i>	T1	PA
Tumor Necrosis Factor Inhibitors, Misc		
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty cd/uc/hs start subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	T1	PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	T1	PA
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (<i>adalimumab-ryvk</i>)	T1	QL (2 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
Local Anesthetics		
Local Anesthetics		
<i>bupivacaine fisiopharma injection solution 0.5 %, 2.5 mg/ml</i>	T1	
<i>bupivacaine hcl (pf) injection solution 0.25 %, 0.5 %, 0.75 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bupivacaine hcl injection solution 0.25 %, 0.5 %</i>	T1	
<i>bupivacaine hcl-nacl epidural solution 0.125-0.9 %</i>	T1	
<i>bupivacaine in dextrose intrathecal solution 0.75-8.25 %</i>	T1	
<i>bupivacaine spinal intrathecal solution 0.75-8.25 %</i>	T1	
<i>bupivacaine-epinephrine (pf) injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>bupivacaine-epinephrine injection solution 0.25% - 1:200000, 0.5% -1:200000</i>	T1	
<i>chloroprocaine hcl (pf) injection solution 2 %</i>	T1	
<i>chloroprocaine hcl (pf) injection solution 3 %</i>	T1	PA
<i>fentanyl cit-ropivacaine-nacl epidural solution 0.2-0.2-0.9 mg/100ml-%, 0.5-0.2-0.9 mg/250ml-%</i>	T1	
<i>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-%</i>	T1	
<i>lidocaine hcl (pf) injection solution 0.5 %</i>	T1	
<i>lidocaine hcl injection solution 0.5 %, 1 %, 2 %</i>	T1	
<i>lidocaine hcl injection solution prefilled syringe 200 mg/10ml</i>	T1	
<i>lidocaine-epinephrine injection solution 0.5 %-1:200000, 1 %-1:100000, 2 %-1:100000</i>	T1	
POLOCAINE INJECTION SOLUTION 1 %, 2 % (<i>mepivacaine hcl</i>)	T1	
POLOCAINE-MPF INJECTION SOLUTION 1 %, 1.5 %, 2 % (<i>mepivacaine hcl</i>)	T1	
<i>ropivacaine hcl injection solution 10 mg/ml, 2 mg/ml, 5 mg/ml, 7.5 mg/ml</i>	T1	
<i>ropivacaine hcl-nacl injection solution 0.2-0.9 %</i>	T1	
<i>bupivacaine-epinephrine</i> (Sensorcaine/Epinephrine Injection Solution 0.25% -1:200000, 0.5% -1:200000)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bupivacaine hcl</i> (Sensorcaine-Mpf Injection Solution 0.75 %)	T1	
<i>bupivacaine-epinephrine</i> (Sensorcaine-Mpf/Epinephrine Injection Solution 0.25% -1:200000)	T1	
SENSORCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 0.75-1:200000 % (<i>bupivacaine-epinephrine</i>)	T1	
<i>tetracaine hcl ophthalmic solution 0.5 %</i>	T1	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION 1 %-1:200000 (<i>lidocaine-epinephrine</i>)	T1	
Miscellaneous Therapeutic Agents		
5-Alpha-Reductase Inhibitors		
<i>finasteride oral tablet 5 mg</i>	T1	
5-Alpha-Reductase Inhibitors (92:04)		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	T1	
<i>finasteride oral tablet 5 mg</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	T1	
Antidotes (92:12)		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	T1	
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	T1	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (<i>glucagon</i>)	T1	
CHEMET ORAL CAPSULE 100 MG (<i>succimer</i>)	T1	
<i>deferoxamine mesylate injection solution reconstituted 2 gm, 500 mg</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glucagon emergency injection solution reconstituted 1 mg, 1 mg/ml</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	T1	PA
LEDERLE LEUCOVORIN ORAL TABLET 5 MG <i>(leucovorin calcium)</i>	T1	
<i>leucovorin calcium oral tablet 5 mg</i>	T1	
<i>magnesium sulfate injection solution 50 %</i>	T1	
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	T1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	T1	
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	T1	
<i>naltrexone hcl oral tablet 50 mg</i>	T1	
<i>phytonadione injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<i>phytonadione oral tablet 5 mg</i>	T1	
<i>sevelamer carbonate oral tablet 800 mg</i>	T1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	T1	PA
<i>vitamin k1 injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	T1	
Antigout Agents		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	
<i>colchicine oral capsule 0.6 mg</i>	T1	PA
<i>colchicine oral tablet 0.6 mg</i>	T1	QL (30 EA per 30 days)
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	T1	
<i>ec-naproxen oral tablet delayed release 500 mg</i>	T1	
<i>indomethacin er oral capsule extended release 75 mg</i>	T1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>indomethacin oral suspension 25 mg/5ml</i>	T1	
<i>naproxen oral suspension 125 mg/5ml</i>	T1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	T1	
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	T1	
<i>naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg</i>	T1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>probenecid oral tablet 500 mg</i>	T1	
Bone Anabolic Agents		
<i>teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml</i>	T1	PA
Bone Resorption Inhibitors		
<i>alendronate sodium oral solution 70 mg/75ml</i>	T1	QL (75 ML per 30 days)
<i>alendronate sodium oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	T1	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (<i>estradiol cypionate</i>)	T1	PA
<i>estradiol</i> (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>estradiol transdermal gel 0.75 mg/1.25 gm (0.06%)</i>	T1	
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	T1	QL (8 EA per 28 days)
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	T1	
<i>estradiol vaginal cream 0.01 %</i>	T1	
<i>estradiol vaginal tablet 10 mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	T1	PA
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (<i>estradiol acetate</i>)	T1	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT (<i>alendronate-cholecalciferol</i>)	T1	PA
<i>ibandronate sodium oral tablet 150 mg</i>	T1	QL (1 EA per 28 days)
<i>estradiol</i> (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	T1	QL (8 EA per 28 days)
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (<i>estrogens conjugated</i>)	T1	
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	T1	
<i>raloxifene hcl oral tablet 60 mg</i>	T1	
<i>risedronate sodium oral tablet 150 mg</i>	T1	QL (1 EA per 30 days)
<i>risedronate sodium oral tablet 35 mg</i>	T1	QL (4 EA per 30 days)
<i>risedronate sodium oral tablet 5 mg</i>	T1	QL (30 EA per 30 days)
<i>estradiol</i> (Yuvaferm Vaginal Tablet 10 Mcg)	T1	
Cariostatic Agents		
DENTA 5000 PLUS DENTAL CREAM 1.1 % (<i>sodium fluoride</i>)	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
PREVIDENT DENTAL GEL 1.1 % (<i>sodium fluoride</i>)	T1	
<i>sf 5000 plus dental cream 1.1 %</i>	T1	
<i>sf dental gel 1.1 %</i>	T1	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental cream 1.1 %</i>	T1	
<i>sodium fluoride dental gel 1.1 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium fluoride mouth/throat solution 0.2 %</i>	T1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	T1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
Complement Inhibitors		
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	T1	PA
Complement Inhibitors (92:32)		
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	T1	PA
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (<i>berotralstat hcl</i>)	T1	PA
Disease-Modifying Antirheumatic Agents		
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty cd/uc/hs start subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	T1	PA
<i>azathioprine oral tablet 50 mg</i>	T1	
<i>azathioprine sodium injection solution reconstituted 100 mg</i>	T1	PA
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	T1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	T1	
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	T1	PA
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	T1	PA
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>sarilumab</i>)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	T1	PA
<i>leflunomide oral tablet 10 mg, 20 mg</i>	T1	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine modified</i>)	T1	
NEORAL ORAL SOLUTION 100 MG/ML (<i>cyclosporine modified</i>)	T1	
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (<i>baricitinib</i>)	T1	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG (<i>abatacept</i>)	T1	PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	T1	PA
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	T1	PA
<i>penicillamine oral capsule 250 mg</i>	T1	PA
<i>penicillamine oral tablet 250 mg</i>	T1	PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	T1	PA
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine</i>)	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)

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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	T1	PA
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	T1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	T1	PA
Gonadotropin-Releasing Hormone Antagnts		
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG (<i>degarelix acetate</i>)	T1	QL (1 EA per 30 days)
<i>ganirelix acetate subcutaneous solution prefilled syringe 250 mcg/0.5ml</i>	T1	PA
Immunomodulatory Agents		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (<i>interferon gamma-1b</i>)	T1	
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-aaty cd/uc/hs start subcutaneous auto-injector kit 80 mg/0.8ml</i>	T1	QL (2 EA per 28 days)
<i>adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
<i>adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml</i>	T1	QL (4 EA per 28 days)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	T1	
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (<i>interferon beta-1a</i>)	T1	
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	T1	PA
<i>azathioprine oral tablet 50 mg</i>	T1	
<i>azathioprine sodium injection solution reconstituted 100 mg</i>	T1	PA
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	T1	
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	T1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	T1	
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	T1	PA
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	T1	PA
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (<i>vedolizumab</i>)	T1	PA
<i> fingolimod hcl oral capsule 0.5 mg</i>	T1	PA
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	T1	
<i>glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml</i>	T1	
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>adalimumab-bwwd</i>)	T1	QL (1.6 ML per 28 days)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML (<i>adalimumab-bwwd</i>)	T1	QL (3.2 ML per 28 days)
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (<i>sarilumab</i>)	T1	PA
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML (<i>sarilumab</i>)	T1	PA
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (<i>anakinra</i>)	T1	PA
<i>leflunomide oral tablet 10 mg, 20 mg</i>	T1	
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	T1	PA

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lowercase bold italics = Generic drugs UPPERCASE = Brand name drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1		
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	T1		
<i>methotrexate sodium oral tablet 2.5 mg</i>	T1		
NEORAL ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine modified</i>)	T1		
NEORAL ORAL SOLUTION 100 MG/ML (<i>cyclosporine modified</i>)	T1		
OLUMIANT ORAL TABLET 1 MG, 2 MG (<i>baricitinib</i>)	T1	PA	
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG (<i>abatacept</i>)	T1	PA	
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML (<i>abatacept</i>)	T1	PA	
OTEZLA ORAL TABLET 20 MG, 30 MG (<i>apremilast</i>)	T1	PA	
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG (<i>apremilast</i>)	T1	PA	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	T1	PA	
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	T1	PA	
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (<i>pomalidomide</i>)	T1	PA	
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (<i>interferon beta-1a</i>)	T1		
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (<i>interferon beta-1a</i>)	T1		
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	T1	PA	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 25 MG, 5 MG (<i>lenalidomide</i>)	T1	PA
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine</i>)	T1	
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML (<i>adalimumab-ryvk</i>)	T1	QL (4 EA per 28 days)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (<i>golimumab</i>)	T1	PA
<i>sulfasalazine oral tablet 500 mg</i>	T1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	T1	
THALOMID ORAL CAPSULE 100 MG, 50 MG (<i>thalidomide</i>)	T1	PA
XELJANZ ORAL SOLUTION 1 MG/ML (<i>tofacitinib citrate</i>)	T1	PA
XELJANZ ORAL TABLET 10 MG, 5 MG (<i>tofacitinib citrate</i>)	T1	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (<i>tofacitinib citrate</i>)	T1	PA
Immunosuppressive Agents		
<i>azathioprine oral tablet 50 mg</i>	T1	
<i>azathioprine sodium injection solution reconstituted 100 mg</i>	T1	PA
<i>cyclophosphamide oral tablet 50 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	T1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	T1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	T1	
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	T1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/ML)	T1	
<i>leflunomide oral tablet 10 mg, 20 mg</i>	T1	
<i>mercaptopurine oral tablet 50 mg</i>	T1	
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	T1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	T1	
<i>mycophenolate mofetil oral capsule 250 mg</i>	T1	
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	T1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	T1	
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	T1	
NEORAL ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine modified</i>)	T1	
NEORAL ORAL SOLUTION 100 MG/ML (<i>cyclosporine modified</i>)	T1	
<i>pimecrolimus external cream 1 %</i>	T1	PA
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	T1	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (<i>cyclosporine</i>)	T1	
<i>sirolimus oral solution 1 mg/ml</i>	T1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	T1	QL (30 GM per 30 days)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	T1	
Kallikrein Inhibitors		
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (<i>berotralstat hcl</i>)	T1	PA
Other Miscellaneous Therapeutic Agents		
<i>acetic acid glacial solution 99 %</i>	T1	
<i>acetic acid solution 5 %</i>	T1	
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	T1	
<i>betaine oral powder</i>	T1	
<i>bp vit 3 oral capsule 1 mg</i>	T1	
<i>complete natal dha oral 29-1-200 & 200 mg</i>	T1	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (<i>cysteamine bitartrate</i>)	T1	
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	T1	PA
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT (<i>abobotulinumtoxina</i>)	T1	PA
ELMIRON ORAL CAPSULE 100 MG (<i>pentosan polysulfate sodium</i>)	T1	PA
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	T1	
<i>levocarnitine oral tablet 330 mg</i>	T1	
<i>levocarnitine sf oral solution 1 gm/10ml</i>	T1	
LODOCO ORAL TABLET 0.5 MG (<i>colchicine</i>)	T1	PA
<i>metirosine oral capsule 250 mg</i>	T1	
<i>nitisinone oral capsule 10 mg, 2 mg, 5 mg</i>	T1	
<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prenatal gummies/dha & fa oral tablet chewable 0.4-32.5 mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	T1	
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG (<i>darunavir-cobicistat</i>)	T1	
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofdf</i>)	T1	
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofaf</i>)	T1	
<i>tiopronin oral tablet 100 mg</i>	T1	PA
TYBOST ORAL TABLET 150 MG (<i>cobicistat</i>)	T1	
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT (<i>incobotulinumtoxina</i>)	T1	PA
Protective Agents		
<i>adapalene external gel 0.1 %</i>	T1	
<i>adapalene external pad 0.1 %</i>	T1	
<i>adapalene external solution 0.1 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	T1	PA
ELMIRON ORAL CAPSULE 100 MG (<i>pentosan polysulfate sodium</i>)	T1	PA
<i>mesna oral tablet 400 mg</i>	T1	
Nonhormonal Contraceptives		
Nonhormonal Contraceptives		
<i>aimsco lubricated</i>	T1	
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>condoms</i>	T1	
DUREX EXTRA SENSITIVE THIN DEVICE (<i>condoms latex lubricated</i>)	T1	
DUREX REALFEEL DEVICE (<i>condoms non-latex lubricated</i>)	T1	
ENCARE VAGINAL SUPPOSITORY 100 MG (<i>nonoxynol-9</i>)	T1	
FANTASY LUBRICATED (<i>condoms latex lubricated</i>)	T1	
FANTASY LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	T1	
FC2 FEMALE CONDOM (<i>condoms - female</i>)	T1	
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (<i>cervical caps</i>)	T1	
KAMELEON LUBRICATED (<i>condoms latex lubricated</i>)	T1	
<i>kimono</i>	T1	
KIMONO COLORS DEVICE (<i>condoms latex lubricated</i>)	T1	
KIMONO MAXX-LARGE FLARE (<i>condoms latex lubricated</i>)	T1	
<i>kimono micro thin</i>	T1	
<i>kimono micro thin plus</i>	T1	
<i>kimono plus</i>	T1	
<i>kimono ps</i>	T1	
<i>kimono ps plus</i>	T1	
<i>kimono sensation</i>	T1	
<i>kimono sensation plus</i>	T1	
KIMONO SPECIAL DEVICE (<i>condoms latex lubricated</i>)	T1	
<i>maxx</i>	T1	
<i>maxx plus</i>	T1	
MIUDELLA INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (<i>copper</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (<i>diaphragms</i>)	T1	
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (<i>nonoxynol-9</i>)	T1	
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (<i>copper</i>)	T1	
REALITY LATEX CONDOMS (<i>condoms latex lubricated</i>)	T1	
REALITY LATEX/ULTRA TEXTURED DEVICE (<i>condoms latex lubricated</i>)	T1	
REALITY LATEX/ULTRA THIN DEVICE (<i>condoms latex lubricated</i>)	T1	
TODAY SPONGE VAGINAL 1000 MG (<i>nonoxynol-9</i>)	T1	
TRUSTEX COLOR CONDOMS + LUBE (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUB/RIBBED/STUDED (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUB/SPERMICIDE EX ST (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUB/SPERMICIDE XL (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUBRICATED (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUBRICATED EX LARGE (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUBRICATED EXTRA ST (<i>condoms latex lubricated</i>)	T1	
TRUSTEX LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	T1	
TRUSTEX NATURAL CONDOMS + LUBE (<i>condoms latex lubricated</i>)	T1	
TRUSTEX NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSTEX RIA LUB/SPERMICIDE (<i>condoms latex lubricated</i>)	T1	
TRUSTEX RIA LUBRICATED (<i>condoms latex lubricated</i>)	T1	
TRUSTEX RIA NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	T1	
TRUSTEX-NONOXYNOL-9/RIB/STUD (<i>condoms latex lubricated</i>)	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (<i>nonoxynol-9</i>)	T1	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (<i>nonoxynol-9</i>)	T1	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	T1	
Oxytocics		
Oxytocics		
<i>methylergonovine maleate injection solution 0.2 mg/ml</i>	T1	
<i>methylergonovine maleate oral tablet 0.2 mg</i>	T1	QL (28 EA per 7 days)

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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mifepristone oral tablet 200 mg</i>	T1	
<i>oxytocin injection solution 10 unit/ml</i>	T1	
Pharmaceutical Aids		
Pharmaceutical Aids		
<i>bacteriostatic water(benz alc) injection solution</i>	T1	
ELLIOTTS B INTRATHECAL SOLUTION (<i>intrathecal elec-dextrose</i>)	T1	
<i>emollient base external cream</i>	T1	
<i>hydrogen peroxide solution 30 %</i>	T1	
PLURONIC F127 POWDER (<i>poloxamer</i>)	T1	
<i>sterile water for injection injection solution</i>	T1	
Respiratory Tract Agents		
Alpha And Beta Adrenergic Agonist(Respr)		
<i>epinephrine (anaphylaxis) injection solution 1 mg/ml, 30 mg/30ml</i>	T1	
<i>epinephrine injection solution 1 mg/ml</i>	T1	
<i>epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	T1	QL (4 EA per 180 days)
<i>epinephrine pf injection solution 1 mg/ml</i>	T1	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	T1	PA
Anticholinergic Agents (Respir.Tract)		
<i>atropine sulfate injection solution 8 mg/20ml</i>	T1	
<i>atropine sulfate injection solution prefilled syringe 0.25 mg/5ml, 0.5 mg/5ml, 1 mg/10ml</i>	T1	
<i>atropine sulfate ophthalmic solution 1 %</i>	T1	
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (<i>ipratropium bromide hfa</i>)	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	T1	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	T1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	T1	
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	T1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	T1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	T1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	T1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	T1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	T1	
<i>hyosyne oral elixir 0.125 mg/5ml</i>	T1	
<i>hyosyne oral solution 0.125 mg/ml</i>	T1	
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (<i>umeclidinium bromide</i>)	T1	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	T1	
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	T1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG (<i>hyoscyamine sulfate</i>)	T1	
<i>oscimin oral tablet 0.125 mg</i>	T1	
<i>oscimin sublingual tablet sublingual 0.125 mg</i>	T1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (<i>tiotropium bromide</i>)	T1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	T1	
<i>tiotropium bromide inhalation capsule 18 mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antifibrotic Agents		
OFEV ORAL CAPSULE 100 MG, 150 MG (<i>nintedanib esylate</i>)	T1	PA
Anti-Inflammatory Agents (Respiratory)		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (<i>mepolizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG (<i>mepolizumab</i>)	T1	PA
Antitussives		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	T1	
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	T1	QL (45 EA per 30 days); AL (Min 18 Years)
<i>hydromet oral solution 5-1.5 mg/5ml</i>	T1	QL (45 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	T1	PA
Corticosteroids (Respiratory Tract)		

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	T1	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	T1	QL (60 ML per 30 days)
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA
<i>fluticasone furoate ellipta inhalation aerosol powder breath activated 100 mcg/act, 200 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	T1	
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	T1	
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	
<i>fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act</i>	T1	PA
<i>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</i>	T1	
<i>mometasone furoate external cream 0.1 %</i>	T1	
<i>mometasone furoate external ointment 0.1 %</i>	T1	
<i>mometasone furoate external solution 0.1 %</i>	T1	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (<i>budesonide</i>)	T1	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	T1	
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone-salmeterol</i> (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)		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	T1	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	T1	PA
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	T1	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	T1	PA
Expectorants		
<i>iodine strong oral solution 5 %</i>	T1	
<i>potassium iodide (expectorant) oral solution 1 gm/ml</i>	T1	
First Generation Antihist.(Respir Tract)		
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	T1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	T1	
<i>clemastine fumarate oral syrup 0.67 mg/5ml</i>	T1	
<i>clemastine fumarate oral tablet 2.68 mg</i>	T1	
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	T1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	T1	
<i>diphenhydramine hcl oral capsule 25 mg</i>	T1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	T1	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	T1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	T1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	T1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	T1	QL (240 ML per 30 days); AL (Min 18 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	T1	
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	T1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	T1	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	T1	PA
Interleukin Antagonists		
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	T1	PA
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (<i>benralizumab</i>)	T1	PA
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 30 MG/ML (<i>benralizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	T1	PA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG (<i>mepolizumab</i>)	T1	PA
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	T1	PA
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	T1	PA
Leukotriene Modifiers		
<i>montelukast sodium oral packet 4 mg</i>	T1	PA
<i>montelukast sodium oral tablet 10 mg</i>	T1	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	T1	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	T1	PA
Mast-Cell Stabilizers		
ALOCRILOPHthalmic SOLUTION 2 % (<i>nedocromil sodium</i>)	T1	
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	T1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	T1	
Mucolytic Agents		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	T1	
NEBUSAL INHALATION NEBULIZATION SOLUTION 3 % (<i>sodium chloride</i>)	T1	
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	T1	PA
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %</i>	T1	
Nasal Preparations (Steroids)		
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	T1	PA
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	T1	
Orally Inhaled Preparations (Steroids)		
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (<i>mometasone furoate</i>)	T1	
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	T1	PA
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	T1	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	T1	QL (60 ML per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	T1	QL (20.4 GM per 30 days)
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT (<i>mometasone furo-formoterol fum</i>)	T1	
<i>fluticasone furoate ellipta inhalation aerosol powder breath activated 100 mcg/act, 200 mcg/act, 50 mcg/act</i>	T1	
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	T1	
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	T1	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (<i>budesonide</i>)	T1	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	T1	
Phosphodiesterase-5 Inhibitors (Respir)		
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	QL (15 EA per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
<i>tadalafil (pah) oral tablet 20 mg</i>	T1	PA
<i>tadalafil oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	T1	PA
Prostacyclin & Prostacyclin Derivatives		
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	T1	PA
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	T1	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
Pulmonary Surfactants		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5ML, 240 MG/3ML (<i>poractant alfa</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFASURF INTRATRACHEAL SUSPENSION 35-0.9 MG/ML-% (<i>calfactant in nacl</i>)	T1	
Respiratory Tract Agents, Miscellaneous		
OFEV ORAL CAPSULE 100 MG, 150 MG (<i>nintedanib esylate</i>)	T1	PA
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	T1	PA
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.91ML (<i>tezepelumab-ekko</i>)	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (<i>omalizumab</i>)	T1	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (<i>omalizumab</i>)	T1	PA
Second Generation Antihist(Respir Tract)		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	T1	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	T1	QL (6 ML per 30 days)
<i>desloratadine oral tablet 5 mg</i>	T1	PA
<i>desloratadine oral tablet dispersible 5 mg</i>	T1	PA
Select.Beta-2-Adrenergic Agonist(Respir)		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	T1	QL (2 GM per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 2.5 mg/0.5ml</i>	T1	
<i>albuterol sulfate inhalation nebulization solution 0.63 mg/3ml, 1.25 mg/3ml</i>	T1	PA
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	T1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	T1	

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lowercase bold italics = Generic drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits
UPPERCASE = Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (<i>budeson-glycopyrrol-formoterol</i>)	T1	PA
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	T1	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (<i>ipratropium-albuterol</i>)	T1	
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT (<i>mometasone furo-formoterol fum</i>)	T1	
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	T1	
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	T1	
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	T1	PA
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>salmeterol xinafoate</i>)	T1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (<i>tiotropium bromide-olodaterol</i>)	T1	
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	T1	
Vasodilating Agents (Respiratory Tract)		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	T1	PA
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	T1	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	T1	PA
OPSUMIT ORAL TABLET 10 MG (<i>macitentan</i>)	T1	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	T1	PA
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	QL (15 EA per 30 days)

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

lowercase bold italics =

Generic drugs

UPPERCASE = Brand name drugs

Drug Tier

T1 = Formulary Medication

Coverage Requirements and Limits

AL = Age Limit

PA = Prior Authorization

QL = Quantity Limit

ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
<i>tadalafil (pah) oral tablet 20 mg</i>	T1	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG (<i>bosentan</i>)	T1	PA
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	T1	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	T1	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	T1	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	T1	PA
Vasodilating Agents, Misc (48:48)		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	T1	PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (<i>selexipag</i>)	T1	PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (<i>selexipag</i>)	T1	PA
Xanthine Derivatives		
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	

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lowercase bold italics = Generic drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits
UPPERCASE = Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Skin And Mucous Membrane Agents		
Adrenergic Agonists		
<i>brimonidine tartrate ophthalmic solution 0.15 %</i>	T1	PA
<i>brimonidine tartrate ophthalmic solution 0.2 %</i>	T1	
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	T1	PA
Allylamines (Skin And Mucous Membrane)		
<i>naftifine hcl external cream 1 %</i>	T1	
Antibacterials (84:04)		
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	T1	
<i>avidoxy oral tablet 100 mg</i>	T1	
<i>azelaic acid external gel 15 %</i>	T1	PA
AZELEX EXTERNAL CREAM 20 % (<i>azelaic acid</i>)	T1	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	T1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	T1	
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	T1	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	T1	ST
<i>clindamycin phosphate</i> (Clindacin Etz External Swab 1 %)	T1	
<i>clindamycin phosphate</i> (Clindacin-P External Swab 1 %)	T1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	T1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	T1	PA
<i>clindamycin phos (once-daily) external gel 1 %</i>	T1	
<i>clindamycin phos (twice-daily) external gel 1 %</i>	T1	
<i>clindamycin phos-benzoyl perox external gel 1-5 %</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clindamycin phosphate external lotion 1 %</i>	T1	
<i>clindamycin phosphate external solution 1 %</i>	T1	
<i>clindamycin phosphate external swab 1 %</i>	T1	
<i>clindamycin phosphate vaginal cream 2 %</i>	T1	
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline hyclate oral tablet 100 mg</i>	T1	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	PA
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	T1	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	T1	
<i>ery external pad 2 %</i>	T1	
<i>erythromycin external gel 2 %</i>	T1	
<i>erythromycin external solution 2 %</i>	T1	
FINACEA EXTERNAL FOAM 15 % (<i>azelaic acid</i>)	T1	PA
<i>gentamicin sulfate external cream 0.1 %</i>	T1	
<i>gentamicin sulfate external ointment 0.1 %</i>	T1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	T1	
<i>levofloxacin oral solution 25 mg/ml</i>	T1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	T1	QL (30 EA per 30 days)
<i>metronidazole external cream 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 0.75 %</i>	T1	QL (45 GM per 30 days)
<i>metronidazole external gel 1 %</i>	T1	QL (60 GM per 30 days)
<i>metronidazole oral capsule 375 mg</i>	T1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	T1	
<i>metronidazole vaginal gel 0.75 %</i>	T1	
<i>minocycline hcl oral capsule 100 mg</i>	T1	QL (60 EA per 30 days)

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>minocycline hcl oral capsule 50 mg</i>	T1	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule 100 Mg)	T1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	T1	QL (21 EA per 21 days)
<i>mupirocin external ointment 2 %</i>	T1	
<i>neomycin sulfate oral tablet 500 mg</i>	T1	
NORITATE EXTERNAL CREAM 1 % (<i>metronidazole</i>)	T1	PA
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	T1	
<i>sodium sulfacetamide external shampoo 10 %</i>	T1	
<i>sss 10-5 external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %</i>	T1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	T1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (<i>mafenide acetate</i>)	T1	PA
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	T1	
Antifulgals (Skin, Mucous Membrane), Misc		
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	T1	
Anti-Inflammatory Agents (Skin, Mucous)		
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	T1	PA
<i>ala-cort external cream 1 %</i>	T1	
<i>alclometasone dipropionate external cream 0.05 %</i>	T1	PA
<i>alclometasone dipropionate external ointment 0.05 %</i>	T1	PA
<i>amcinonide external cream 0.1 %</i>	T1	PA
<i>anucort-hc rectal suppository 25 mg</i>	T1	

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lowercase bold italics =
Generic drugs
UPPERCASE = Brand name drugs

Drug Tier
T1 = Formulary Medication

Coverage Requirements and Limits
AL = Age Limit
PA = Prior Authorization
QL = Quantity Limit
ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	T1	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	T1	PA
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	T1	PA
<i>betamethasone dipropionate external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	T1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	T1	
<i>betamethasone valerate external cream 0.1 %</i>	T1	
<i>betamethasone valerate external foam 0.12 %</i>	T1	PA
<i>betamethasone valerate external lotion 0.1 %</i>	T1	
<i>betamethasone valerate external ointment 0.1 %</i>	T1	
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
<i>clobetasol prop emollient base external cream 0.05 %</i>	T1	
<i>clobetasol propionate e external cream 0.05 %</i>	T1	
<i>clobetasol propionate external cream 0.05 %</i>	T1	
<i>clobetasol propionate external foam 0.05 %</i>	T1	
<i>clobetasol propionate external gel 0.05 %</i>	T1	
<i>clobetasol propionate external lotion 0.05 %</i>	T1	
<i>clobetasol propionate external ointment 0.05 %</i>	T1	
<i>clobetasol propionate external shampoo 0.05 %</i>	T1	PA
<i>clobetasol propionate external solution 0.05 %</i>	T1	
<i>clocortolone pivalate external cream 0.1 %</i>	T1	PA
<i>clobetasol propionate</i> (Clodan External Shampoo 0.05 %)	T1	PA
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	T1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	T1	

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lowercase bold italics =
Generic drugs
UPPERCASE = Brand name drugs

Drug Tier
T1 = Formulary Medication

Coverage Requirements and Limits
AL = Age Limit
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ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (<i>flurandrenolide</i>)	T1	PA
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	T1	PA
<i>desonide external cream 0.05 %</i>	T1	
<i>desonide external lotion 0.05 %</i>	T1	PA
<i>desonide external ointment 0.05 %</i>	T1	
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	T1	PA
<i>desoximetasone external gel 0.05 %</i>	T1	PA
<i>desoximetasone external ointment 0.25 %</i>	T1	PA
<i>diflorasone diacetate external cream 0.05 %</i>	T1	PA
<i>diflorasone diacetate external ointment 0.05 %</i>	T1	PA
EPIFOAM EXTERNAL FOAM 1-1 % (<i>pramoxine-hc</i>)	T1	PA
<i>fluocinolone acetonide body external oil 0.01 %</i>	T1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	T1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	T1	
<i>fluocinolone acetonide external solution 0.01 %</i>	T1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	T1	
<i>fluocinonide emulsified base external cream 0.05 %</i>	T1	
<i>fluocinonide external cream 0.05 %, 0.1 %</i>	T1	
<i>fluocinonide external gel 0.05 %</i>	T1	
<i>fluocinonide external ointment 0.05 %</i>	T1	
<i>fluocinonide external solution 0.05 %</i>	T1	
<i>flurandrenolide external lotion 0.05 %</i>	T1	PA
<i>fluticasone propionate external cream 0.05 %</i>	T1	
<i>fluticasone propionate external ointment 0.005 %</i>	T1	
<i>halcinonide external cream 0.1 %</i>	T1	PA
<i>halobetasol propionate external cream 0.05 %</i>	T1	
<i>halobetasol propionate external ointment 0.05 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HALOG EXTERNAL SOLUTION 0.1 % (<i>halcinonide</i>)	T1	PA
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	T1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 2.5 %</i>	T1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>lidocaine-hydrocort (perianal) external cream 3-0.5 %</i>	T1	
<i>lidocaine-hydrocortisone ace rectal kit 3-0.5 %</i>	T1	
LIDOCORT EXTERNAL CREAM 3-0.5 % (<i>lidocaine-hydrocortisone ace</i>)	T1	
<i>mometasone furoate external cream 0.1 %</i>	T1	
<i>mometasone furoate external ointment 0.1 %</i>	T1	
<i>mometasone furoate external solution 0.1 %</i>	T1	
<i>triamcinolone acetamide</i> (Oralene Mouth/Throat Paste 0.1 %)	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>pramoxine-hc</i>)	T1	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	T1	PA
PRAMOSONE EXTERNAL OINTMENT 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCTOFOAM HC EXTERNAL FOAM 1-1 % <i>(hydrocortisone ace-pramoxine)</i>	T1	PA
<i>hydrocortisone</i> (Procto-Med Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctosol Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctozone-Hc External Cream 2.5 %)	T1	
TEXACORT EXTERNAL SOLUTION 2.5 % <i>(hydrocortisone)</i>	T1	
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	T1	PA
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	T1	
<i>triamcinolone in absorbase external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide</i> (Triderm External Cream 0.5 %)	T1	
Antiproliferants		
<i>bexarotene oral capsule 75 mg</i>	T1	PA
<i>fluorouracil external cream 5 %</i>	T1	
<i>fluorouracil external solution 2 %, 5 %</i>	T1	
<i>imiquimod external cream 5 %</i>	T1	
Antipruritics And Local Anesthetics		
CETACAINE EXTERNAL AEROSOL 2-2-14 % (<i>butamben-tetracaine-benzocaine</i>)	T1	
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	T1	
CRYODOSE TA EXTERNAL AEROSOL (<i>pentafluoroprop-tetrafluoroeth</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxepin hcl external cream 5 %</i>	T1	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	T1	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	T1	
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	T1	PA
EPIFOAM EXTERNAL FOAM 1-1 % (<i>pramoxine-hc</i>)	T1	PA
<i>ethyl chloride external aerosol</i>	T1	
GEBAUERS PAIN EASE EXTERNAL AEROSOL (<i>pentafluoroprop-tetrafluoroeth</i>)	T1	
GEBAUERS SPRAY AND STRETCH EXTERNAL AEROSOL (<i>pentafluoroprop-tetrafluoroeth</i>)	T1	
<i>lidocaine hcl</i> (Glydo External Prefilled Syringe 2 %)	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>lidocaine external ointment 5 %</i>	T1	QL (60 GM per 30 days)
<i>lidocaine external patch 5 %</i>	T1	PA
<i>lidocaine hcl external cream 3 %</i>	T1	
<i>lidocaine hcl external solution 4 %</i>	T1	PA
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	T1	
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	T1	
<i>lidocaine-hydrocort (perianal) external cream 3-0.5 %</i>	T1	
<i>lidocaine-hydrocortisone ace rectal kit 3-0.5 %</i>	T1	
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	T1	QL (60 GM per 30 days)
LIDOCORT EXTERNAL CREAM 3-0.5 % (<i>lidocaine-hydrocortisone ace</i>)	T1	
<i>lidopin external cream 3 %</i>	T1	QL (85 GM per 30 days)
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>pramoxine-hc</i>)	T1	

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lowercase bold italics = Generic drugs		Drug Tier T1 = Formulary Medication	Coverage Requirements and Limits
UPPERCASE = Brand name drugs			AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % <i>(pramoxine-hc)</i>	T1	PA
PRAMOSONE EXTERNAL OINTMENT 1-1 %, 1-2.5 % <i>(pramoxine-hc)</i>	T1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 % <i>(hydrocortisone ace-pramoxine)</i>	T1	PA
REGENECARE EXTERNAL GEL 2 % <i>(lidocaine-collagen-aloe vera)</i>	T1	
<i>zionodil external lotion 3 %</i>	T1	
Antivirals (Skin And Mucous Membrane)		
<i>acyclovir external cream 5 %</i>	T1	PA
<i>acyclovir external ointment 5 %</i>	T1	PA
<i>acyclovir oral capsule 200 mg</i>	T1	
<i>acyclovir oral suspension 200 mg/5ml</i>	T1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	T1	
Astringents (84:12)		
DRYSOL EXTERNAL SOLUTION 20 % <i>(aluminum chloride)</i>	T1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T1	
XERAC AC EXTERNAL SOLUTION 6.25 % <i>(aluminum chloride in alcohol)</i>	T1	
Astringents, Anti-Infective		
<i>benzalkonium chloride external solution , 50 %</i>	T1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>iodine strong oral solution 5 %</i>	T1	
IODOFLEX EXTERNAL PAD 0.9 % <i>(cadexomer iodine)</i>	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<i>selenium sulfide external lotion 2.5 %</i>	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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>selenium sulfide external shampoo 2.25 %</i>	T1	
<i>silver sulfadiazine external cream 1 %</i>	T1	
Azoles (Skin And Mucous Membrane)		
<i>clotrimazole external cream 1 %</i>	T1	
<i>clotrimazole external solution 1 %</i>	T1	
<i>clotrimazole mouth/throat troche 10 mg</i>	T1	
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	T1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	T1	
<i>econazole nitrate external cream 1 %</i>	T1	
GYNAZOLE-1 VAGINAL CREAM 2 % (<i>butoconazole nitrate (1 dose)</i>)	T1	
<i>ketoconazole external cream 2 %</i>	T1	
<i>ketoconazole external shampoo 2 %</i>	T1	
<i>miconazole 3 vaginal suppository 200 mg</i>	T1	
<i>miconazole nitrate external cream 2 %</i>	T1	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	T1	
<i>terconazole vaginal suppository 80 mg</i>	T1	PA
Basic Ointments And Protectants		
<i>calcipotriene external cream 0.005 %</i>	T1	PA
<i>calcipotriene external foam 0.005 %</i>	T1	PA
<i>calcipotriene external ointment 0.005 %</i>	T1	PA
<i>calcipotriene external solution 0.005 %</i>	T1	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
<i>emollient base external cream</i>	T1	
<i>hydrocortisone external cream 1 %</i>	T1	
REGENECARE EXTERNAL GEL 2 % (<i>lidocaine-collagen-aloe vera</i>)	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

lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	T1	
Cell Stimulants And Proliferants		
<i>finasteride oral tablet 5 mg</i>	T1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	T1	
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin external gel 0.01 %, 0.025 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	T1	QL (50 GM per 30 days); AL (Max 29 Years)
<i>tretinoin oral capsule 10 mg</i>	T1	PA
Corticosteroids (Skin, Mucous Membrane)		
ALA SCALP EXTERNAL LOTION 2 % (<i>hydrocortisone</i>)	T1	PA
<i>ala-cort external cream 1 %</i>	T1	
<i>alclometasone dipropionate external cream 0.05 %</i>	T1	PA
<i>alclometasone dipropionate external ointment 0.05 %</i>	T1	PA
<i>amcinonide external cream 0.1 %</i>	T1	PA
<i>anucort-hc rectal suppository 25 mg</i>	T1	
ANUSOL-HC EXTERNAL CREAM 2.5 % (<i>hydrocortisone</i>)	T1	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	T1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	T1	PA
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	T1	PA
<i>betamethasone dipropionate external cream 0.05 %</i>	T1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	T1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>betamethasone valerate external cream 0.1 %</i>	T1	
<i>betamethasone valerate external foam 0.12 %</i>	T1	PA
<i>betamethasone valerate external lotion 0.1 %</i>	T1	
<i>betamethasone valerate external ointment 0.1 %</i>	T1	
<i>budesonide rectal foam 2 mg</i>	T1	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
<i>clobetasol prop emollient base external cream 0.05 %</i>	T1	
<i>clobetasol propionate e external cream 0.05 %</i>	T1	
<i>clobetasol propionate external cream 0.05 %</i>	T1	
<i>clobetasol propionate external foam 0.05 %</i>	T1	
<i>clobetasol propionate external gel 0.05 %</i>	T1	
<i>clobetasol propionate external lotion 0.05 %</i>	T1	
<i>clobetasol propionate external ointment 0.05 %</i>	T1	
<i>clobetasol propionate external shampoo 0.05 %</i>	T1	PA
<i>clobetasol propionate external solution 0.05 %</i>	T1	
<i>clocortolone pivalate external cream 0.1 %</i>	T1	PA
<i>clobetasol propionate</i> (Clodan External Shampoo 0.05 %)	T1	PA
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	T1	
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	T1	
CORDRAN EXTERNAL TAPE 4 MCG/SQCM (<i>flurandrenolide</i>)	T1	PA
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	T1	
CORTIFOAM EXTERNAL FOAM 10 % (<i>hydrocortisone acetate</i>)	T1	PA
<i>desonide external cream 0.05 %</i>	T1	
<i>desonide external lotion 0.05 %</i>	T1	PA
<i>desonide external ointment 0.05 %</i>	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	T1	PA
<i>desoximetasone external gel 0.05 %</i>	T1	PA
<i>desoximetasone external ointment 0.25 %</i>	T1	PA
<i>diflorasone diacetate external cream 0.05 %</i>	T1	PA
<i>diflorasone diacetate external ointment 0.05 %</i>	T1	PA
EPIFOAM EXTERNAL FOAM 1-1 % (<i>pramoxine-hc</i>)	T1	PA
<i>fluocinolone acetonide body external oil 0.01 %</i>	T1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	T1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	T1	
<i>fluocinolone acetonide external solution 0.01 %</i>	T1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	T1	
<i>fluocinonide emulsified base external cream 0.05 %</i>	T1	
<i>fluocinonide external cream 0.05 %, 0.1 %</i>	T1	
<i>fluocinonide external gel 0.05 %</i>	T1	
<i>fluocinonide external ointment 0.05 %</i>	T1	
<i>fluocinonide external solution 0.05 %</i>	T1	
<i>flurandrenolide external lotion 0.05 %</i>	T1	PA
<i>fluticasone propionate external cream 0.05 %</i>	T1	
<i>fluticasone propionate external ointment 0.005 %</i>	T1	
<i>halcinonide external cream 0.1 %</i>	T1	PA
<i>halobetasol propionate external cream 0.05 %</i>	T1	
<i>halobetasol propionate external ointment 0.05 %</i>	T1	
HALOG EXTERNAL SOLUTION 0.1 % (<i>halcinonide</i>)	T1	PA
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone ace-pramoxine external cream 1-1 %, 2.5-1 %</i>	T1	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	T1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	T1	PA
<i>hydrocortisone butyrate external ointment 0.1 %</i>	T1	PA

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone butyrate external solution 0.1 %</i>	T1	PA
<i>hydrocortisone external cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone external lotion 2.5 %</i>	T1	
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	T1	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	T1	
<i>hydrocortisone valerate external cream 0.2 %</i>	T1	PA
<i>hydrocortisone valerate external ointment 0.2 %</i>	T1	PA
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>hydrocort-pramoxine (perianal) external cream 2.5-1 %</i>	T1	
<i>lidocaine-hydrocort (perianal) external cream 3-0.5 %</i>	T1	
<i>lidocaine-hydrocortisone ace rectal kit 3-0.5 %</i>	T1	
LIDOCORT EXTERNAL CREAM 3-0.5 % (<i>lidocaine-hydrocortisone ace</i>)	T1	
<i>mometasone furoate external cream 0.1 %</i>	T1	
<i>mometasone furoate external ointment 0.1 %</i>	T1	
<i>mometasone furoate external solution 0.1 %</i>	T1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	T1	
<i>triamcinolone acetonide</i> (Oralene Mouth/Throat Paste 0.1 %)	T1	
PRAMOSONE EXTERNAL CREAM 1-1 % (<i>pramoxine-hc</i>)	T1	
PRAMOSONE EXTERNAL LOTION 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	T1	PA
PRAMOSONE EXTERNAL OINTMENT 1-1 %, 1-2.5 % (<i>pramoxine-hc</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCTOFOAM HC EXTERNAL FOAM 1-1 % <i>(hydrocortisone ace-pramoxine)</i>	T1	PA
<i>hydrocortisone</i> (Procto-Med Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctosol Hc External Cream 2.5 %)	T1	
<i>hydrocortisone</i> (Proctozone-Hc External Cream 2.5 %)	T1	
TEXACORT EXTERNAL SOLUTION 2.5 % <i>(hydrocortisone)</i>	T1	
<i>triamcinolone acetonide external aerosol solution 0.147 mg/gm</i>	T1	PA
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	T1	
<i>triamcinolone in absorbase external ointment 0.05 %</i>	T1	PA
<i>triamcinolone acetonide</i> (Triderm External Cream 0.5 %)	T1	
Detergents		
<i>polysorbate 80 oral liquid</i>	T1	
Hydroxypyridones (Skin, Mucous Membrane)		
<i>ciclopirox</i> (Ciclodan External Solution 8 %)	T1	
<i>ciclopirox external gel 0.77 %</i>	T1	
<i>ciclopirox external shampoo 1 %</i>	T1	
<i>ciclopirox external solution 8 %</i>	T1	
<i>ciclopirox olamine external cream 0.77 %</i>	T1	
<i>ciclopirox olamine external suspension 0.77 %</i>	T1	
Immunomodulatory Agents (84:06)		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	T1	PA
<i>pimecrolimus external cream 1 %</i>	T1	PA
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	T1	
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (<i>brodalumab</i>)	T1	PA
<i>sirolimus oral solution 1 mg/ml</i>	T1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	T1	
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	T1	QL (30 GM per 30 days)
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	T1	
Janus Kinase Inhibitors (84:06)		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	T1	PA
Keratolytic Agents		
<i>isotretinoin</i> (Accutane Oral Capsule 40 Mg)	T1	PA
<i>acitretin oral capsule 10 mg, 25 mg</i>	T1	
<i>adapalene external gel 0.1 %</i>	T1	
<i>adapalene external pad 0.1 %</i>	T1	
<i>adapalene external solution 0.1 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
<i>isotretinoin</i> (Amnesteem Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	T1	
<i>benzoyl peroxide external gel 10 %</i>	T1	
<i>benzoyl peroxide wash external liquid 10 %</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>isotretinoin</i> (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
<i>clindamycin phos-benzoyl perox external gel 1-5 %</i>	T1	PA
CONDYLOX EXTERNAL GEL 0.5 % (<i>podofilox</i>)	T1	QL (7 GM per 365 days)
EXODERM EXTERNAL LOTION 25-1 % (<i>sod thiosulfate-salicylic acid</i>)	T1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	T1	PA
<i>podofilox external solution 0.5 %</i>	T1	
<i>salicylic acid external shampoo 6 %</i>	T1	
<i>selenium sulfide external shampoo 2.25 %</i>	T1	
<i>sss 10-5 external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %</i>	T1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	T1	
<i>tazarotene external cream 0.05 %, 0.1 %</i>	T1	
<i>tazarotene external gel 0.05 %, 0.1 %</i>	T1	
<i>isotretinoin</i> (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
Keratoplastic Agents		
<i>coal tar external solution 20 %</i>	T1	
<i>coal tar solution , 20 %</i>	T1	
Local Anti-Infectives, Miscellaneous		
<i>acetic acid glacial solution 99 %</i>	T1	
<i>acetic acid solution 5 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)
AVAR-E EMOLLIENT EXTERNAL CREAM 10-5 % (<i>sulfacetamide sodium-sulfur</i>)	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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>benzalkonium chloride external solution , 50 %</i>	T1	
<i>benzoyl peroxide external gel 10 %</i>	T1	
<i>benzoyl peroxide wash external liquid 10 %</i>	T1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	T1	
<i>clindamycin phos-benzoyl perox external gel 1-5 %</i>	T1	PA
CORTANE-B EXTERNAL LOTION 10-10-1 MG/ML (<i>hc-pramoxine-chloroxylonol</i>)	T1	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	T1	
FEM PH VAGINAL GEL 0.9-0.025 % (<i>acetic acid-oxyquinoline</i>)	T1	
<i>hydrocortisone-iodoquinol external cream 1-1 %</i>	T1	
<i>hydrogen peroxide solution 30 %</i>	T1	
IODOFLEX EXTERNAL PAD 0.9 % (<i>cadexomer iodine</i>)	T1	
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	T1	
<i>selenium sulfide external lotion 2.5 %</i>	T1	
<i>selenium sulfide external shampoo 2.25 %</i>	T1	
<i>silver nitrate external solution 0.5 %</i>	T1	
<i>silver sulfadiazine external cream 1 %</i>	T1	
<i>sodium sulfacetamide external shampoo 10 %</i>	T1	
<i>sss 10-5 external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external cream 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external lotion 10-5 %</i>	T1	
<i>sulfacetamide sodium-sulfur external suspension 10-5 %</i>	T1	
<i>sulfacetamide-sulfur in urea external emulsion 10-5 %</i>	T1	
SULFAMYLON EXTERNAL CREAM 85 MG/GM (<i>mafenide acetate</i>)	T1	PA
Nonsteroidal Anti-Inflammat.Agents(Skin)		

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diclofenac epolamine external patch 1.3 %</i>	T1	PA
<i>diclofenac sodium external gel 1 %</i>	T1	
<i>diclofenac sodium external gel 3 %</i>	T1	PA
Pigmenting Agents		
UVADEX EXTRACORPOREAL SOLUTION 20 MCG/ML (<i>methoxsalen (photopheresis)</i>)	T1	
Polyenes (Skin And Mucous Membrane)		
<i>nystatin</i> (Nyamyc External Powder 100000 Unit/Gm)	T1	
<i>nystatin external cream 100000 unit/gm</i>	T1	
<i>nystatin external ointment 100000 unit/gm</i>	T1	
<i>nystatin external powder 100000 unit/gm</i>	T1	
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	T1	
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	T1	
<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	T1	
Scabicides And Pediculicides		
<i>malathion external lotion 0.5 %</i>	T1	PA
<i>permethrin external cream 5 %</i>	T1	
<i>spinosad external suspension 0.9 %</i>	T1	PA
Skin And Mucous Membrane Agents, Misc.		
<i>isotretinoin</i> (Accutane Oral Capsule 40 Mg)	T1	PA
<i>acitretin oral capsule 10 mg, 25 mg</i>	T1	
<i>adapalene external gel 0.1 %</i>	T1	
<i>adapalene external pad 0.1 %</i>	T1	
<i>adapalene external solution 0.1 %</i>	T1	
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %</i>	T1	QL (45 GM per 30 days); AL (Max 30 Years)

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

		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>isotretinoin</i> (Amnesteem Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-axxq</i>)	T1	PA
<i>azelaic acid external gel 15 %</i>	T1	PA
AZELEX EXTERNAL CREAM 20 % (<i>azelaic acid</i>)	T1	
<i>calcipotriene external cream 0.005 %</i>	T1	PA
<i>calcipotriene external foam 0.005 %</i>	T1	PA
<i>calcipotriene external ointment 0.005 %</i>	T1	PA
<i>calcipotriene external solution 0.005 %</i>	T1	PA
<i>calcipotriene-betameth diprop external suspension 0.005-0.064 %</i>	T1	PA
<i>calcitriol external ointment 3 mcg/gm</i>	T1	PA
<i>isotretinoin</i> (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
CONDYLOX EXTERNAL GEL 0.5 % (<i>podofilox</i>)	T1	QL (7 GM per 365 days)
<i>dapsone oral tablet 100 mg, 25 mg</i>	T1	
DEBACTEROL MOUTH/THROAT SOLUTION 30-50 % (<i>sulfuric acid-sulf phenolics</i>)	T1	
<i>diclofenac epolamine external patch 1.3 %</i>	T1	PA
<i>diclofenac sodium external gel 1 %</i>	T1	
<i>diclofenac sodium external gel 3 %</i>	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	T1	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (<i>dupilumab</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	T1	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML (<i>etanercept</i>)	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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	T1	PA
FEM PH VAGINAL GEL 0.9-0.025 % (<i>acetic acid-oxyquinoline</i>)	T1	
FINACEA EXTERNAL FOAM 15 % (<i>azelaic acid</i>)	T1	PA
<i>fluorouracil external cream 5 %</i>	T1	
<i>fluorouracil external solution 2 %, 5 %</i>	T1	
GELCLAIR MOUTH/THROAT GEL (<i>povidone-nahyaluron-glycyrrhet</i>)	T1	
<i>imiquimod external cream 5 %</i>	T1	
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-dyyb</i>)	T1	PA
<i>infliximab intravenous solution reconstituted 100 mg</i>	T1	PA
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	T1	PA
ORAMAGICRX MOUTH/THROAT SUSPENSION RECONSTITUTED (<i>oral wound care products</i>)	T1	
OTEZLA ORAL TABLET 20 MG, 30 MG (<i>apremilast</i>)	T1	PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG (<i>apremilast</i>)	T1	PA
<i>pimecrolimus external cream 1 %</i>	T1	PA
<i>podofilox external solution 0.5 %</i>	T1	
RADIAPLEXRX EXTERNAL GEL (<i>wound dressings</i>)	T1	
REGENECARE EXTERNAL GEL 2 % (<i>lidocaine-collagen-aloe vera</i>)	T1	
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (<i>infliximab-abda</i>)	T1	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM (<i>collagenase</i>)	T1	
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (<i>brodalumab</i>)	T1	PA
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	T1	QL (30 GM per 30 days)

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lowercase bold italics =

Generic drugs

UPPERCASE = Brand name drugs

Drug Tier

T1 = Formulary Medication

Coverage Requirements and Limits

AL = Age Limit

PA = Prior Authorization

QL = Quantity Limit

ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tazarotene external cream 0.05 %, 0.1 %</i>	T1	
<i>tazarotene external gel 0.05 %, 0.1 %</i>	T1	
<i>isotretinoin</i> (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	T1	PA
Smooth Muscle Relaxants		
Antimuscarinics		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	T1	PA
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	T1	PA
<i>flavoxate hcl oral tablet 100 mg</i>	T1	PA
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	T1	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	T1	
<i>oxybutynin chloride oral tablet 5 mg</i>	T1	
OXYTROL TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (<i>oxybutynin</i>)	T1	PA
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	T1	
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	T1	QL (30 EA per 30 days)
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	T1	
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	T1	PA
<i>tropium chloride oral tablet 20 mg</i>	T1	PA
Genitourinary Smooth Muscle Relaxants		
<i>flavoxate hcl oral tablet 100 mg</i>	T1	PA
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	T1	
<i>oxybutynin chloride oral tablet 5 mg</i>	T1	

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lowercase bold italics =

Generic drugs

UPPERCASE = Brand name drugs

Drug Tier

T1 = Formulary Medication

Coverage Requirements and Limits

AL = Age Limit

PA = Prior Authorization

QL = Quantity Limit

ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXYTROL TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (<i>oxybutynin</i>)	T1	PA
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	T1	
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	T1	PA
<i>tropium chloride oral tablet 20 mg</i>	T1	PA
Respiratory Smooth Muscle Relaxants		
<i>sildenafil citrate oral tablet 20 mg</i>	T1	PA
THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG, 400 MG (<i>theophylline</i>)	T1	
<i>theophylline er oral tablet extended release 12 hour 300 mg, 450 mg</i>	T1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	T1	
<i>theophylline oral elixir 80 mg/15ml</i>	T1	
Selective Beta-3-Adrenergic Agonists		
GEMTESA ORAL TABLET 75 MG (<i>vibegron</i>)	T1	PA
<i>mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg</i>	T1	PA
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML (<i>mirabegron</i>)	T1	PA
Vitamins		
Multivitamin Preparations		
<i>actical oral capsule</i>	T1	
<i>b complex formula 1 (lipotrop) oral tablet</i>	T1	
<i>b complex-c oral tablet</i>	T1	
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	
<i>b complex-c-folic acid oral tablet</i>	T1	
<i>balance b-100 oral tablet</i>	T1	
<i>balance b-50 oral tablet</i>	T1	

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lowercase bold italics = Generic drugs		Coverage Requirements and Limits
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	AL = Age Limit PA = Prior Authorization QL = Quantity Limit ST = Step Therapy

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b-complex (folic acid) oral tablet</i>	T1	
<i>b-complex/vitamin c oral tablet</i>	T1	
<i>b-complex-c oral tablet</i>	T1	
<i>centravites 50 plus oral tablet</i>	T1	
<i>childrens chew multivitamin oral tablet chewable</i>	T1	
<i>childrens chewable vitamins oral tablet chewable</i>	T1	
<i>classic prenatal oral tablet 28-0.8 mg</i>	T1	
<i>complete natal dha oral 29-1-200 & 200 mg</i>	T1	
<i>cvs b complex plus c oral tablet</i>	T1	
<i>cvs one daily essential oral tablet</i>	T1	
<i>cvs super b complex/c oral tablet</i>	T1	
<i>daily value multivitamin oral tablet</i>	T1	
<i>daily vite oral tablet</i>	T1	
<i>daily vites oral tablet</i>	T1	
<i>daily-vite multivitamin oral tablet</i>	T1	
<i>daily-vite oral tablet</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG (<i>b complex-c-biotin-e-min-fa</i>)	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	T1	
DIALYVITE/ZINC ORAL TABLET (<i>b complex-c-zn-folic acid</i>)	T1	
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	T1	
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	T1	
<i>essential one daily multivit oral tablet</i>	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	T1	
<i>folbee plus oral tablet</i>	T1	
<i>full spectrum b/vitamin c oral tablet 0.8 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GERITOL TONIC ORAL LIQUID (<i>iron-vitamins</i>)	T1	
<i>gnp essential one daily oral tablet</i>	T1	
<i>gnp prenatal oral tablet 28-0.8 mg</i>	T1	
GUMMI BEAR MULTIVITAMIN/MIN ORAL TABLET CHEWABLE (<i>pediatric multivit-minerals</i>)	T1	
<i>hylavite oral tablet</i>	T1	
<i>kobee oral tablet</i>	T1	
<i>m-natal plus oral tablet 27-1 mg</i>	T1	
<i>multiple vitamins oral tablet</i>	T1	
<i>multiple vitamins-iron oral tablet chewable 15 mg</i>	T1	
<i>multivitamin adult oral tablet</i>	T1	
<i>multivitamin childrens (w/ fa) oral tablet chewable</i>	T1	
<i>multivitamin childrens oral tablet chewable</i>	T1	
<i>multivitamin oral tablet</i>	T1	
<i>multi-vitamin oral tablet</i>	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
<i>nephro vitamins oral tablet 0.8 mg</i>	T1	
NEPHRO-VITE ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	T1	
NUTRIVIT ORAL LIQUID (<i>b complex-lysine-min-fe-fa</i>)	T1	
<i>one-daily multi-vitamin oral tablet</i>	T1	
<i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>prenatal gummies/dha & fa oral tablet chewable 0.4-32.5 mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	T1	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	T1	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prenatal plus oral tablet 27-1 mg</i>	T1	
<i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i>	T1	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	T1	
<i>prenatal/iron oral tablet , 28-0.8 mg</i>	T1	
<i>qc prenatal oral tablet 28-0.8 mg</i>	T1	
<i>quintabs oral tablet</i>	T1	
RENAL ORAL CAPSULE 1 MG (<i>b complex-c-folic acid</i>)	T1	
<i>renal vitamin oral tablet 0.8 mg</i>	T1	
<i>rena-vite oral tablet</i>	T1	
<i>rena-vite rx oral tablet 1 mg</i>	T1	
<i>reno caps oral capsule 1 mg</i>	T1	
<i>stress formula oral tablet</i>	T1	
<i>super b complex/fa/vit c oral tablet</i>	T1	
<i>super b/c oral capsule</i>	T1	
<i>super b-complex + vitamin c oral tablet</i>	T1	
<i>super b-complex/vit c/fa oral tablet</i>	T1	
<i>support oral liquid</i>	T1	
SUPPORT-500 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	
TAB-A-VITE ORAL TABLET (<i>multiple vitamin</i>)	T1	
THERA ORAL TABLET (<i>multiple vitamin</i>)	T1	
<i>thrivite rx oral tablet 29-1 mg</i>	T1	
<i>triphrocaps oral capsule 1 mg</i>	T1	
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
<i>v-c forte oral capsule</i>	T1	
VIC-FORTE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITALETS CHILDRENS ORAL TABLET CHEWABLE <i>(pediatric multivit-minerals)</i>	T1	
<i>wescaps oral capsule 1 mg</i>	T1	
<i>westab plus oral tablet 27-1 mg</i>	T1	
Vitamin A		
AQUASOL A INTRAMUSCULAR SOLUTION 50000 UNIT/ML (<i>vitamin a</i>)	T1	
<i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
Vitamin B Complex		
<i>b complex-c oral tablet</i>	T1	
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	
<i>b complex-c-folic acid oral tablet</i>	T1	
<i>balance b-100 oral tablet</i>	T1	
<i>balance b-50 oral tablet</i>	T1	
<i>b-complex (folic acid) oral tablet</i>	T1	
<i>b-complex/b-12 oral tablet</i>	T1	PA
<i>b-complex/vitamin c oral tablet</i>	T1	
<i>b-complex-c oral tablet</i>	T1	
<i>bp vit 3 oral capsule 1 mg</i>	T1	
<i>centravites 50 plus oral tablet</i>	T1	
<i>childrens chew multivitamin oral tablet chewable</i>	T1	
<i>childrens chewable vitamins oral tablet chewable</i>	T1	
<i>classic prenatal oral tablet 28-0.8 mg</i>	T1	
<i>complete natal dha oral 29-1-200 & 200 mg</i>	T1	
<i>cvs b complex plus c oral tablet</i>	T1	
<i>cvs one daily essential oral tablet</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cvs super b complex/c oral tablet</i>	T1	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG (<i>b complex-c-biotin-e-min-fa</i>)	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	T1	
DIALYVITE/ZINC ORAL TABLET (<i>b complex-c-zn-folic acid</i>)	T1	
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	T1	
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	T1	
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	T1	
<i>essential one daily multivit oral tablet</i>	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	T1	
<i>folbee plus oral tablet</i>	T1	
<i>folic acid injection solution 5 mg/ml</i>	T1	
<i>folic acid oral tablet 1 mg, 400 mcg</i>	T1	
<i>folplex 2.2 oral tablet 2.2-25-0.5 mg</i>	T1	
<i>full spectrum b/vitamin c oral tablet 0.8 mg</i>	T1	
GERITOL TONIC ORAL LIQUID (<i>iron-vitamins</i>)	T1	
<i>gnp essential one daily oral tablet</i>	T1	
<i>gnp prenatal oral tablet 28-0.8 mg</i>	T1	
<i>hematinic plus vit/minerals oral tablet 106-1 mg</i>	T1	
<i>hematinic/folic acid oral tablet 324-1 mg</i>	T1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG (<i>fe fum-vit c-vit b12-fa</i>)	T1	
<i>hydroxocobalamin acetate intramuscular solution 1000 mcg/ml</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics =		AL = Age Limit
Generic drugs		PA = Prior Authorization
UPPERCASE = Brand name	Drug Tier	QL = Quantity Limit
drugs	T1 = Formulary Medication	ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hylavite oral tablet</i>	T1	
<i>kobee oral tablet</i>	T1	
<i>kp folic acid oral tablet 1 mg</i>	T1	
LEDERLE LEUCOVORIN ORAL TABLET 5 MG (<i>leucovorin calcium</i>)	T1	
<i>leucovorin calcium oral tablet 5 mg</i>	T1	
METAFOLBIC ORAL TABLET 6-1-50-5 MG (<i>J-methylfolate-b12-b6-b2</i>)	T1	
<i>m-natal plus oral tablet 27-1 mg</i>	T1	
<i>multivitamin adult oral tablet</i>	T1	
<i>multivitamin childrens (w/ fa) oral tablet chewable</i>	T1	
<i>multivitamin childrens oral tablet chewable</i>	T1	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	T1	
<i>nephro vitamins oral tablet 0.8 mg</i>	T1	
NEPHRO-VITE ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	T1	
<i>neurin-sl sublingual tablet sublingual 600-600 mcg</i>	T1	
<i>niacin (antihyperlipidemic) oral tablet 500 mg</i>	T1	
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	T1	PA
NUTRIVIT ORAL LIQUID (<i>b complex-lysine-min-fe-fa</i>)	T1	
<i>poly-iron 150 forte oral capsule 150-25-1 mg-mcg-mg</i>	T1	
<i>prenatal gummies/dha & fa oral tablet chewable 0.4-32.5 mg</i>	T1	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	T1	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	T1	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg</i>	T1	
<i>prenatal plus oral tablet 27-1 mg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i>	T1	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	T1	
<i>prenatal/iron oral tablet , 28-0.8 mg</i>	T1	
<i>pyridoxine hcl injection solution 100 mg/ml</i>	T1	
<i>qc prenatal oral tablet 28-0.8 mg</i>	T1	
<i>quintabs oral tablet</i>	T1	
RENAL ORAL CAPSULE 1 MG (<i>b complex-c-folic acid</i>)	T1	
<i>renal vitamin oral tablet 0.8 mg</i>	T1	
<i>rena-vite oral tablet</i>	T1	
<i>rena-vite rx oral tablet 1 mg</i>	T1	
<i>reno caps oral capsule 1 mg</i>	T1	
<i>stress formula oral tablet</i>	T1	
<i>super b complex/fa/vit c oral tablet</i>	T1	
<i>super b/c oral capsule</i>	T1	
<i>super b-complex + vitamin c oral tablet</i>	T1	
<i>super b-complex/vit c/fa oral tablet</i>	T1	
SUPPORT-500 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	
TAB-A-VITE ORAL TABLET (<i>multiple vitamin</i>)	T1	
<i>thiamine hcl injection solution 100 mg/ml, 200 mg/2ml</i>	T1	
<i>thrivite rx oral tablet 29-1 mg</i>	T1	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	T1	
<i>triphrocaps oral capsule 1 mg</i>	T1	
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	T1	
<i>v-c forte oral capsule</i>	T1	
VIC-FORTE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	
<i>vitamin b complex oral tablet</i>	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

		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>wescaps oral capsule 1 mg</i>	T1	
<i>westab plus oral tablet 27-1 mg</i>	T1	
Vitamin C		
<i>ascorbic acid injection solution 500 mg/ml</i>	T1	
<i>b complex-c oral tablet</i>	T1	
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	
<i>b complex-c-folic acid oral tablet</i>	T1	
<i>b-complex/vitamin c oral tablet</i>	T1	
<i>b-complex-c oral tablet</i>	T1	
<i>childrens chew multivitamin oral tablet chewable</i>	T1	
<i>childrens chewable vitamins oral tablet chewable</i>	T1	
<i>cvs b complex plus c oral tablet</i>	T1	
<i>cvs super b complex/c oral tablet</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG (<i>b complex-c-biotin-e-min-fa</i>)	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	T1	
DIALYVITE/ZINC ORAL TABLET (<i>b complex-c-zn-folic acid</i>)	T1	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	T1	
<i>folbee plus oral tablet</i>	T1	
<i>full spectrum b/vitamin c oral tablet 0.8 mg</i>	T1	
GUMMI BEAR MULTIVITAMIN/MIN ORAL TABLET CHEWABLE (<i>pediatric multivit-minerals</i>)	T1	
<i>hematinic plus vit/minerals oral tablet 106-1 mg</i>	T1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG (<i>fe fum-vit c-vit b12-fa</i>)	T1	
<i>hylavite oral tablet</i>	T1	
<i>multivitamin childrens (w/ fa) oral tablet chewable</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization QL = Quantity Limit ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>multivitamin childrens oral tablet chewable</i>	T1	
<i>nephro vitamins oral tablet 0.8 mg</i>	T1	
NEPHRO-VITE ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	T1	
<i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i>	T1	
RENAL ORAL CAPSULE 1 MG (<i>b complex-c-folic acid</i>)	T1	
<i>renal vitamin oral tablet 0.8 mg</i>	T1	
<i>rena-vite oral tablet</i>	T1	
<i>rena-vite rx oral tablet 1 mg</i>	T1	
<i>reno caps oral capsule 1 mg</i>	T1	
<i>stress formula oral tablet</i>	T1	
<i>super b complex/fa/vit c oral tablet</i>	T1	
<i>super b/c oral capsule</i>	T1	
<i>super b-complex + vitamin c oral tablet</i>	T1	
<i>super b-complex/vit c/fa oral tablet</i>	T1	
SUPPORT-500 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	T1	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	T1	
<i>triphrocaps oral capsule 1 mg</i>	T1	
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
VITALETS CHILDRENS ORAL TABLET CHEWABLE (<i>pediatric multivit-minerals</i>)	T1	
<i>vitamin b complex oral tablet</i>	T1	PA
<i>wescaps oral capsule 1 mg</i>	T1	
Vitamin D		
<i>actical oral capsule</i>	T1	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	T1	

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		Coverage Requirements and Limits
lowercase bold italics = Generic drugs		AL = Age Limit
UPPERCASE = Brand name drugs	Drug Tier T1 = Formulary Medication	PA = Prior Authorization
		QL = Quantity Limit
		ST = Step Therapy
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcitriol oral solution 1 mcg/ml</i>	T1	
<i>doxercalciferol oral capsule 0.5 mcg, 2.5 mcg</i>	T1	
<i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	T1	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT (<i>alendronate-cholecalciferol</i>)	T1	PA
<i>pc pediatric tri-vitamin drops oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	T1	
<i>tri-vite/fluoride oral solution 0.25 mg/ml</i>	T1	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)</i>	T1	
Vitamin E		
<i>b complex-c-biotin-e-fa oral tablet 0.4 mg</i>	T1	
DIALYVITE 3000 ORAL TABLET 3 MG (<i>b complex-c-biotin-e-min-fa</i>)	T1	
Vitamin K Activity		
<i>multivitamin adult oral tablet</i>	T1	
<i>phytonadione injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	
<i>phytonadione oral tablet 5 mg</i>	T1	
<i>vitamin k1 injection solution 1 mg/0.5ml, 10 mg/ml</i>	T1	

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Contra Costa Health Plan Commercial Formulary

A

abacavir sulfate	16	adapalene-benzoyl peroxide	232, 262, 263, 265	ambrisentan	80, 240, 245
abacavir sulfate-lamivudine	16	adefovir dipivoxil	21	amcinonide	249, 257
.....	16	ADEMPAS	80, 245, 246	Amethyst	162, 174, 194
ABRYSVO	29	AEROCHAMBER PLUS FLO-VU LARGE	119	amiloride hcl	77, 128
acamprosate calcium ..	1, 99	AEROCHAMBER PLUS FLO-VU SMALL	119	amiloride-hydrochlorothiazide ...	77, 78, 128, 132
acarbose	158	Afirmelle	162, 174, 194	aminocaproic acid	49
ACCU-CHEK SOFTCLIX LANCETS	118	AFLURIA	30	amiodarone hcl	69
Accutane	262, 265	AFLURIA PRESERVATIVE FREE	30	amitriptyline hcl	116
ACD-A NOCLOT-50	47	AFTERA	159, 162, 194	amlodipine besy-benazepril hcl ..	57, 58, 62, 70, 71, 79, 81
ACE AEROSOL CLOUD ENHANCER	119	AFTERPILL	159, 162, 194	amlodipine besylate .	62, 70, 71, 79, 81
acebutolol hcl 43, 60, 66, 68, 74, 79		AIMOVIG	91, 99	Amnesteem	262, 266
acetaminophen-codeine 84, 103, 105		aimsco lubricated	232	amoxapine	116
acetazolamide ... 65, 86, 127, 138		AJOVY	91, 99	amoxicill-clarithro-lansopraz	8, 22, 152
acetazolamide er	65, 86, 127, 138	AKYNZEO	145, 146, 152	amoxicillin	8, 147
acetic acid	127, 137, 143, 231, 263	ALA SCALP ... 139, 154, 249, 257		amoxicillin-pot clavulanate	8
acetic acid glacial .	127, 231, 263	ala-cort ... 139, 154, 249, 257		amoxicillin-pot clavulanate er	8
acetylcysteine ... 1, 218, 231, 242		albendazole	9	AMPHADASE	133
acitretin	262, 265	albuterol sulfate	42, 244	amphetamine-dextroamphet er	83
ACTHIB	29	albuterol sulfate hfa 42, 244		amphetamine-dextroamphetamine	83
actical	129, 269, 278	alclometasone dipropionate	249, 257	ampicillin	8
ACTIMMUNE	225	ALECENSA	25	ampicillin sodium	9
acyclovir	21, 255	alendronate sodium	220	ampicillin-sulbactam sodium	9
ADACEL	29, 30	alfuzosin hcl er	42	AMVISC	143
adalimumab-aaty (1 pen)	149, 215, 222, 225	allopurinol	219	anagrelide hcl	54
adalimumab-aaty (2 pen)	149, 215, 222, 225	ALOCRI	134, 241	anastrozole	25, 159
adalimumab-aaty (2 syringe)	149, 215, 222, 226	alogliptin benzoate	174	ANNOVERA ... 162, 174, 194	
adalimumab-aaty cd/uc/hs start	149, 215, 222, 226	alogliptin-metformin hcl	161, 174	anucort-hc	139, 154, 249, 257
adalimumab-fkjp (2 pen)	149, 215, 222, 226	alogliptin-pioglitazone .	174, 209	ANUSOL-HC ..	139, 154, 250, 257
adalimumab-fkjp (2 syringe)	149, 215, 222, 226	aloksetron hcl	147	APIDRA	189, 206
adapalene	232, 262, 265	alprazolam	97	APIDRA SOLOSTAR	189, 206
		alprazolam er	97	apraclonidine hcl ... 134, 143	
		ALPRAZOLAM INTENSOL	97	aprepitant	152
		alprazolam xr	97	APRETUDE	14
		ALREX	139	Apri	162, 175, 194
		Altavera	162, 174, 194		
		alyacen 1/35 ... 162, 174, 194			
		alyacen 7/7/7 .. 162, 174, 194			
		amantadine hcl	7, 83		

APTIVUS..... 18
AQUALANCE LANCETS
30G..... 119
AQUASOL A..... 273
ARANELLE..... 162, 175, 194
AREXVY 30
ARGYLE STERILE SALINE
..... 127
aripiprazole..... 89, 95
ARMOUR THYROID..... 210
Ascomp-Codeine 85, 91, 96,
105, 109, 112
ascorbic acid 277
asenapine maleate 89, 95
Ashlyna 162, 175, 194
ASMANEX (120 METERED
DOSES)..... 154
ASMANEX (14 METERED
DOSES)..... 154
ASMANEX (30 METERED
DOSES)..... 154
ASMANEX (60 METERED
DOSES)..... 154
ASMANEX HFA..... 154, 242
aspartame (for
compounding)..... 132
aspirin 52, 54, 91, 113
aspirin 81 52, 54, 91, 112
aspirin adult low dose ... 52,
54, 91, 112
aspirin adult low strength
..... 52, 54, 91, 112
aspirin childrens 52, 54, 91,
112
aspirin ec adult low dose
..... 52, 54, 91, 113
aspirin ec low dose.. 52, 54,
91, 113
aspirin ec low strength .. 52,
54, 91, 113
aspirin low dose . 52, 54, 91,
113
aspirin low strength . 52, 54,
91, 113
aspirin regimen .. 52, 54, 91,
113
aspirin-dipyridamole er . 52,
75, 81, 113, 124
atazanavir sulfate..... 18
atenolol 43, 60, 66, 68, 74
atenolol-chlorthalidone.. 43,
60, 66, 68, 74, 79, 133
atomoxetine hcl..... 99, 109
atorvastatin calcium..... 72
atovaquone 10
atovaquone-proguanil hcl 9
atropine sulfate 1, 2, 35,
144, 218, 236
ATROVENT HFA 35, 236
Aubra Eq 162, 175, 194
Aurovela 1.5/30..... 162, 175,
194
Aurovela 1/20. 163, 175, 194
Aurovela 24 Fe..... 163, 175,
194
Aurovela Fe 1.5/30 163, 175,
195
Aurovela Fe 1/20... 163, 175,
195
AUSTEDO..... 99, 117
AUSTEDO XR..... 117
AUSTEDO XR PATIENT
TITRATION 117
AVAR-E EMOLLIENT... 247,
262, 263
AVERI 163, 175, 195
Aviane 163, 175, 195
avidoxy..... 9, 24, 247
AVONEX PEN..... 212, 226
AVONEX PREFILLED ... 212,
226
AVSOLA 149, 212, 215, 223,
226, 266
Ayuna 163, 175, 195
azathioprine .. 210, 223, 226,
229
azathioprine sodium 211,
223, 226, 229
azelaic acid 247, 266
azelastine hcl..... 134, 244
AZELEX..... 247, 266
azithromycin 22
Azurette..... 163, 175, 195
B
b complex formula 1
(lipotrop)..... 151, 269
b complex-c .. 151, 269, 273,
277
b complex-c-biotin-e-fa 269,
273, 277, 279
b complex-c-folic acid.. 269,
273, 277
Bac (Butalbital-Acetamin-
Caff) 84, 96, 103, 109
bacitracin 12, 135, 247
bacitracin-polymyxin b .. 12,
135, 247
bacitra-neomycin-
polymyxin-hc..... 12, 135,
139, 247
baclofen 40
bacteriostatic water(benz
alc) 236
balance b-100. 151, 269, 273
balance b-50 269, 273
balsalazide disodium 147
Balziva..... 163, 175, 195
BAQSIMI ONE PACK 1, 186,
218
BAQSIMI TWO PACK 1, 186,
218
BAYER ASPIRIN EC LOW
DOSE 52, 54, 91, 113
BAYER LOW DOSE .. 52, 54,
91, 113
bcg vaccine..... 30
b-complex (folic acid) .. 270,
273
b-complex/b-12..... 273
b-complex/vitamin c..... 129,
270, 273, 277
b-complex-c ... 270, 273, 277
BD DISP NEEDLE 119
BD DISP NEEDLES..... 119
BD INSULIN SYRINGE... 119
BD INSULIN SYRINGE
MICROFINE..... 119
BD INSULIN SYRINGE
ULTRAFINE 119
BD INTEGRA SYRINGE. 119
BD LUER-LOK SYRINGE
..... 119
BD PEN NEEDLE MINI U/F
..... 119
BD PEN NEEDLE MINI
ULTRAFINE 119
BD PEN NEEDLE NANO
2ND GEN..... 119
BD PEN NEEDLE NANO
ULTRAFINE 119

BD PEN NEEDLE ORIG
ULTRAFINE 119
BD PEN NEEDLE SHORT
ULTRAFINE 120
BD PLASTIPAK SYRINGE
..... 120
BD SYRINGE/NEEDLE .. 120
BD TB SYRINGE 120
BD VEO INSULIN SYR
ULTRAFINE 120
BELSOMRA 94, 108
benazepril hcl 57, 58
benazepril-
hydrochlorothiazide ... 57,
58, 78, 132
benzalkonium chloride 255,
264
benzonatate 238
benzoyl peroxide... 262, 264
benzoyl peroxide wash 262,
264
benztropine mesylate 37, 86
BETADINE OPHTHALMIC
PREP 137
betaine 231
betamethasone
dipropionate 155, 250, 257
betamethasone
dipropionate aug 154,
155, 250, 257
betamethasone valerate
..... 155, 250, 258
BETASERON 213, 226
betaxolol hcl . 43, 60, 66, 68,
74, 79, 138
bethanechol chloride 41
BETIMOL 40, 60, 68, 138
BETOPTIC-S 44, 68, 138
bexarotene 25, 253
BEXSERO 30
bicalutamide 25
BICILLIN C-R 20
BICILLIN C-R 900/300 20
BICILLIN L-A 20
BIKTARVY 15, 17
bimatoprost 145
BINAXNOW COVID-19 AG
HOME TEST 120, 125
bisoprolol fumarate.. 44, 60,
66, 68, 74
bisoprolol-
hydrochlorothiazide ... 44,
60, 66, 68, 74, 78, 132
Blisovi 24 Fe .. 163, 175, 195
Blisovi Fe 1.5/30 ... 163, 175,
195
Blisovi Fe 1/20 163, 176, 195
BOOSTRIX 29, 30
bosentan 81, 240, 245
bp vit 3 59, 231, 273
BREZTRI AEROSPHERE 35,
42, 155, 236, 242, 245
briellyn 163, 176, 195
brimonidine tartrate 134,
247
brimonidine tartrate-timolol
..... 134, 138, 247
brinzolamide 139
bromocriptine mesylate 100
budesonide... 155, 239, 242,
258
budesonide er 155
budesonide-formoterol
fumarate 42, 155, 242, 245
bumetanide 73, 128
bupivacaine fisiopharma
..... 216
bupivacaine hcl 217
bupivacaine hcl (pf) 216
bupivacaine hcl-nacl 129,
217
bupivacaine in dextrose
..... 126, 217
bupivacaine spinal 126, 217
bupivacaine-epinephrine 34,
217
bupivacaine-epinephrine
(pf) 34, 217
buprenorphine hcl 108
buprenorphine hcl-
naloxone hcl 107, 108
bupropion hcl 88
bupropion hcl er (smoking
det) 44, 88
bupropion hcl er (sr) 88
bupropion hcl er (xl) 88
buspirone hcl 94, 102
butalbital-acetaminophen
..... 84, 96, 103
butalbital-apap-caff-cod 84,
85, 91, 96, 103, 105, 109
butalbital-apap-caffeine 84,
85, 91, 96, 103, 109
butalbital-asa-caff-codeine
... 85, 92, 96, 105, 110, 113
butalbital-aspirin-caffeine
..... 52, 54, 92, 96, 110, 113
C
CABENUVA 15, 16
cabergoline 100
CABOMETYX 25
calcipotriene 256, 266
calcipotriene-betameth
diprop . 250, 256, 258, 266
calcitonin (salmon) 161,
193, 220
calcitriol 266, 278, 279
calcium acetate 128, 129
calcium acetate (phos
binder) 128, 129
Camila 163, 195
Camrese 163, 176, 195
Camrese Lo 163, 176, 195
candesartan cilexetil 56, 57
candesartan cilexetil-hctz
..... 56, 57, 78, 132
capecitabine 25
captopril 57, 58
captopril-
hydrochlorothiazide ... 58,
78, 132
CAPVAXIVE 30
carbamazepine 86, 89
carbamazepine er 86, 89
CARBATROL 87, 89
carbidopa 99, 100
carbidopa-levodopa 100
carbidopa-levodopa er .. 100
carbinoxamine maleate 3, 4,
240
CARESTART COVID-19
HOME TEST 125
carteolol hcl 138, 143
Cartia Xt .. 61, 63, 64, 69, 75,
81
carvedilol 40, 42, 55, 60, 66,
68, 74, 79
CAVERJECT 71, 81

CAVERJECT IMPULSE .. 71, 81
CAYA..... 232
cefaclor 6
cefaclor er..... 6
cefadroxil 6
cefdinir 7
cefixime..... 7
cefpodoxime proxetil 7
cefprozil 6
cefuroxime axetil..... 7
celecoxib..... 100
centravites 50 plus129, 270, 273
cephalexin..... 6
CEQUA 137, 142, 211
CETACAINE 253
cetorelix acetate..... 159
cevimeline hcl..... 41
Charlotte 24 Fe..... 163, 176, 195
Chateal Eq..... 164, 176, 195
CHEMET..... 1, 153, 218
childrens aspirin 52, 54, 92, 113
childrens chew
multivitamin 270, 273, 277
childrens chewable
vitamins 270, 273, 277
chlordiazepoxide hcl..... 97
chlordiazepoxide-
amitriptyline 98, 116
chlordiazepoxide-clidinium
..... 35, 98
chlorhexidine gluconate.. 7, 137, 138, 255, 264
chlorprocaine hcl (pf) . 217
chloroquine phosphate 9
chlorpromazine hcl 109
chlorthalidone 79, 133
chlorzoxazone 39
cholestyramine..... 61
cholestyramine light..... 61
chorionic gonadotropin186, 188
Ciclodan..... 261
ciclopirox..... 261
ciclopirox olamine..... 261
cilostazol..... 53, 75
CILOXAN..... 135
CIMDUO..... 17
cimetidine 5, 151
cimetidine hcl 5, 151
ciprofloxacin hcl 11, 23, 135
ciprofloxacin-
dexamethasone . 135, 139
ciprofloxacin-
hydrocortisone .. 135, 139
citalopram hydrobromide
..... 115
Claravis 263, 266
clarithromycin ... 11, 22, 147
clarithromycin er11, 22, 147
classic prenatal 50, 129, 270, 273
clemastine fumarate..... 3, 4, 240
CLEOCIN..... 19, 247
CLIMARA PRO..... 176, 195
Clindacin Etz..... 19, 247
Clindacin-P 19, 247
clindamycin hcl 19, 247
clindamycin palmitate hcl
..... 19, 247
clindamycin phos (once-
daily) 19, 247
clindamycin phos (twice-
daily) 19, 247
clindamycin phos-benzoyl
perox..... 19, 247, 263, 264
clindamycin phosphate . 19, 248
clobazam..... 97, 98
clobetasol prop emollient
base 250, 258
clobetasol propionate .. 250, 258
clobetasol propionate e250, 258
clocortolone pivalate ... 250, 258
Clodan 250, 258
clomiphene citrate 174
clomipramine hcl..... 116
clonazepam..... 97, 98
clonidine 35, 66, 71
clonidine hcl 35, 66, 71
clopidogrel bisulfate 53
clorazepate dipotassium97, 98
clotrimazole 256
clotrimazole-
betamethasone . 250, 256, 258
clozapine..... 95
coal tar 263
codeine sulfate 105, 238
colchicine..... 219
colchicine-probenecid . 133, 219
colestipol hcl 61
COMBIPATCH..... 176, 196
COMBIVENT RESPIMAT 35, 42, 237, 245
COMFORT EZ PEN
NEEDLES..... 120
COMIRNATY 30
COMIRNATY 5-11 YEARS30
COMPACT SPACE
CHAMBER 120
complete natal dha . 50, 129, 231, 270, 273
Compro 109, 146
condoms 233
CONDYLOX 263, 266
constulose 126
CONTRAVE 85, 86
CORDRAN..... 251, 258
CORTANE-B.. 139, 155, 253, 258, 264
CORTIFOAM . 139, 155, 251, 258
CORTISPORIN-TC . 135, 139
CORTROPHIN 124, 193
CORTROPHIN GEL 124, 193
COTELLIC 25
COVARYX 159, 176
COVARYX HS..... 159, 176
CREON 134, 148
CRINONE..... 196
cromolyn sodium . 134, 135, 143, 241, 242
CRYODOSE TA..... 253
Cryelle-28..... 164, 176, 196
CUROSURF 243
cvs aspirin adult low dose
..... 53, 54, 92, 113
cvs aspirin ec 53, 54, 92, 113

cvs aspirin low dose 53, 54, 92, 113
cvs aspirin low strength 53, 54, 92, 113
cvs b complex plus c ... 270, 273, 277
cvs nicotine ... 37, 38, 44, 45
cvs nicotine polacrilex... 37, 38, 44, 45
cvs one daily essential 129, 270, 273
cvs super b complex/c. 270, 274, 277
cyanocobalamin 52, 274
cyclobenzaprine hcl..... 39
CYCLOMYDRIL..... 144, 145
cyclopentolate hcl..... 144
cyclophosphamide. 25, 212, 229
cycloserine 11
cyclosporine . 137, 142, 211, 223, 226, 230
cyclosporine modified . 137, 211, 223, 226, 230
*cyproheptadine hcl*3, 4, 240
Cyred Eq 164, 176, 196
CYSTAGON..... 231
D
dabigatran etexilate mesylate 48
daily value multivitamin 270
daily vite..... 270
daily vites..... 270
daily-vite 270
daily-vite multivitamin .. 270
dalfampridine er 231, 232
danazol..... 159
dantrolene sodium 40
dapsone 9, 10, 248, 266
darifenacin hydrobromide er..... 268
darunavir..... 18
dasatinib 25
Dasetta 1/35 (28)... 164, 176, 196
Dasetta 7/7/7 .. 164, 176, 196
Daysee 164, 176, 196
DAYVIGO..... 94, 109
DEBACTEROL 143, 264, 266
Deblitane..... 164, 196
deferasirox..... 153
deferasirox granules..... 153
deferiprone 153
deferoxamine mesylate.... 1, 153, 218
DELSTRIGO 16, 17
demeclocycline hcl 24
DENTA 5000 PLUS 117, 118, 221
DEPAKOTE .. 87, 89, 92, 101
DEPAKOTE ER ... 87, 89, 92, 101
DEPAKOTE SPRINKLES 87, 89, 92
DEPO-ESTRADIOL 176, 220
DEPO-PROVERA ... 164, 196
DEPO-SUBQ PROVERA 104..... 164, 196
DESCOVY..... 17, 21
desipramine hcl..... 116
desloratadine..... 6, 244
desmopressin ace spray refrig 49, 193
desmopressin acetate.... 49, 193
*desmopressin acetate pf*49, 193
desmopressin acetate spray 49, 193
desogestrel-ethinyl estradiol..... 164, 177, 196
desonide 251, 258
desoximetasone 251, 259
dexamethasone 139, 155
DEXAMETHASONE INTENSOL 139, 155
dexamethasone sodium phosphate 140
dexmethylphenidate hcl 85, 110
dexmethylphenidate hcl er 110
dextroamphetamine sulfate 83
dextroamphetamine sulfate er..... 83
DIALYVITE 3000 ... 129, 270, 274, 277, 279
DIALYVITE 800 270, 274, 277
DIALYVITE/ZINC ... 129, 270, 274, 277
diazepam..... 97, 98
Diazepam Intensol..... 97, 98
diazoxide..... 161
diclofenac epolamine... 104, 265, 266
diclofenac potassium.... 104
diclofenac sodium.. 25, 104, 111, 117, 143, 265, 266
diclofenac sodium er 104
dicloxacillin sodium 22
dicyclomine hcl 35, 36
diflorasone diacetate ... 251, 259
diflunisal 104, 111
difluprednate..... 140
Digox 59, 65
digoxin 59, 65
dihydroergotamine mesylate 41, 92
DILANTIN 67, 101
DILANTIN INFATABS 67, 101
diltiazem hcl.. 62, 63, 64, 70, 76, 81
diltiazem hcl er ... 62, 63, 64, 70, 76, 81
diltiazem hcl er beads 61, 63, 64, 69, 76, 81
diltiazem hcl er coated beads ... 62, 63, 64, 69, 70, 76, 81
dilt-xr .. 62, 63, 65, 70, 76, 81
dimethyl fumarate . 212, 226
dimethyl fumarate starter pack 212, 226
diphenhydramine hcl ... 3, 4, 37, 86, 94, 238, 240
diphenoxylate-atropine.. 36, 146, 237
dipyridamole 53, 76, 81, 124
DISKETS..... 105
disopyramide phosphate 67
disulfiram 1, 218
DIURIL 78, 132
divalproex sodium.... 87, 89, 92, 101
*divalproex sodium er*87, 89, 92, 101

<i>dofetilide</i>	69	EDURANT	16	EMVERM	9
Dolishale	164, 177, 196	EDURANT PED	16	enalapril maleate	58
donepezil hcl	41	EEMT	159, 177	enalapril-	
dorzolamide hcl	139	EEMT HS	159, 177	hydrochlorothiazide ...	58,
dorzolamide hcl-timolol		efavirenz	16	78, 132	
mal	138, 139	efavirenz-emtricitab-tenofo		ENBREL .	215, 223, 226, 266
Dotti	177, 220	df	16, 17	ENBREL SURECLICK ...	215,
DOVATO	15, 17	efavirenz-lamivudine-		223, 227, 267	
doxazosin mesylate .	41, 55,	tenofovir	16, 17	ENCARE	233
56, 60, 80		EFFER-K	129	Endocet	84, 103, 105
doxepin hcl	116, 254	ELIGARD ...	25, 26, 186, 187,	ENGERIX-B	30
doxercalciferol	279	188		enoxaparin sodium	50
doxycycline hyclate ...	9, 24,	Elinest	164, 177, 197	Enskyce	165, 177, 197
135, 248		ELIQUIS	47	entacapone	99
doxycycline monohydrate 9,		ELIQUIS (1.5 MG PACK) ..	47	entecavir	21
10, 24, 248		ELIQUIS (2 MG PACK)	47	ENTRESTO	56, 57, 77
dronabinol	146, 149	ELIQUIS DVT/PE STARTER		ENTYVIO 149, 151, 211, 227	
DROPLET INSULIN		PACK	47	enulose	126
SYRINGE	120	ELITE-OB	50, 270, 274	EPIDIOLEX	87
DROPLET MICRON	120	ELLA	165, 197	EPIFOAM	251, 254, 259
DROPLET PEN NEEDLES		ELLIOTTS B ...	126, 129, 236	epinastine hcl	6, 135
.....	120	ellume covid-19 home test		epinephrine	34, 137, 144,
drospiren-eth estrad-		.....	125	145, 236	
levomefol ... 164, 177, 196,		ELMIRON	231, 232	epinephrine (anaphylaxis)	
274		Eluryng	165, 177, 197	.....	34, 137, 144, 145, 236
drospirenone-ethinyl		EMBECTA AUTOSHIELD		epinephrine pf. 34, 137, 144,	
estradiol 164, 177, 196		DUO	120	145, 236	
DROXIA	25	EMBECTA INS SYR U/F 1/2		eplerenone	73, 77, 128
DRYSOL	255	UNIT	121	EPOGEN	46, 48
DULERA ...	42, 156, 242, 245	EMBECTA INSULIN SYR		eq aspirin adult low dose	
duloxetine hcl	100, 114	ULTRAFINE	121	.....	53, 55, 92, 113
DUPIXENT	241, 262, 266	EMBECTA INSULIN		eq aspirin low dose ..	53, 55,
DUREX EXTRA SENSITIVE		SYRINGE	121	92, 113	
THIN	233	EMBECTA INSULIN		eq nicotine	38, 45
DUREX REALFEEL	233	SYRINGE U-100	121	eq nicotine polacrilex 38, 45	
DYSPORT	39, 44, 231	EMBECTA PEN NEEDLE		eq nicotine step 3	38, 45
E		NANO	121	eq space chamber anti-	
EASIVENT	120	EMBECTA PEN NEEDLE		static	121
easy comfort lancets ...	120	NANO 2 GEN	121	eql aspirin low dose .	53, 55,
EASY TOUCH INSULIN		EMBECTA PEN NEEDLE		92, 114	
SYRINGE	120	ULTRAFINE	121	eql prenatal formula 50, 129,	
EASY TOUCH PEN		EMBRACE LANCETS		270, 274	
NEEDLES	120	ULTRA THIN 30G	121	ergocalciferol	279
ec-naproxen	92, 104, 111,	emollient base	236, 256	ergotamine-caffeine .	41, 92,
219		emtricitabine	17	110	
econazole nitrate	256	emtricitabine-tenofovir df		erlotinib hcl	26
ECONTRA ONE-STEP ..	160,	.....	17, 21	Errin	165, 197
164, 196		emtricitab-rilpivir-tenofov		ery	13, 135, 248
ECOTRIN LOW STRENGTH		df	16, 17, 21	erythromycin	13, 20, 135,
.....	53, 55, 92, 113	EMTRIVA	17	248	

<i>erythromycin base</i> 13, 19	FC2 FEMALE CONDOM 233	<i>fluocinonide</i> 251, 259
<i>erythromycin</i>	<i>Feirza 1.5/30</i> ... 165, 178, 197	<i>fluocinonide emulsified</i>
<i>ethylsuccinate</i> .. 13, 19, 20	<i>Feirza 1/20</i> 165, 178, 197	<i>base</i> 251, 259
<i>escitalopram oxalate</i> 115	<i>felbamate</i> 87	<i>fluorometholone</i> 140
<i>esomeprazole magnesium</i>	<i>felodipine er</i> .. 63, 70, 71, 80,	<i>fluorouracil</i> 26, 253, 267
..... 153	82	<i>fluoxetine hcl</i> 115
<i>essential one daily multivit</i>	FEM PH 264, 267	<i>fluoxetine hcl (pmd)</i> ... 115
..... 129, 270, 274	FEMCAP 121, 233	<i>fluphenazine hcl</i> 109
<i>est estrogens-methyltest</i>	FEMLYV 165, 178, 197	<i>flurandrenolide</i> 251, 259
..... 159, 177	FEMRING 178, 221	<i>flurazepam hcl</i> 98
<i>est estrogens-methyltest</i>	<i>fenofibrate</i> 72	<i>flurbiprofen</i> 104, 111, 143
<i>ds</i> 159, 177	<i>fenofibrate micronized</i> ... 72	<i>flurbiprofen sodium</i> 111,
<i>est estrogens-methyltest</i>	<i>fentanyl</i> 105	143
<i>hs</i> 159, 177	<i>fentanyl cit-ropivacaine-</i>	<i>fluticasone furoate ellipta</i>
Estarilla 165, 177, 197	<i>nacl</i> 105, 129, 217	..... 140, 156, 239, 242
<i>estazolam</i> 98	<i>fentanyl-bupivacaine-nacl</i>	<i>fluticasone furoate-</i>
<i>estradiol</i> 177, 178, 220	..... 106, 129, 217	<i>vilanterol</i> 43, 140, 156,
<i>estradiol valerate</i> ... 178, 221	FERRIPROX 153	239
<i>estradiol-norethindrone</i>	FERRIPROX TWICE-A-DAY	<i>fluticasone propionate</i> . 140,
<i>acet</i> 178, 197	..... 153	156, 239, 242, 251, 259
<i>eszopiclone</i> 94, 102	<i>fesoterodine fumarate er</i>	<i>fluticasone propionate</i>
<i>ethacrynic acid</i> 73, 128	..... 268	<i>diskus</i> . 140, 156, 239, 242
<i>ethambutol hcl</i> 11	FINACEA 248, 267	<i>fluticasone propionate hfa</i>
<i>ethosuximide</i> 116	<i>finasteride</i> 218, 257	..... 140, 156, 239, 243
<i>ethyl chloride</i> 254	<i>finolimid hcl</i> 215, 227	<i>fluticasone-salmeterol</i> ... 43,
<i>ethynodiol diac-eth</i>	<i>Finzala</i> 165, 178, 197	140, 156, 239, 243, 245
<i>estradiol</i> 165, 178, 197	FIRMAGON 26, 160, 225	<i>fluvastatin sodium</i> 72
<i>etodolac</i> 104, 111	FLAREX 140	<i>fluvastatin sodium er</i> 72
<i>etodolac er</i> 104, 111	<i>flavoxate hcl</i> 268	<i>flvoxamine maleate</i> 115
<i>etonogestrel-ethinyl</i>	<i>flecainide acetate</i> 68	FLUZONE 31
<i>estradiol</i> 165, 178, 197	FLINTSTONES/MY FIRST	FLUZONE HIGH-DOSE 31
<i>etoposide</i> 26	..... 270, 274, 277	FML FORTE 140
<i>etravirine</i> 16	FLOWFLEX COVID-19 AG	<i>folbee plus</i> 270, 274, 277
EVOTAZ 18, 231	HOME TEST 125	<i>folic acid</i> 274
<i>exemestane</i> 26, 159	FLUAD 31	FOLLISTIM AQ 187, 188
EXODERM 3, 249, 263	FLUARIX 31	<i>folplex 2.2</i> 274
<i>ezetimibe</i> 67	FLUBLOK 31	<i>fondaparinux sodium</i> 47, 50
F	FLUCELVAX 31	FOSAMAX PLUS D 221, 279
<i>Falmina</i> 165, 178, 197	<i>fluconazole</i> 12	<i>fosamprenavir calcium</i> ... 18
<i>famciclovir</i> 21	<i>fludrocortisone acetate</i> . 156	<i>fosfomycin tromethamine</i>
<i>famotidine</i> 5, 151	FLULAVAL 31	..... 25
FANTASY LUBRICATED 233	FLUMIST 31	<i>fosinopril sodium</i> 58, 59
FANTASY	<i>flunisolid</i> 140, 156, 239,	<i>fosinopril sodium-hctz</i> ... 58,
LUBRICATED/SPERMICI	242	59, 78, 132
DE 233	<i>fluocinolone acetonide</i> 140,	FRAGMIN 50
FARXIGA 208	251, 259	FREESTYLE LANCETS . 121
FASENRA 241	<i>fluocinolone acetonide</i>	FREESTYLE LIBRE 14 DAY
FASENRA PEN 241	<i>body</i> 140, 251, 259	READER 121
<i>fastep covid-19 antigen test</i>	<i>fluocinolone acetonide</i>	FREESTYLE LIBRE 14 DAY
..... 125	<i>scalp</i> 140, 251, 259	SENSOR 121

FREESTYLE LIBRE 2 PLUS	GLEOSTINE	HADLIMA PUSHTOUCH 150,
SENSOR	glimpiride	215, 216, 223, 227
FREESTYLE LIBRE 2	glipizide	HAEGARDA
READER	glipizide er	222
FREESTYLE LIBRE 2	glipizide-metformin hcl 161,	Hailey 1.5/30 ... 165, 178, 198
SENSOR	209	Hailey 24 Fe ... 165, 179, 198
FREESTYLE LIBRE 3 PLUS	glucagon emergency 1, 186,	Hailey Fe 1.5/30 165, 179,
SENSOR	219	198
FREESTYLE LIBRE 3	glyburide	Hailey Fe 1/20 166, 179, 198
READER	209	halcinonide
FREESTYLE LIBRE 3	glyburide-metformin 161,	251, 259
SENSOR	209	halobetasol propionate 251,
full spectrum b/vitamin c	glycine	259
..... 270, 274, 277	127	Haloette
FULPHILA	glycine urologic 127	166, 179, 198
48	glycopyrrolate	HALOG
furosemide 73, 128	36, 255	252, 259
Fyavolv 178, 197	Glydo 144, 254	haloperidol 98
FYLNETRA	gnp adult aspirin low	haloperidol decanoate 98
48	strength 53, 55, 93, 114	haloperidol lactate 98
G	gnp aspirin ... 53, 55, 93, 114	HAVRIX 31
gabapentin 84, 87, 101	gnp aspirin low dose 53, 55,	Heather 166, 198
Galbriela 165, 178, 197	93, 114	hematinic plus vit/minerals
GALZIN 130, 154	gnp essential one daily 271,	..... 51, 130, 274, 277
ganirelix acetate 160, 225	274	hematinic/folic acid .51, 274
GARDASIL 9	gnp naloxone hcl 1, 107	HEMATOGEN FA 51, 274,
31	gnp nicotine 38, 45	277
GAVILYTE-C	gnp nicotine mini 38, 45	heparin na (pork) lock flsh
148	gnp nicotine polacrilex .. 38,	pf
Gavilyte-G	45	50
148	gnp prenatal 51, 130, 271,	heparin sod (pork) lock
Gavilyte-N With Flavor	274	flush
Pack	GONAL-F 187, 188	50, 122
148	GONAL-F RFF REDIJECT	heparin sodium (porcine) 50
GEBAUERS PAIN EASE	..... 187	heparin sodium (porcine)
..... 122, 254	goodsense aspirin ... 53, 55,	pf
GEBAUERS SPRAY AND	93, 114	50
STRETCH 122, 254	goodsense aspirin low	HEPLISAV-B
gefitinib	dose	31
26	53, 55, 93, 114	HER STYLE 160, 166, 198
GELCLAIR 122, 267	goodsense nicotine ... 38, 45	HIBERIX 32
GELFILM	granisetron hcl	144
49, 143	145	HOMATROPAIRE 144
gemfibrozil 72	GRANIX	144
Gemmily 165, 178, 197	48	HUMALOG 190, 207
GEMTESA	griseofulvin microsize 9	HUMALOG MIX 50/50
269	griseofulvin ultramicrosize	KWIKPEN 189, 191, 206
generlac .....	..... 9	HUMALOG MIX 75/25 ... 190,
126	guanfacine hcl 66, 72, 99	191, 206
Gengraf . 137, 211, 223, 227,	guanfacine hcl er 72, 99	HUMATROPE
230	GUMMI BEAR	193, 209
GENOTROPIN 193, 209	MULTIVITAMIN/MIN .. 130,	HUMULIN 70/30 190, 191,
GENOTROPIN MINIQUICK	271, 277	207
..... 193, 208	GYNAZOLE-1	207
gentamicin sulfate 8, 135,	256	HUMULIN 70/30 KWIKPEN
248	H	..... 190, 191, 207
GENVOYA	HADLIMA 150, 216, 223, 227	HUMULIN N
15, 17		190, 192
GERITOL TONIC 51, 271,		HUMULIN N KWIKPEN . 190,
274		191
glatiramer acetate . 210, 227		HUMULIN R
		190, 207
		HUMULIN R U-500
		KWIKPEN 190, 207

hydralazine hcl 72
hydrochlorothiazide 78, 132
hydrocod poli-chlorphe poli er..... 4, 6, 238
hydrocodone bit-homatrop mbr..... 36, 238
hydrocodone-acetaminophen ... 84, 103, 106
hydrocodone-ibuprofen 104, 106, 111
hydrocortisone..... 141, 156, 157, 252, 256, 260
hydrocortisone (perianal) 140, 156, 252, 259
hydrocortisone ace-pramoxine . 140, 156, 252, 254, 259
hydrocortisone acetate 141, 156, 252, 259
hydrocortisone butyrate 141, 156, 252, 259, 260
hydrocortisone valerate 141, 157, 252, 260
hydrocortisone-acetic acid 137, 141, 143, 157, 260
hydrocortisone-iodoquinol 7, 255, 260, 264
hydrocort-pramoxine (perianal) ... 141, 157, 252, 254, 260
hydrogen peroxide 236, 264
hydromet..... 36, 238
hydromorphone hcl 106
hydroxocobalamin acetate 52, 274
hydroxychloroquine sulfate 10, 212, 223, 227
hydroxyurea..... 26
hydroxyzine hcl..... 4, 5, 94
hydroxyzine pamoate .. 4, 5, 6, 94
hylavite..... 271, 275, 277
hyoscyamine sulfate.... 1, 2, 36, 237
hyoscyamine sulfate er ... 1, 36, 237
hyosyne 2, 36, 237
HYPERRHO..... 29

I
ibandronate sodium..... 221
IBRANCE..... 26
IBSRELA 150
ibuprofen..... 93, 104, 111
lclevia 166, 179, 198
ICLUSIG..... 26
IHEALTH COVID-19 RAPID TEST 125
imatinib mesylate 26
imipramine hcl..... 116
imipramine pamoate 116
imiquimod 253, 267
IMOVAX RABIES 32
IMULDOSA 213
Incassia 166, 198
INCRUSE ELLIPTA .. 36, 237
indapamide 79, 133
indomethacin 104, 112, 219, 220
indomethacin er ... 104, 111, 219
INFASURF 130, 244
INFED 51
INFLECTRA... 150, 212, 216, 223, 227, 267
infliximab 150, 212, 216, 223, 227, 267
INGREZZA..... 99, 117
INNOPRAN XL 40, 60, 66, 68, 74, 80, 93
insulin asp prot & asp flexpen..... 190, 192, 207
insulin aspart..... 207
insulin aspart flexpen .. 190, 207
insulin aspart penfill 190, 207
insulin aspart prot & aspart 190, 192, 207
insulin glargine-yfgn..... 192
insulin lispro..... 207
insulin lispro (1 unit dial) 190, 207
insulin lispro prot & lispro 190, 192, 207
insulin syringe..... 122
INTELENCE..... 16
INTELISWAB COVID-19 RAPID TEST 125

Introvale 166, 179, 198
INVOKAMET..... 161, 208
INVOKANA 208
iodine strong. 2, 9, 161, 219, 240, 255
IODOFLEX..... 255, 264
IOPIDINE 134, 143
IPOL..... 32
ipratropium bromide 36, 143, 237
*ipratropium-albuterol*36, 43, 237, 245
irbesartan..... 56, 57
irbesartan-hydrochlorothiazide ... 56, 57, 78, 132
ISENTRESS..... 15
ISENTRESS HD..... 15
Isibloom 166, 179, 198
isoniazid..... 11
isosorbide dinitrate..... 74
isosorbide mononitrate .. 74
isosorbide mononitrate er 74
isotretinoin..... 263, 267
isradipine . 63, 70, 71, 80, 82
itraconazole 12
ivermectin 9
J
Jaimiess..... 166, 179, 198
JAKAFI 26, 262
Jantoven 47
JANUMET..... 161, 174
JANUMET XR..... 161, 174
JANUVIA 174
JARDIANCE 208
Jasmiel 166, 179, 198
Jencycla 166, 198
Jinteli..... 179, 198
Jolessa 166, 179, 198
Juleber 166, 179, 198
JULUCA..... 15, 16
Junel 1.5/30.... 166, 179, 198
Junel 1/20..... 166, 179, 199
Junel Fe 1.5/30..... 166, 179, 199
Junel Fe 1/20.. 166, 179, 199
Junel Fe 24.... 166, 180, 199
K
Kaitlib Fe..... 167, 180, 199

Kalliga 167, 180, 199
KAMELEON LUBRICATED
..... 233
Kariva 167, 180, 199
Kelnor 1/35..... 167, 180, 199
KERENDIA 73
ketoconazole 12, 256
ketoprofen..... 93, 104
ketoprofen er 93, 104
ketorolac tromethamine
..... 104, 112, 143
KEVZARA213, 223, 224, 227
kimono 233
KIMONO COLORS..... 233
KIMONO MAXX-LARGE
FLARE..... 233
kimono micro thin..... 233
kimono micro thin plus. 233
kimono plus 233
kimono ps 233
kimono ps plus..... 233
kimono sensation..... 233
kimono sensation plus . 233
KIMONO SPECIAL..... 233
KINERET 213, 224, 227
Klor-Con..... 130
Klor-Con M10..... 130
Klor-Con M20..... 130
KLOXXADO..... 2, 107
KLS QUIT2 38, 45
KLS QUIT4 38, 45
kobee..... 271, 275
kp folic acid 275
K-PHOS 126, 130
K-PHOS NO 2..... 125
Kurvelo..... 167, 180, 199
KYLEENA..... 160, 167, 199
L
labetalol hcl .. 40, 42, 56, 60,
66, 68, 74
lacosamide..... 87, 102
lactated ringers 127, 130
lactulose 126
lactulose encephalopathy
..... 126
LAGEVRIO 21
lamivudine 17
lamivudine-zidovudine ... 17
lamotrigine..... 87, 89
lancets 28g thin 122
lancets micro thin 33g .. 122
lancets super thin 28g .. 122
lancets ultra thin 30g 122
lancing device 122
LANOXIN..... 59, 66
lansoprazole 153
lanthanum carbonate... 128,
219
LANTUS..... 191, 192
LANTUS SOLOSTAR.... 190,
192
lapatinib ditosylate..... 26
Larin 1.5/30 167, 180, 199
Larin 1/20 167, 180, 199
Larin 24 Fe 167, 180, 199
Larin Fe 1.5/30167, 180, 199
Larin Fe 1/20 .. 167, 180, 199
latanoprost..... 145
LEDERLE LEUCOVORIN.. 3,
219, 275
leflunomide ... 214, 224, 227,
230
lenalidomide 26, 227
Lessina..... 167, 180, 199
letrozole 26, 159
leucovorin calcium... 3, 219,
275
LEUKERAN 26
levalbuterol hcl..... 43, 245
levetiracetam 87
levobunolol hcl..... 138
levocarnitine 231
levocarnitine sf..... 231
levofloxacin 11, 23, 248
Levonest 167, 180, 200
levonorgest-eth est & eth
est..... 167, 180, 200
levonorgest-eth estrad 91-
day 167, 180, 200
levonorgest-eth estradiol-
iron..... 167, 180, 200
levonorgestrel 160, 167, 200
levonorgestrel-ethinyl
estrad..... 168, 181, 200
levonorg-eth estrad
triphasic..... 168, 181, 200
Levora 0.15/30 (28)168, 181,
200
levorphanol tartrate..... 106
Levo-T 210
levothyroxine sodium ... 210
Levoxyl..... 210
lidocaine..... 254
lidocaine hcl .. 144, 217, 254
lidocaine hcl (pf)..... 217
lidocaine hcl
urethral/mucosal 144, 254
lidocaine viscous hcl 144
lidocaine-epinephrine 35,
217
lidocaine-hydrocort
(perianal) 252, 254, 260
lidocaine-hydrocortisone
ace..... 252, 254, 260
lidocaine-prilocaine..... 254
LIDOCORT 252, 254, 260
lidopin 254
LILETTA (52 MG) .. 160, 168,
200
linezolid..... 22
LINZESS 150, 151
liothyronine sodium 210
lisdexamphetamine
dimesylate 83, 84
lisinopril 58, 59
lisinopril-
hydrochlorothiazide ... 58,
59, 78, 132
lithium carbonate 89
lithium carbonate er 89
LITHOBID 90
LITHOSTAT 126
LO LOESTRIN FE.. 168, 181,
200
LODOCO 47, 231
Lojaimiess..... 168, 181, 200
LOKELMA 128
loperamide hcl..... 146
lopinavir-ritonavir..... 18
lorazepam 97, 98
Lorazepam Intensol... 97, 98
Loryna 168, 181, 200
losartan potassium ... 56, 57
losartan potassium-hctz 56,
57, 78, 132
loteprednol etabonate... 141
lovastatin 72
Low-Ogestrel . 168, 181, 200
loxapine succinate .. 94, 100

Lo-Zumandimine .. 168, 181, 200	MENQUADFI 32	metoprolol-
lubiprostone 148, 150	MENVEO 32	hydrochlorothiazide ... 44,
LUCIRA CHECK IT COVID-19 TEST 125	meperidine hcl 106	60, 66, 68, 74, 78, 133
LUMIGAN 145	meprobamate 94, 102	metronidazole . 7, 10, 20, 21,
LUPRON DEPOT (1-MONTH) 27, 187, 188	mercaptapurine 27, 212, 230	147, 248
LUPRON DEPOT (3-MONTH) 27, 187, 188	mesalamine 147	metyrosine 125, 231
LUPRON DEPOT (4-MONTH) 27, 187, 188	mesalamine er 147	mexiletine hcl 67
LUPRON DEPOT-PED (1-MONTH) 27, 187, 188	mesna 232	Mibelas 24 Fe . 168, 181, 201
LUPRON DEPOT-PED (3-MONTH) 27, 187, 188	METAFOLBIC 275	miconazole 3 256
LUPRON DEPOT-PED (6-MONTH) 187	metaxalone 39	miconazole nitrate 256
lurasidone hcl 95	metformin hcl 162	MICROCHAMBER 122
Lutera 168, 181, 200	metformin hcl er 161	Microgestin 1.5/30 168, 181,
Lyleq 168, 200	methadone hcl 106	201
Lyllana 181, 221	Methadone Hcl Intensol 106	Microgestin 1/20 ... 169, 181,
LYSODREN 27	methamphetamine hcl 84	201
Lyza 168, 200	methazolamide 65, 139	Microgestin Fe 1.5/30 ... 169,
M	methenamine hippurate .. 25	181, 201
magnesium chloride 87, 130	methenamine mandelate 25	Microgestin Fe 1/20 169,
magnesium sulfate 2, 59, 87, 219	methimazole 161	181, 201
malathion 265	methocarbamol 16, 39	MICROLET LANCETS 122
maraviroc 14	methotrexate sodium 27,	midodrine hcl 35
marlissa 168, 181, 200	212, 224, 228, 230	mifepristone 236
MATULANE 27	methotrexate sodium (pf)	MIGERGOT 41, 93, 111
Matzim La 62, 63, 65, 70, 76, 82	..... 27, 212, 224, 228, 230	miglitol 159
MAVYRET 13, 14	methscopolamine bromide	Mili 169, 182, 201
MAXIDEX 141	..... 36	Mimvey 182, 201
maxx 233	methyldopa 35, 66, 72	minocycline hcl 10, 24, 135,
maxx plus 233	methylergonovine maleate	248, 249
meclizine hcl 4, 6, 146	..... 235	minoxidil 72, 257
meclofenamate sodium 104, 112	methylphenidate hcl 85, 86, 110	MIOCHOL-E 144
MEDROL 157	methylphenidate hcl er .. 85, 110	MIOSTAT 144
medroxyprogesterone	methylphenidate hcl er (cd)	mirabegron er 269
acetate 168, 201	..... 110	MIRENA (52 MG) ... 160, 169,
mefenamic acid 104, 112	methylphenidate hcl er (la)	201
mefloquine hcl 10	..... 85, 110	mirtazapine 88, 115
megestrol acetate 27, 201	methylphenidate hcl er (osm) 85, 110	misoprostol 152
meloxicam 104, 112	methylprednisolone 157	MIUDELLA INTRAUTERINE COPPER 233
memantine hcl 99	methyltestosterone 159	mm aspirin ... 53, 55, 93, 114
MENOPUR 187, 188	metoclopramide hcl 152	M-M-R II 32
	metoclopramide hcl +rfid	m-natal plus 51, 130, 271,
	..... 152	275
	metolazone 79, 133	MNEXSPIKE 32
	metoprolol succinate er . 44,	modafinil 86, 117
	60, 66, 68, 74	mometasone furoate 141,
	metoprolol tartrate ... 44, 60,	157, 239, 252, 260
	66, 68, 74	Mondoxyne NI 10, 24, 249
		Mono-Linyah .. 169, 182, 201
		montelukast sodium 241
		morphine sulfate ... 106, 107

morphine sulfate
 (concentrate)..... 106
morphine sulfate er..... 106
morphine sulfate er beads
 106
MOTOFEN 36, 146
MOUNJARO 189
MOVANTIK..... 150, 152
moxifloxacin hcl11, 23, 135,
 249
moxifloxacin hcl (2x day)
 23, 135
MRESVIA..... 32
MULTAQ..... 69
multiple vitamins..... 271
multiple vitamins-iron.... 51,
 271
multivitamin 51, 271
multi-vitamin..... 271
multivitamin adult .. 51, 271,
 275, 279
multivitamin childrens . 271,
 275, 278
**multivitamin childrens (w/
 fa)**..... 271, 275, 277
multivitamin/fluoride.... 117,
 118, 221, 271, 275
mupirocin..... 249
MY CHOICE.... 160, 169, 201
MY WAY 160, 169, 201
mycophenolate mofetil 211,
 230
mycophenolate sodium 230
MYLERAN 27
MYRBETRIQ..... 269
N
na sulfate-k sulfate-mg sulf
 148
nabumetone..... 105, 112
nadolol 40, 44, 55, 60, 66,
 68, 74
nafcillin sodium..... 23
naftifine hcl..... 247
naloxone hcl .. 2, 3, 108, 219
naltrexone hcl. 1, 3, 45, 108,
 218, 219
naproxen.. 93, 105, 112, 220
naproxen sodium ... 93, 105,
 112, 220
naproxen sodium er93, 105,
 112, 220
naratriptan hcl..... 114
NATACYN..... 136
NATAZIA 169, 182, 201
nateglinide 192
NEBUSAL..... 122, 130, 242
Necon 0.5/35 (28).. 169, 182,
 201
nefazodone hcl..... 116
neomycin sulfate8, 135, 249
**neomycin-bacitracin zn-
 polymyx**..... 136
**neomycin-polymyxin-
 dexameth**..... 136, 141
**neomycin-polymyxin-
 gramicidin** 136
neomycin-polymyxin-hc
 136, 141
NEORAL 137, 211, 224, 228,
 230
neostigmine methylsulfate
 41, 125
nephro vitamins ... 271, 275,
 278
NEPHRO-VITE 271, 275, 278
NEULASTA..... 48
NEUPOGEN..... 48
neurin-sl..... 52, 275
nevirapine 16
nevirapine er..... 16
NEW DAY 160, 169, 202
NEXLETOL 55, 59
NEXLIZET..... 55, 59, 67
NEXPLANON.. 160, 169, 202
NEXTSTELLIS 169, 182, 202
niacin (antihyperlipidemic)
 59, 275
niacin er
(antihyperlipidemic).... 59,
 275
nicardipine hcl63, 71, 80, 82
nicotine 39, 46
nicotine mini 38, 45
nicotine polacrilex.... 38, 45,
 46
nicotine polacrilex mini .38,
 45
nicotine step 1 39, 46
nicotine step 2..... 39, 46
nicotine step 3 39, 46
NICOTROL NS..... 39, 46
nifedipine 63, 71, 80, 82
nifedipine er... 63, 71, 80, 82
**nifedipine er osmotic
 release** 63, 71, 80, 82
Nikki..... 169, 182, 202
nilutamide 27
nimodipine 63, 71, 80, 82
nitazoxanide 10
nitisinone 133, 231
NITRO-BID..... 74
nitrofurantoin..... 25
nitrofurantoin macrocrystal
 25
**nitrofurantoin monohyd
 macro**..... 25
nitroglycerin 74, 75
NITRO-TIME 75
niva thyroid..... 210
NIVESTYM..... 48
nizatidine..... 5, 151
Nora-Be 169, 202
NORDITROPIN FLEXP
 193, 209
**norelgestromin-eth
 estradiol**..... 169, 182, 202
norethin ace-eth estrad-fe
 169, 182, 202
norethindrone..... 170, 202
norethindrone acetate... 202
**norethindrone acet-ethinyl
 est** 170, 182, 202
norethindrone-eth estradiol
 182, 202
norethin-eth estradiol-fe
 170, 182, 202
norgesic forte ... 40, 44, 111,
 114
norgestimate-eth estradiol
 170, 182, 202
**norgestim-eth estrad
 triphasic**..... 170, 182, 202
NORITATE..... 7, 21, 249
Norlyda 170, 202
NORPACE CR 67
Nortrel 0.5/35 (28) . 170, 182,
 202
Nortrel 1/35 (21) 170, 182,
 202

Nortrel 1/35 (28).... 170, 183, 202
Nortrel 7/7/7 ... 170, 183, 203
nortriptyline hcl..... 116, 117
NORVIR..... 18
NOVAREL..... 187, 189
NOVOFINE PEN NEEDLE
..... 122
NOVOLIN 70/30..... 191, 192, 207
NOVOLIN 70/30 FLEXPEN
..... 191, 192, 207
NOVOLIN N..... 191, 192
NOVOLIN N FLEXPEN.. 191, 192
NOVOLIN R..... 191, 208
NOVOLIN R FLEXPEN.. 191, 208
NOVOLIN R RELION..... 191, 208
NP THYROID..... 210
NUCALA..... 238, 241
NUCYNTA..... 107
NUCYNTA ER..... 107
NULEV..... 2, 37, 237
NURTEC..... 99
NUTRIVIT. 51, 127, 130, 271, 275
NUTROPIN AQ NUSPIN 10
..... 193, 209
nuvaxovid covid-19 vaccine..... 32
Nyamyc..... 23, 265
Nylia 1/35..... 170, 183, 203
Nylia 7/7/7..... 170, 183, 203
NYPOZI..... 48
nystatin..... 23, 265
nystatin-triamcinolone... 23, 260, 265
Nystop..... 23, 265
NYVEPRIA..... 48
O
octreotide acetate 150, 208, 231
ODEFSEY..... 16, 17, 21
OFEV..... 238, 244
ofloxacin..... 23, 136
olanzapine..... 90, 95, 146
olmesartan medoxomil .. 56, 57

olmesartan medoxomil-hctz..... 56, 57, 79, 133
olopatadine hcl..... 5, 135
OLUMIANT..... 214, 224, 228
omega-3-acid ethyl esters
..... 59, 75
omeprazole..... 153
omeprazole-sodium bicarbonate..... 146, 153
OMNIFLEX DIAPHRAGM
..... 234
OMNITROPE..... 193, 209
ondansetron..... 145
ondansetron hcl..... 145
one-daily multi-vitamin . 271
ONETOUCH DELICA PLUS LANCET30G..... 122
ONETOUCH DELICA PLUS LANCET33G..... 122
OPCICON ONE-STEP... 160, 170, 203
OPILL..... 170, 203
opium..... 107, 146
OPSUMIT..... 82, 240, 245
OPTICHAMBER DIAMOND
..... 123
OPTICHAMBER DIAMOND-LG MASK..... 123
OPTICHAMBER DIAMOND-MD MASK..... 123
OPTICHAMBER DIAMOND-SM MASK..... 123
OPTION 2..... 160, 170, 203
OPTIONS GYNOL II CONTRACEPTIVE..... 234
ORACIT..... 126
Oralone..... 252, 260
ORAMAGICRX..... 123, 267
ORENCIA..... 211, 224, 228
ORENITRAM 82, 243, 245
ORLISSA..... 160
ORLADEYO..... 73, 222, 231
orphenadrine citrate. 40, 44, 86
orphenadrine citrate er .. 40, 44, 86
orphenadrine-aspirin-caffeine... 40, 44, 111, 114
ORPHENGESIC FORTE.. 40, 44, 111, 114

Orsythia..... 170, 183, 203
oscimin..... 2, 37, 237
oseltamivir phosphate 20
OTEZLA.. 214, 224, 228, 267
OTEZLA XR..... 215
OTEZLA/OTEZLA XR INITIATION PK..... 215
OTULFI..... 213, 214
OVIDREL..... 187
oxacillin sodium..... 23
oxaprozin..... 105, 112
oxazepam..... 98
oxcarbazepine..... 87, 102
oxybutynin chloride..... 268
oxybutynin chloride er.. 268
oxycodone hcl..... 107
oxycodone-acetaminophen
..... 84, 85, 103, 107
oxytocin..... 236
OXYTROL..... 268, 269
OZEMPIC (0.25 OR 0.5 MG/DOSE)..... 189
OZEMPIC (1 MG/DOSE). 189
OZEMPIC (2 MG/DOSE). 189
P
pantoprazole sodium 153
PARAGARD INTRAUTERINE COPPER
..... 234
paroxetine hcl..... 115
paroxetine hcl er..... 115
PAXLOVID (150/100).. 12, 13
PAXLOVID (300/100 & 150/100)..... 12, 13
PAXLOVID (300/100).. 12, 13
pb-hyoscy-atropine-scopolamine..... 37, 96
pc pediatric tri-vitamin drops... 271, 273, 278, 279
PEDVAX HIB..... 32
peg 3350-kcl-na bicarb-nacl
..... 148
peg-3350/electrolytes 148
PEGASYS... 19, 27, 213, 228
PENBRAYA..... 32
penicillamine 2, 154, 224
penicillin g potassium..... 20
penicillin g sodium..... 20
penicillin v potassium..... 20
penmenvy..... 32

pentamidine isethionate . 10
pentazocine-naloxone hcl
..... 108
pentetate calcium
trisodium 154
pentetate zinc trisodium 154
pentoxifylline er..... 49
perindopril erbumine 58, 59
Periogard .. 7, 137, 138, 255,
264
permethrin 265
perphenazine..... 109
perphenazine-amitriptyline
..... 109, 117
Pfizerpen..... 20
phenazopyridine hcl 254
phenelzine sulfate..... 102
phenobarbital 96, 97
phenobarbital-belladonna
alk 37, 96, 97
PHENOHYTRO..... 37, 96, 97
phenoxybenzamine hcl.. 41,
80
phenylephrine hcl 145
phenytoin..... 67, 101
Phenytoin Infatabs .. 67, 101
phenytoin sodium
extended..... 67, 101
Philith 170, 183, 203
PHOSPHA 250 NEUTRAL
..... 126, 130
PHOSPHOLINE IODIDE. 144
phosphorous 126, 130
PHOSPHO-TRIN K500 ... 130
PHYSIOLYTE 127
phytonadione.... 2, 219, 279
PIFELTRO 16
pilocarpine hcl..... 41, 144
pimecrolimus. 230, 262, 267
pimozide..... 94, 100
Pimtrea 170, 183, 203
pindolol ... 40, 60, 66, 68, 75,
80
pioglitazone hcl..... 210
Pirmella 7/7/7 . 171, 183, 203
piroxicam 105, 112
PLAN B ONE-STEP 160,
171, 203
PLURONIC F127 148, 236
PNEUMOVAX 23..... 32
POCKET CHAMBER..... 123
podofilox 263, 267
POLOCAINE..... 217
POLOCAINE-MPF 217
poly-iron 150 forte... 51, 275
polymyxin b-trimethoprim
..... 23, 136, 249
polysorbate 80..... 143, 261
POMALYST 27, 228
Portia-28..... 171, 183, 203
posaconazole 12
pot & sod cit-cit ac 126
potassium chloride 131
potassium chloride crys er
..... 130
potassium chloride er.. 130,
131
potassium citrate er 126
potassium citrate-citric
acid 126
potassium iodide
(expectorant)..... 240
PRALUENT..... 75
pramipexole
dihydrochloride 103
PRAMOSONE 252, 254, 255,
260
prasugrel hcl..... 53
pravastatin sodium 73
praziquantel..... 9
prazosin hcl ... 41, 55, 56, 60
PRED MILD 141, 157
prednisolone..... 142, 157
prednisolone acetate ... 141,
157
prednisolone sodium
phosphate 142, 157
prednisone..... 157
PREDNISON INTENSOL
..... 157
pregabalin .. 85, 88, 100, 101
PREMARIN 183, 221
PREMPHASE 183, 203
PREMPRO 183, 203
prenatal 51, 131, 271, 275
prenatal gummies/dha & fa
..... 131, 232, 271, 275
PRENATAL MULTIVITAMIN
+ DHA... 51, 131, 232, 271,
275
prenatal one daily... 51, 131,
271, 275
prenatal plus ... 51, 131, 272,
275
prenatal vitamin and
mineral..... 51, 272, 276
prenatal vitamins.... 51, 131,
272, 276
prenatal/iron ... 51, 131, 272,
276
Prevalite 61
PREVIDENT... 117, 118, 221
PREVNAR 20..... 33
PREZCOBIX 18, 232
PREZISTA 18
PRIALT 85, 103
PRIFTIN 11, 24
primaquine phosphate 10
primidone..... 96
PRIORIX 33
probenecid..... 133, 220
prochamber vhc 123
prochlorperazine ... 109, 146
prochlorperazine maleate
..... 109, 146
PROCRIT 46, 48
PROCTOFOAM HC 142, 158,
253, 255, 261
Procto-Med Hc..... 142, 158,
253, 261
Proctosol Hc . 142, 158, 253,
261
Proctozone-Hc..... 142, 158,
253, 261
progesterone 203
PROGRAF 211, 230, 262
promethazine hcl 3, 4, 5, 94,
146, 149, 240
promethazine-codeine . 4, 5,
107, 238, 240
promethazine-dm . 4, 5, 238,
240
promethazine-
phenylephrine 4, 5, 35,
240
Promethegan .. 4, 5, 94, 146,
149, 241
PROMETHEGAN..... 4, 5, 95,
146, 149, 241
propafenone hcl 68

<i>propafenone hcl er</i> 68	<i>raloxifene hcl</i> 174, 221	<i>ritonavir</i> 18
<i>proparacaine hcl</i> 144	<i>ramipril</i> 58, 59	<i>rivastigmine tartrate</i> 42
<i>propranolol hcl</i> ... 40, 60, 66, 69, 75, 80, 93	<i>rasagiline mesylate</i> 102	<i>Rivelsa</i> 171, 183, 203
<i>propranolol hcl er</i> 40, 60, 66, 68, 75, 80, 93	REALITY LATEX	RIVIVE 2, 108
<i>propylthiouracil</i> 161	CONDOMS 234	<i>rizatriptan benzoate</i> 115
PROQUAD 33	REALITY LATEX/ULTRA	ROCKLATAN 137, 145
<i>protriptyline hcl</i> 117	TEXTURED 234	<i>ropinirole hcl</i> 103
<i>prucalopride succinate</i> . 150	REALITY LATEX/ULTRA	<i>ropivacaine hcl</i> 217
<i>pseudoeph-bromphen-dm</i> 5, 6, 35, 236, 238, 241	THIN 234	<i>ropivacaine hcl-nacl</i> 131, 217
PULMICORT FLEXHALER 158, 239, 243	REBIF 213, 228	<i>rosuvastatin calcium</i> 73
PULMOZYME 134, 242	REBIF TITRATION PACK 213, 228	<i>Rosyrax</i> 171, 183, 204
<i>pyrazinamide</i> 11	<i>Reclipsen</i> 171, 183, 203	<i>rufinamide</i> 88, 102
<i>pyridostigmine bromide</i> .42	RECOMBIVAX HB 33	RUKOBIA 14
<i>pyridostigmine bromide er</i> 42	REGENECARE 123, 255, 256, 267	RYBELSUS 189
<i>pyridoxine hcl</i> 276	RELENZA DISKHALER ... 20	S
<i>pyrimethamine</i> 10	<i>releuko</i> 49	<i>sacubitril-valsartan</i> .. 56, 57, 77
Q	RELION TRUE MET AIR	<i>salicylic acid</i> 263
<i>qc aspirin low dose</i> .. 53, 55, 93, 114	GLUC METER 123	<i>saline bacteriostatic</i> 131
<i>qc nicotine transdermal</i> <i>system</i> 39, 46	RELION TRUE METRIX	<i>salsalate</i> 114
<i>qc prenatal</i> 51, 272, 276	TEST STRIPS 124	SANDIMMUNE 137, 211, 224, 229, 230
QELBREE 99, 111	RELISTOR 108, 150, 152	SANTYL 134, 257, 267
<i>quazepam</i> 98	RENAL 272, 276, 278	SAVELLA 101, 114
<i>quetiapine fumarate</i> .. 90, 95	<i>renal vitamin</i> .. 272, 276, 278	SELARSDI 214
<i>quetiapine fumarate er</i> ... 90, 95	<i>rena-vite</i> 272, 276, 278	<i>selegiline hcl</i> 102
QUICKVUE AT-HOME	<i>rena-vite rx</i> 272, 276, 278	<i>selenium sulfide</i> ... 255, 256, 263, 264
COVID-19 TEST .. 123, 125	RENFLEXIS ... 150, 212, 216, 224, 228, 267	SELZENTRY 14
<i>quinapril hcl</i> 58, 59	<i>reno caps</i> 272, 276, 278	Sensorcaine/Epinephrine 35, 217
<i>quinapril-</i> <i>hydrochlorothiazide</i> ... 58, 59, 79, 133	<i>repaglinide</i> 192	Sensorcaine-Mpf 218
<i>quinidine gluconate er</i> ... 10, 67	REPATHA 59, 75	Sensorcaine- Mpf/Epinephrine ... 35, 218
<i>quinidine sulfate</i> 10, 67	REPATHA SURECLICK .. 60, 75	SENSORCAINE- MPF/EPINEPHRINE 35, 218
<i>quinine sulfate</i> 10	RETACRIT 46, 49	SEREVENT DISKUS 43, 245
<i>quintabs</i> 272, 276	RETROVIR 17	SEROSTIM 194, 209
QUVIVIQ 109	REVLIMID 27, 229	<i>sertraline hcl</i> 115
QVAR REDHALER 158, 239, 243	REXTOVY 2, 108	<i>Setlakin</i> 171, 184, 204
R	REYATAZ 18	<i>sevelamer carbonate</i> 3, 128, 219
RABAVERT 33	REZVOGLAR KWIKPEN 192	<i>sevelamer hcl</i> 3, 128, 219
<i>rabeprazole sodium</i> 153	RHOGAM ULTRA-	sf118 , 221
RADIAPLEXRX 123, 267	FILTERED PLUS 29	sf 5000 plus 117, 118, 221
	<i>ribavirin</i> 21	SFROWASA 147
	<i>rifabutin</i> 11, 24	<i>Sharobel</i> 171, 204
	<i>rifampin</i> 12, 24	SHINGRIX 33
	<i>riluzole</i> 84, 99	
	<i>rimantadine hcl</i> 7	
	<i>ringers irrigation</i> 127	
	<i>risedronate sodium</i> 221	
	<i>risperidone</i> 90, 95	

SIKLOS..... 27
sildenafil citrate..... 76, 243, 245, 246, 269
SILIQ..... 262, 267
silver nitrate..... 137, 264
silver sulfadiazine . 256, 264
SIMLANDI (1 PEN) 150, 216, 224, 229
SIMLANDI (2 PEN) 151, 216, 225, 229
SIMLANDI (2 SYRINGE) 151, 216, 225, 229
Simliya 171, 184, 204
Simpesse 171, 184, 204
SIMPONI. 151, 216, 225, 229
SIMPONI ARIA 151, 216, 225, 229
simvastatin 73
sirolimus 214, 230, 262
SKYLA..... 160, 171, 204
SLYND..... 160, 171, 204
sm nicotine 39, 46
sm nicotine polacrilex ... 39, 46
sod citrate-citric acid 126
sodium chloride ... 123, 127, 131, 242
sodium chloride (pf)..... 131
sodium chloride bacteriostatic 131
sodium fluoride 118, 221, 222
sodium fluoride 5000 plus 118, 221
sodium phenylbutyrate. 126
sodium sulfacetamide . 249, 264
sofosbuvir-velpatasvir ... 13, 14
solifenacin succinate 268
SOMAVERT..... 209
sorafenib tosylate 28
sorbitol..... 148
sorbitol-mannitol... 127, 128
sotalol hcl40, 61, 67, 69, 75, 80
sotalol hcl (af)40, 61, 67, 69, 75, 80
SPIKEVAX..... 33
SPIKEVAX 6M-11Y 33
spinosad 265
SPIRIVA RESPIMAT 37, 237
spironolactone ... 73, 74, 77, 128
spironolactone-hctz . 73, 74, 77, 79, 128, 133
Sprintec 28..... 171, 184, 204
Sronyx 171, 184, 204
sss 10-5..... 249, 263, 264
STEGLUJAN 174, 208
sterile water for injection 236
sterile water for irrigation 127
STIMUFEND 49
STIOLTO RESPIMAT 37, 43, 237, 245
streptomycin sulfate ... 8, 12
stress formula 131, 272, 276, 278
STRIBILD..... 15, 17, 232
SUBLOCADE 108
Subvenite..... 88, 90
SUCRAID..... 134
sucralfate 152
sulfacetamide sodium... 136
sulfacetamide sodium-sulfur..... 249, 263, 264
sulfacetamide-prednisolone 136, 142
sulfacetamide-sulfur in urea 249, 263, 264
sulfadiazine..... 24
sulfamethoxazole-trimethoprim ... 10, 11, 24, 25
SULFAMYLON 249, 264
sulfasalazine... 24, 147, 212, 225, 229
sulindac..... 105, 112
sumatriptan succinate .. 115
sunitinib malate..... 28
SUNLENCA 11, 14
super b complex/fa/vit c 272, 276, 278
super b/c 272, 276, 278
super b-complex + vitamin c 272, 276, 278
super b-complex/vit c/fa 272, 276, 278
support..... 131, 272
SUPPORT-500..... 131, 272, 276, 278
sure comfort insulin syringe..... 123
sure comfort lancets 30g 123
sure comfort pen needles 123
SUTAB..... 148
Syeda..... 171, 184, 204
SYMPROIC 151, 152
SYMTUZA..... 18, 21, 232
SYNAREL..... 187, 189
SYNJARDY..... 162, 208
SYNJARDY XR..... 162, 208
SYNTHROID 210
T
TAB-A-VITE 51, 131, 272, 276
TABLOID 28
tacrolimus 211, 231, 262, 267
tadalafil..... 76, 243
tadalafil (pah) ... 76, 243, 246
TAKE ACTION 160, 171, 204
TALZENNA..... 28
tamoxifen citrate..... 28, 174
tamsulosin hcl 42
Tarina 24 Fe ... 171, 184, 204
Tarina Fe 1/20 Eq. 172, 184, 204
TASIGNA 28
Taysofy..... 172, 184, 204
tazarotene 263, 268
techlite insulin syringe . 123
TECHLITE PEN NEEDLES 123
TEGRETOL..... 88, 90
TEGRETOL-XR..... 88, 90
telmisartan 56, 57
telmisartan-hctz.. 56, 57, 79, 133
temazepam..... 98
temozolomide 28
TENIVAC 29
tenofovir disoproxil fumarate 18
terazosin hcl . 41, 55, 56, 61, 80

terbinafine hcl 7	tizanidine hcl 39	Tri-Linyah 172, 184, 205
terbutaline sulfate ... 43, 245	TOBRADEX 8, 136, 142	Tri-Lo-Estarylla 172, 184, 205
terconazole 256	tobramycin 8, 136	Tri-Lo-Marzia .. 172, 184, 205
teriparatide 193, 220	tobramycin-	Tri-Lo-Mili 172, 185, 205
testosterone 159, 161	dexamethasone 8, 136, 142	Tri-Lo-Sprintec 172, 185, 205
testosterone cypionate 159, 160, 161	TOBEX 8, 136	trimethobenzamide hcl . 147
testosterone enanthate 159, 161	TODAY SPONGE 234	trimethoprim 25
tetrabenazine 100, 117	tolcapone 99	Tri-Mili 172, 185, 205
tetracaine hcl 144, 218	tolterodine tartrate 268, 269	trimipramine maleate 117
tetracycline hcl . 10, 24, 147, 249	tolterodine tartrate er 268	TRINTELLIX 116
TEXACORT ... 142, 158, 253, 261	topiramate 88, 94	triphrocaps ... 272, 276, 278
TEZSPIRE 241, 244	toremifene citrate 28, 174	Tri-Sprintec 172, 185, 205
THALITONE 79, 133	torseamide 73, 128	TRIUMEQ 15, 18
THALOMID 28, 229	TRACLEER 82, 240, 246	triumeq pd 15, 18
THEO-24 .. 72, 111, 127, 246, 269	tramadol hcl 107	tri-vite pediatric 272, 273, 278, 279
theophylline 72, 111, 127, 246, 269	tramadol-acetaminophen	tri-vite/fluoride 118, 222, 272, 273, 278, 279
theophylline er 72, 111, 127, 246, 269	..... 85, 94, 103, 107	Trivora (28) 172, 185, 205
THERA 272	trandolapril 58, 59	Tri-Vylibra 172, 185, 205
thiamine hcl 276	tranylcypromine sulfate 102	Tri-Vylibra Lo . 172, 185, 205
thioridazine hcl 109	travoprost (bak free) 145	TROGARZO 14
thiothixene 116	trazodone hcl 116	tropicamide 145
thrivite rx 51, 272, 276	TRELEGY ELLIPTA .. 37, 43, 142, 158, 239	tropium chloride .. 268, 269
thyroid 210	TRELSTAR MIXJECT 28, 187, 188	tropium chloride er 268, 269
Tiadyt Er . 62, 64, 65, 70, 76, 82	treprostinil 82, 243, 246	TRUE METRIX AIR
tiagabine hcl 88, 101	tretinoin 28, 257	GLUCOSE METER 123
ticagrelor 53	tretinoin microsphere 28, 257	TRUE METRIX BLOOD
TICE BCG 28, 33	tretinoin microsphere	GLUCOSE TEST 124
TIGAN 147	pump 28, 257	TRUE METRIX METER .. 124
Tilia Fe 172, 184, 204	Tri Femynor ... 172, 184, 204	TRUE METRIX PRO BLOOD
timolol maleate ... 41, 61, 67, 69, 75, 80, 94, 138	triamcinolone acetonide	GLUCOSE 125
timolol maleate (once-daily)	..... 158, 253, 261	TRUEPLUS 5-BEVEL PEN
..... 40, 61, 69, 138	triamcinolone in absorbase	NEEDLES 124
Timolol Maleate OcuDose	..... 158, 253, 261	TRUEPLUS LANCETS 28G
..... 41, 61, 69, 138	triamterene 77, 129	..... 124
timolol maleate pf 41, 61, 69, 138	triamterene-hctz 77, 79, 129, 133	TRUEPLUS LANCETS 30G
tinidazole 11	triazolam 98	..... 124
tiopronin 232	tricitrates 126	TRUEPLUS LANCETS 33G
tiotropium bromide . 37, 237	Triderm 158, 253, 261	..... 124
TIVICAY 15	trientine hcl 154	TRUEPLUS SAFETY
TIVICAY PD 15	Tri-Estarylla ... 172, 184, 204	LANCETS 28G 124
	trifluoperazine hcl 109	TRUETRACK BLOOD
	trifluridine 138	GLUCOSE 124
	trigels-f forte 51, 276, 278	TRUETRACK TEST 125
	trihexyphenidyl hcl 37, 86	TRULANCE 151
	Tri-Legest Fe .. 172, 184, 205	TRULICITY 189

TRUMENBA	33	umecclidinium-vilanterol .	37,	vitamin b complex .	276, 278
TRUSTEX COLOR		43		vitamin d (ergocalciferol)	
CONDOMS + LUBE	234	UNIFINE PENTIPS PLUS	124	.....	279
TRUSTEX		Unithroid	210	vitamin k1	2, 219, 279
LUB/RIBBED/STUDED		UPTRAVI	83, 246	VIVITROL .	1, 3, 46, 108, 218,
.....	234	UPTRAVI TITRATION	83,	219	
TRUSTEX		246		VIVOTIF	34
LUB/SPERMICIDE EX ST		ursodiol	148	VOCABRIA	15
.....	234	UVADEX	265	Volnea	173, 185, 206
TRUSTEX		V		voriconazole	12
LUB/SPERMICIDE XL	234	valacyclovir hcl	21	VORTEX VALVED	
TRUSTEX LUBRICATED	234	valganciclovir hcl	22	HOLDING CHAMBER .	124
TRUSTEX LUBRICATED EX		valproic acid 88, 90, 94, 101		VYALEV	100
LARGE	234	valsartan	56, 57	Vyfemla	173, 186, 206
TRUSTEX LUBRICATED		valsartan-		Vylibra	173, 186, 206
EXTRA ST	234	hydrochlorothiazide ...	56,	W	
TRUSTEX		57, 79, 133		warfarin sodium	47
LUBRICATED/SPERMICI		Valtva 1/50	173, 185, 205	water for irrigation, sterile	
DE	234	vancomycin hcl	13	.....	127
TRUSTEX NATURAL		VAQTA	34	Wera	173, 186, 206
CONDOMS + LUBE	234	varenicline tartrate	39, 46	wescaps	273, 277, 278
TRUSTEX NON-		varenicline tartrate (starter)		wes-phos 250 neutral	132
LUBRICATED	234	.....	39, 46	westab plus	51, 132, 273,
TRUSTEX RIA		VARIVAX	34	277	
LUB/SPERMICIDE	235	VAXELIS	29, 34	WIDE-SEAL DIAPHRAGM	
TRUSTEX RIA		VAXNEUVANCE	34	60	235
LUBRICATED	235	v-c forte	131, 272, 276	WIDE-SEAL DIAPHRAGM	
TRUSTEX RIA NON-		VCF VAGINAL		65	235
LUBRICATED	235	CONTRACEPTIVE	235	WIDE-SEAL DIAPHRAGM	
TRUSTEX-NONOXYNOL-		VECAMYL	80	70	235
9/RIB/STUD	235	VELIVET	173, 185, 205	WIDE-SEAL DIAPHRAGM	
TWINRIX	33	VELTASSA	128	75	235
TWIRLA	173, 185, 205	VEMLIDY	22	WIDE-SEAL DIAPHRAGM	
TYBLUME	173, 185, 205	venlafaxine hcl	114	80	235
TYBOST	232	venlafaxine hcl er	114	WIDE-SEAL DIAPHRAGM	
Tydemy ..	173, 185, 205, 276	verapamil hcl 62, 64, 65, 70,		85	235
TYENNE	214	77, 83		WIDE-SEAL DIAPHRAGM	
TYPHIM VI	34	verapamil hcl er ..	62, 64, 65,	90	235
TYRVAYA	46, 143	70, 76, 77, 83		WIDE-SEAL DIAPHRAGM	
TYVASO	82, 243, 246	VERQUVO	67, 83	95	235
TYVASO REFILL KIT	82,	VERZENIO	28	Wixela Inhub ...	43, 142, 158,
243, 246		Vestura	173, 185, 206	240	
TYVASO STARTER KIT ..	82,	VIC-FORTE	131, 272, 276	Wymzya Fe	173, 186, 206
243, 246		VICTOZA	86, 189	X	
U		Vienna	173, 185, 206	XALKORI	28
UBRELVY	99	viorele	173, 185, 206	XARELTO	47
UDENYCA	49	VIRACEPT	19	XARELTO STARTER PACK	
UDENYCA ONBODY	49	VIREAD	18	.....	47
ULTICARE MICRO PEN		VITALETS CHILDRENS ..	51,	XELJANZ	214, 225, 229
NEEDLES	124	132, 273, 278		XELJANZ XR ..	214, 225, 229

Xelria Fe 173, 186, 206
XEOMIN 39, 44, 232
XERAC AC 255
XIFAXAN 24
XIGDUO XR 162, 208
XIIDRA 138, 142
XOLAIR 213, 244
XTANDI 28, 29
XYLOCAINE-
 MPF/EPINEPHRINE 35,
 218
Y
YESINTEK 214

YEZTUGO 11, 14
Yuvafem 186, 221
Z
zafirlukast 241
zaleplon 95, 102
ZARXIO 49
ZELBORAF 29
Zenatane 263, 268
ZENPEP 134, 149
ZEPATIER 14
zidovudine 18
ZIEXTENZO 49
zionodil 255

ziprasidone hcl 90, 95
ziprasidone mesylate 90, 96
ZOLADEX 29, 188, 189
ZOLINZA 29
zolpidem tartrate 95, 102
zolpidem tartrate er. 95, 102
ZOMACTON 194, 209
zonisamide 88, 102
Zovia 1/35 (28) 173, 186, 206
Zumandimine. 173, 186, 206
ZYLET 136, 142