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Medicare Plus Blue<sup>SM</sup> PPO  
Essential, Vitality, Signature & Assure

## 2021 Plus Comprehensive Formulary

(List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT  
THE DRUGS WE COVER IN THIS PLAN.**

This formulary was updated on September 1, 2020. For more recent information or other questions, please contact us, **Medicare Plus Blue PPO** Customer Service, at 1-877-241-2583 or, for TTY users, 711, Monday through Friday, 8 a.m. to 9 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m. Eastern time, seven days a week, or visit [www.bcbsm.com/medicare](http://www.bcbsm.com/medicare).



When visiting your doctor(s), please bring your personal drug list, this 2021 Blue Cross Drug List (formulary) and your 2021 Rx Savings Guide with you.

*Updated: 09/01/2020  
Formulary 21362, Version 6*

[www.bcbsm.com/medicare](http://www.bcbsm.com/medicare)



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# Medicare Advantage Plans

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Blue Cross Blue Shield of Michigan. When it refers to “plan” or “our plan,” it means **Medicare Plus Blue PPO**.

This document includes a list of the drugs (formulary) for our plan which is current as of September 1, 2020. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2022, and from time to time during the year.

## What is the Medicare Plus Blue PPO Essential, Vitality, Signature & Assure Plus Formulary?

A formulary is a list of covered drugs selected by **Medicare Plus Blue PPO** in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. **Medicare Plus Blue PPO** will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a **Medicare Plus Blue PPO** network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

### Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

**Changes that can affect you this year:** In the below cases, you will be affected by coverage changes during the year:

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make

changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 31-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the **Medicare Plus Blue PPO Essential, Vitality, Signature & Assure Plus** Formulary?"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of September 1, 2020. To get updated information about the drugs covered by **Medicare Plus Blue PPO**, please contact us. Our contact information appears on the front and back cover pages. In the event of a mid-year non-maintenance formulary change, we will send out an errata sheet to notify you of this change.

## How do I use the Formulary?

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page Index 1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

**Medicare Plus Blue PPO** covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

## Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization: Medicare Plus Blue PPO** requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from **Medicare Plus Blue PPO** before you fill your prescriptions. If you don't get approval, **Medicare Plus Blue PPO** may not cover the drug.
- **Quantity Limits:** For certain drugs, **Medicare Plus Blue PPO** limits the amount of the drug that **Medicare Plus Blue PPO** will cover. For example, **Medicare Plus Blue PPO** provides thirty-one tablets per prescription for *pioglitazone*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, **Medicare Plus Blue PPO** requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, **Medicare Plus Blue PPO** may not cover Drug B unless you try Drug A first. If Drug A does not work for you, **Medicare Plus Blue PPO** will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explains our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask **Medicare Plus Blue PPO** to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the **Medicare Plus Blue PPO** formulary?" on page iii for information about how to request an exception.

## What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service and ask if your drug is covered.

If you learn that **Medicare Plus Blue PPO** does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by **Medicare Plus Blue PPO**. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by **Medicare Plus Blue PPO**.
- You can ask **Medicare Plus Blue PPO** to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the Medicare Plus Blue PPO Essential, Vitality, Signature & Assure Plus Formulary?

You can ask **Medicare Plus Blue PPO** to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- For **Medicare Plus Blue PPO**: You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, **Medicare Plus Blue PPO** limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, **Medicare Plus Blue PPO** will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

## What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31-day supply of medication. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you move into (or out of) a long-term care facility, a skilled nursing facility or if you are discharged from a hospital, you will continue to have access to your medications during the transition. If needed, limits on early prescription refills will be waived to assure that your medications are available through a new pharmacy provider when you are moving to or from a long-term care facility or a skilled nursing facility? Contact Customer Service if you require assistance in your transition. For more detailed information about our Transition Policy, refer to your Evidence of Coverage or visit our website at [www.bcbsm.com/medicare/help/forms-documents.html](http://www.bcbsm.com/medicare/help/forms-documents.html).

## For more information

For more detailed information about your **Medicare Plus Blue PPO** prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about **Medicare Plus Blue PPO**, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit [www.medicare.gov](http://www.medicare.gov).

## Medicare Plus Blue PPO Essential, Vitality, Signature & Assure Plus Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by **Medicare Plus Blue PPO**. If you have trouble finding your drug in the list, turn to the Index that begins on page Index 1.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., ENTRESTO®) and generic drugs are listed in lower-case italics (e.g., *pioglitazone*).

The information in the Requirements/Limits column tells you if **Medicare Plus Blue PPO** has any special requirements for coverage of your drug.

## Tier Descriptions

Medicare Plus Blue PPO Drug Tier Costs							
Tier	Drug Description	Up to a 31-day supply				Up to a 90-day supply*	
		Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)	Long-term care (LTC) cost sharing	Out-of network cost sharing	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
<b>Tier 1</b>	Preferred Generic	See your <i>Evidence of Coverage</i> Chart for member cost-share details					
<b>Tier 2</b>	Generic						
<b>Tier 3</b>	Preferred Brand						
<b>Tier 4</b>	Non-Preferred Drug						
<b>Tier 5</b>	Specialty Tier	See your <i>Evidence of Coverage</i> Chart for member cost-share details				90-day supply is not available	
<b>Tier 6</b>	Select Care Drugs	See your <i>Evidence of Coverage</i> Chart for member cost-share details					

Out-of-network pharmacy coverage is limited to certain situations. Consult your *Evidence of Coverage* for details.

\*Most pharmacies will fill a 90-day supply of medication. Check with your pharmacist.

## Drug Notes Code Definitions

Symbol	Definition
<b>HRM</b>	High Risk Medication. Medicine that may be unsafe in patients greater than 65 years of age. Our formulary does include coverage for some of these drugs, but alternatives may be found on the formulary. Please discuss with your doctor if there are alternatives to these medications that would be appropriate for you to use.
<b>B/D</b>	This prescription drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
<b>EX</b>	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count toward your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving Extra Help to pay for your prescriptions, you will not get any extra help to pay for this drug.
<b>LA</b>	Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, call <b>Medicare Plus Blue PPO</b> Customer Service at 1-877-241-2583, Monday through Friday, 8 a.m. to 9 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m. Eastern time, seven days a week. TTY users should call 711.
<b>PA</b>	Prior Authorization. The plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don't get approval, we may not cover the drug.
<b>QL</b>	Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.
<b>ST</b>	Step Therapy. In some cases, the plan requires you to first try a certain drug to treat your condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
<b>NEDS</b>	Non-Extended Day Supply. These drugs are not offered at a 90-day supply. They are offered up to a 31-day supply.

Drug Name	Drug Tier	Requirements /Limits
<b>ANALGESICS</b>		
<b>NONSTEROIDAL ANTI-INFLAMMATORY DRUGS</b>		
<i>celecoxib oral capsule 100 mg</i>	2	QL (270 per 90 days)
<i>celecoxib oral capsule 200 mg, 400 mg</i>	2	QL (180 per 90 days)
<i>celecoxib oral capsule 50 mg</i>	2	QL (540 per 90 days)
DICLOFENAC EPOLAMINE TRANSDERMAL PATCH 12 HOUR	4	PA; HRM
<i>diclofenac potassium oral tablet</i>	2	HRM
<i>diclofenac sodium oral tablet extended release 24 hr</i>	2	HRM
<i>diclofenac sodium oral tablet, delayed release (dr/ec)</i>	2	HRM
<i>diclofenac sodium topical gel 1 %</i>	2	HRM; QL (1000 per 31 days)
<i>diclofenac-misoprostol oral tablet, ir, delayed rel, biphasic</i>	2	
<i>diflunisal oral tablet</i>	2	HRM
<i>ec-naproxen oral tablet, delayed release (dr/ec)</i>	2	HRM

Drug Name	Drug Tier	Requirements /Limits
<i>etodolac oral capsule</i>	2	HRM
<i>etodolac oral tablet</i>	2	HRM
<i>etodolac oral tablet extended release 24 hr</i>	2	HRM
<i>fenoprofen oral tablet</i>	2	HRM
FLECTOR TRANSDERMAL PATCH 12 HOUR	4	PA; HRM
<i>flurbiprofen oral tablet 100 mg</i>	2	
<i>ibu oral tablet 400 mg</i>	2	HRM
<i>ibu oral tablet 600 mg, 800 mg</i>	1	HRM
<i>ibuprofen oral suspension</i>	2	HRM
<i>ibuprofen oral tablet 400 mg</i>	2	HRM
<i>ibuprofen oral tablet 600 mg, 800 mg</i>	1	HRM
<i>ketoprofen oral capsule</i>	2	HRM
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	2	HRM; QL (90 per 90 days)
<i>meclofenamate oral capsule</i>	4	HRM
<i>mefenamic acid oral capsule</i>	3	HRM
<i>meloxicam oral tablet</i>	1	HRM

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are lower-case italics.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>nabumetone oral tablet</i>	2	HRM
<i>naproxen oral suspension</i>	2	HRM
<i>naproxen oral tablet</i>	2	HRM
<i>naproxen oral tablet, delayed release (dr/ec)</i>	2	HRM
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	HRM
<i>oxaprozin oral tablet</i>	2	HRM
<i>piroxicam oral capsule</i>	2	HRM
<i>salsalate oral tablet 750 mg</i>	2	
<i>sulindac oral tablet</i>	2	HRM
<i>tolmetin oral capsule</i>	2	HRM
<i>tolmetin oral tablet 600 mg</i>	2	HRM
<b>OPIOID ANALGESICS, LONG-ACTING</b>		
<i>buprenorphine transdermal patch weekly</i>	4	QL (12 per 84 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	4	QL (45 per 90 days)
<i>levorphanol tartrate oral tablet 2 mg</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>methadone oral solution</i>	2	
<i>methadone oral tablet</i>	2	
<i>morphine intravenous syringe 2 mg/ml</i>	4	
<i>morphine oral capsule, extended release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	4	QL (180 per 90 days)
<i>morphine oral tablet extended release 100 mg, 15 mg, 30 mg, 60 mg</i>	4	QL (270 per 90 days)
<i>morphine oral tablet extended release 200 mg</i>	4	QL (90 per 90 days)
<i>oxycodone oral tablet extended release 12 hr</i>	4	QL (180 per 90 days)
<i>tramadol oral tablet extended release 24 hr</i>	2	QL (90 per 90 days)
<i>tramadol oral tablet, extended release 24 hr</i>	2	QL (90 per 90 days)
<b>OPIOID ANALGESICS, SHORT-ACTING</b>		
<i>acetaminophen-codeine oral solution 120 mg-12 mg /5 ml (5 ml), 120-12 mg/5 ml, 300 mg-30 mg /12.5 ml</i>	2	QL (5167 per 31 days)

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are lower-case italics.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	2	QL (1080 per 90 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	2	QL (540 per 90 days)
<i>butorphanol nasal spray, non-aerosol</i>	2	QL (15 per 90 days)
<i>codeine sulfate oral tablet</i>	2	QL (540 per 90 days)
<i>duramorph (pf) injection solution 0.5 mg/ml</i>	4	QL (4133 per 31 days)
<i>duramorph (pf) injection solution 1 mg/ml</i>	4	QL (6000 per 90 days)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (1080 per 90 days)
<i>fentanyl citrate buccal lozenge on a handle</i>	5	PA; NEDS
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml (15 ml)</i>	2	QL (185 per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	2	QL (5735 per 31 days)

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	2	QL (1080 per 90 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	2	QL (450 per 90 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	4	
<i>hydromorphone injection solution 1 mg/ml</i>	4	
<i>hydromorphone injection solution 2 mg/ml</i>	2	
<i>hydromorphone injection syringe 1 mg/ml, 2 mg/ml, 4 mg/ml</i>	4	
<i>hydromorphone oral liquid</i>	2	
<i>hydromorphone oral tablet</i>	2	
<i>ibuprofen-oxycodone oral tablet</i>	2	QL (360 per 90 days)
<i>lorcet (hydrocodone) oral tablet</i>	2	QL (1080 per 90 days)
<i>lorcet hd oral tablet</i>	2	QL (1080 per 90 days)

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>lorcet plus oral tablet 7.5-325 mg</i>	2	QL (1080 per 90 days)
<i>morphine (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	4	
<i>morphine concentrate oral solution</i>	2	
<i>morphine intravenous solution 4 mg/ml</i>	4	
<i>morphine oral solution</i>	2	
<i>morphine oral tablet</i>	2	
<i>nalbuphine injection solution 10 mg/ml</i>	2	QL (6.67 per 1 day)
<i>nalbuphine injection solution 20 mg/ml</i>	2	QL (3.34 per 1 day)
NUCYNTA ORAL TABLET 100 MG	4	QL (543 per 90 days)
NUCYNTA ORAL TABLET 50 MG	4	QL (1086 per 90 days)
NUCYNTA ORAL TABLET 75 MG	4	QL (726 per 90 days)
<i>oxycodone oral capsule</i>	2	
<i>oxycodone oral solution</i>	4	
<i>oxycodone oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (1080 per 90 days)
<i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i>	2	
<i>oxycodone-aspirin oral tablet</i>	2	QL (1080 per 90 days)
<i>oxymorphone oral tablet</i>	4	
<i>tramadol oral tablet 50 mg</i>	2	QL (720 per 90 days)
<i>tramadol-acetaminophen oral tablet</i>	2	QL (1080 per 90 days)

## ANESTHETICS

### LOCAL ANESTHETICS

<i>lidocaine topical adhesive patch, medicated 5 %</i>	3	PA; QL (270 per 90 days)
<i>lidocaine-prilocaine topical cream</i>	4	

## ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

### ALCOHOL DETERRENTS/ANTI-CRAVING

<i>acamprosate oral tablet, delayed release (dr/ec)</i>	2	
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**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>disulfiram oral tablet</i>	2	
<b>OPIOID DEPENDENCE</b>		
<i>buprenorphine hcl sublingual tablet</i>	1	
<i>buprenorphine-naloxone sublingual film</i>	1	
<i>buprenorphine-naloxone sublingual tablet</i>	1	
<i>naltrexone oral tablet</i>	1	
<b>OPIOID REVERSAL AGENTS</b>		
<i>naloxone injection solution</i>	1	
<i>naloxone injection syringe 0.4 mg/ml</i>	2	
<i>naloxone injection syringe 1 mg/ml</i>	1	
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	3	
<b>SMOKING CESSATION AGENTS</b>		
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr</i>	2	
CHANTIX CONTINUING MONTH BOX ORAL TABLET	3	

Drug Name	Drug Tier	Requirements /Limits
CHANTIX ORAL TABLET	3	
CHANTIX STARTING MONTH BOX ORAL TABLETS, DOSE PACK	3	
NICOTROL INHALATION CARTRIDGE	4	
NICOTROL NS NASAL SPRAY, NON-AEROSOL	4	
<b>ANTIBACTERIALS</b>		
<b>AMINOGLYCOSIDES</b>		
<i>amikacin injection solution 500 mg/2 ml</i>	4	
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION	5	PA; NEDS
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	4	
<i>gentamicin injection solution 40 mg/ml</i>	4	
<i>gentamicin sulfate (ped) (pf) injection solution</i>	4	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>gentamicin topical cream</i>	2	
<i>gentamicin topical ointment</i>	2	
<i>neomycin oral tablet</i>	2	
<i>paromomycin oral capsule</i>	2	
<i>tobramycin sulfate injection recon soln</i>	4	
<i>tobramycin sulfate injection solution</i>	4	
<b>ANTIBACTERIALS, OTHER</b>		
<i>acetic acid otic (ear) solution</i>	2	
<i>aztreonam injection recon soln 1 gram</i>	4	
<i>clindamycin hcl oral capsule</i>	2	
CLINDAMYCIN IN 0.9 % SOD CHLOR INTRAVENOUS PIGGYBACK	4	
<i>clindamycin in 5 % dextrose intravenous piggyback</i>	4	
<i>clindamycin palmitate hcl oral recon soln</i>	4	
<i>clindamycin pediatric oral recon soln</i>	4	
<i>clindamycin phosphate injection solution</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	4	
<i>colistin (colistimethate na) injection recon soln</i>	4	
<i>daptomycin intravenous recon soln 500 mg</i>	5	NEDS
FIRVANQ ORAL RECON SOLN	4	
<i>linezolid in dextrose 5% intravenous piggyback</i>	5	NEDS
<i>linezolid oral suspension for reconstitution</i>	2	QL (1680 per 28 days)
<i>linezolid oral tablet</i>	4	QL (56 per 28 days)
<i>linezolid-0.9% sodium chloride intravenous parenteral solution</i>	5	NEDS
<i>methenamine hippurate oral tablet</i>	2	
<i>metro i.v. intravenous piggyback</i>	4	
<i>metronidazole in nacl (iso-os) intravenous piggyback</i>	4	
<i>metronidazole oral capsule</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>metronidazole oral tablet</i>	2	
<i>metronidazole topical cream</i>	2	
<i>metronidazole topical gel</i>	2	
<i>metronidazole topical gel with pump</i>	2	
<i>metronidazole topical lotion</i>	2	
<i>metronidazole vaginal gel</i>	2	
MONUROL ORAL PACKET	4	
<i>neomycin-polymyxin b gu irrigation solution</i>	4	
<i>nitrofurantoin macrocrystal oral capsule</i>	2	HRM
<i>nitrofurantoin monohyd/m-cryst oral capsule</i>	2	HRM
<i>nitrofurantoin oral suspension</i>	2	HRM
<i>polymyxin b sulfate injection recon soln</i>	4	
<i>tinidazole oral tablet</i>	2	
<i>trimethoprim oral tablet</i>	2	
VANCOMYCIN INJECTION RECON SOLN	4	

Drug Name	Drug Tier	Requirements /Limits
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	4	
<i>vancomycin oral capsule 125 mg</i>	4	QL (360 per 90 days)
<i>vancomycin oral capsule 250 mg</i>	4	QL (720 per 90 days)
<i>vancomycin oral recon soln</i>	4	
<i>vandazole vaginal gel</i>	2	
XENLETA ORAL TABLET	5	NEDS
XIFAXAN ORAL TABLET 550 MG	5	PA; QL (270 per 90 days); NEDS
<b>BETA-LACTAM, CEPHALOSPORINS</b>		
<i>cefaclor oral capsule</i>	2	
<i>cefaclor oral tablet extended release 12 hr</i>	2	
<i>cefadroxil oral capsule</i>	2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	2	
<i>cefadroxil oral tablet</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml</i>	4	
<i>cefazolin injection recon soln 1 gram, 10 gram, 100 gram, 300 g, 500 mg</i>	4	
<i>cefazolin intravenous recon soln</i>	4	
<i>cefdinir oral capsule</i>	2	
<i>cefdinir oral suspension for reconstitution</i>	2	
<b>CEFEPIME IN DEXTROSE 5 % INTRAVENOUS PIGGYBACK 1 GRAM/50 ML</b>	4	
<i>cefepime in dextrose, iso-osm intravenous piggyback 1 gram/50 ml</i>	4	
<i>cefepime injection recon soln 1 gram</i>	4	
<i>cefixime oral capsule</i>	2	
<i>cefixime oral suspension for reconstitution</i>	2	
<i>cefotaxime injection recon soln 1 gram</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>cefoxitin in dextrose, iso-osm intravenous piggyback</i>	4	
<i>cefoxitin intravenous recon soln</i>	4	
<i>cefpodoxime oral suspension for reconstitution</i>	2	
<i>cefpodoxime oral tablet</i>	2	
<i>cefprozil oral suspension for reconstitution</i>	2	
<i>cefprozil oral tablet</i>	2	
<i>ceftazidime injection recon soln 6 gram</i>	4	
<i>ceftriaxone in dextrose, iso-os intravenous piggyback</i>	4	
<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	4	
<i>ceftriaxone intravenous recon soln</i>	4	
<i>cefuroxime axetil oral tablet</i>	2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	4	
<i>cefuroxime sodium intravenous recon soln</i>	4	

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Drug Name	Drug Tier	Requirements /Limits
<i>cephalexin oral capsule 250 mg, 500 mg</i>	1	
<i>cephalexin oral suspension for reconstitution</i>	1	
<i>cephalexin oral tablet</i>	1	
FETROJA INTRAVENOUS RECON SOLN	5	NEDS
TEFLARO INTRAVENOUS RECON SOLN	4	
<b>BETA-LACTAM, PENICILLINS</b>		
<i>amoxicillin oral capsule</i>	1	
<i>amoxicillin oral suspension for reconstitution</i>	1	
<i>amoxicillin oral tablet</i>	1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	2	
<i>amoxicillin-pot clavulanate oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	2	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	2	
<i>ampicillin oral capsule</i>	2	
<i>ampicillin sodium injection recon soln 1 gram, 125 mg, 250 mg, 500 mg</i>	4	
<i>ampicillin sodium intravenous recon soln</i>	4	
<i>ampicillin-sulbactam injection recon soln</i>	4	
<i>ampicillin-sulbactam intravenous recon soln</i>	4	
BICILLIN C-R INTRAMUSCULAR SYRINGE	4	
BICILLIN L-A INTRAMUSCULAR SYRINGE	4	
<i>dicloxacillin oral capsule</i>	2	
<i>nafcillin in dextrose iso-osm intravenous piggyback 1 gram/50 ml</i>	4	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>nafcillin injection recon soln 1 gram, 10 gram</i>	4	
<i>nafcillin intravenous recon soln 1 gram</i>	4	
<i>oxacillin in dextrose(iso-osm) intravenous piggyback</i>	4	
<i>oxacillin injection recon soln</i>	4	
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	4	
<i>penicillin g sodium injection recon soln</i>	4	
<i>penicillin v potassium oral recon soln</i>	1	
<i>penicillin v potassium oral tablet</i>	1	
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram</i>	4	
<b>CARBAPENEMS</b>		
<i>ertapenem injection recon soln</i>	4	
<i>imipenem-cilastatin intravenous recon soln</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>meropenem intravenous recon soln</i>	4	
MEROPENEM-0.9% SODIUM CHLORIDE INTRAVENOUS PIGGYBACK	4	
<b>MACROLIDES</b>		
<i>azithromycin intravenous recon soln</i>	4	
<i>azithromycin oral packet</i>	2	
<i>azithromycin oral suspension for reconstitution</i>	2	
<i>azithromycin oral tablet</i>	2	
<i>clarithromycin oral suspension for reconstitution</i>	2	
<i>clarithromycin oral tablet</i>	2	
<i>clarithromycin oral tablet extended release 24 hr</i>	2	
DIFICID ORAL TABLET	5	QL (20 per 10 days); NEDS
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	4	

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Drug Name	Drug Tier	Requirements /Limits
<i>erythrocin (as stearate) oral tablet 250 mg</i>	2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	2	
<i>erythromycin ethylsuccinate oral tablet</i>	2	
<i>erythromycin oral capsule, delayed release(dr/ec)</i>	2	
<i>erythromycin oral tablet</i>	2	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	2	
<b>QUINOLONES</b>		
<i>ciprofloxacin hcl oral tablet 100 mg, 750 mg</i>	2	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg</i>	1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	4	
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>levofloxacin intravenous solution</i>	4	
<i>levofloxacin oral solution</i>	2	
<i>levofloxacin oral tablet</i>	2	
<i>moxifloxacin oral tablet</i>	2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	2	
<b>SULFONAMIDES</b>		
<i>sulfacetamide sodium (acne) topical suspension</i>	2	
<i>sulfadiazine oral tablet</i>	2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1	
<b>TETRACYCLINES</b>		
<i>demeclocycline oral tablet</i>	4	
<i>doxy-100 intravenous recon soln</i>	4	
<i>doxycycline hyclate intravenous recon soln</i>	4	
<i>doxycycline hyclate oral capsule</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	2	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	2	
<i>minocycline oral capsule</i>	2	
<i>minocycline oral tablet</i>	2	
<i>morgidox oral capsule 100 mg</i>	2	
<i>tetracycline oral capsule</i>	2	

## ANTICONVULSANTS

### ANTICONVULSANTS, OTHER

BRIVIACT ORAL SOLUTION	5	PA; QL (620 per 31 days); NEDS
BRIVIACT ORAL TABLET	5	PA; QL (62 per 31 days); NEDS
<i>divalproex oral capsule, delayed rel sprinkle</i>	2	
<i>divalproex oral tablet extended release 24 hr</i>	2	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	2	
EPIDIOLEX ORAL SOLUTION	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>felbamate oral suspension</i>	4	
<i>felbamate oral tablet</i>	4	
FYCOMPA ORAL SUSPENSION	4	
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	5	NEDS
FYCOMPA ORAL TABLET 2 MG	4	
<i>lamotrigine oral tablet</i>	2	
<i>lamotrigine oral tablet extended release 24hr</i>	4	
<i>lamotrigine oral tablet, chewable dispersible</i>	2	
<i>lamotrigine oral tablet, disintegrating</i>	4	
<i>lamotrigine oral tablets, dose pack</i>	2	
<i>levetiracetam oral solution</i>	2	
<i>levetiracetam oral tablet</i>	2	
<i>levetiracetam oral tablet extended release 24 hr</i>	2	
<i>roweepra oral tablet</i>	2	
<i>roweepra xr oral tablet extended release 24 hr</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
SPRITAM ORAL TABLET FOR SUSPENSION	4	
<i>subvenite oral tablet</i>	2	
<i>subvenite starter (blue) kit oral tablets,dose pack</i>	2	
<i>subvenite starter (green) kit oral tablets,dose pack</i>	2	
<i>subvenite starter (orange) kit oral tablets,dose pack</i>	2	
<i>topiramate oral capsule, sprinkle</i>	2	
<i>topiramate oral tablet</i>	2	
<i>valproic acid (as sodium salt) oral solution</i>	2	
<i>valproic acid oral capsule</i>	2	
XCOPRI MAINTENANCE PACK ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	4	PA; QL (168 per 84 days)
XCOPRI MAINTENANCE PACK ORAL TABLET 350 MG/DAY (200 MG X1-150MG X1)	5	PA; QL (56 per 28 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
XCOPRI ORAL TABLET 100 MG, 50 MG	5	PA; QL (31 per 31 days); NEDS
XCOPRI ORAL TABLET 150 MG, 200 MG	5	PA; QL (62 per 31 days); NEDS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	PA; QL (84 per 84 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	PA; QL (28 per 28 days); NEDS
<b>CALCIUM CHANNEL MODIFYING AGENTS</b>		
CELONTIN ORAL CAPSULE 300 MG	3	
<i>ethosuximide oral capsule</i>	2	
<i>ethosuximide oral solution</i>	2	
<b>GAMMA-AMINO BUTYRIC ACID (GABA) AUGMENTING AGENTS</b>		
<i>clobazam oral suspension</i>	4	PA; QL (1440 per 90 days)
<i>clobazam oral tablet 10 mg</i>	4	PA; QL (180 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>clobazam oral tablet 20 mg</i>	3	PA; QL (62 per 31 days)
DIASTAT ACUDIAL RECTAL KIT	4	HRM
DIASTAT RECTAL KIT	4	HRM
<i>diazepam rectal kit</i>	4	HRM
<i>gabapentin oral capsule</i>	2	QL (810 per 90 days)
<i>gabapentin oral solution</i>	2	QL (6480 per 90 days)
<i>gabapentin oral tablet 600 mg</i>	2	QL (540 per 90 days)
<i>gabapentin oral tablet 800 mg</i>	2	QL (360 per 90 days)
NAYZILAM NASAL SPRAY, NON- AEROSOL	4	
<i>phenobarbital oral elixir</i>	2	HRM
<i>phenobarbital oral tablet</i>	2	HRM
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 50 mg</i>	4	QL (270 per 90 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	4	QL (180 per 90 days)
<i>pregabalin oral capsule 25 mg, 75 mg</i>	4	QL (360 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>pregabalin oral solution</i>	4	QL (2700 per 90 days)
<i>primidone oral tablet</i>	2	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PA; NEDS
SYMPAZAN ORAL FILM 5 MG	4	PA
<i>tiagabine oral tablet</i>	4	
VALTOCO NASAL SPRAY, NON- AEROSOL	4	
<i>vigabatrin oral powder in packet</i>	5	PA; LA; QL (186 per 31 days); NEDS
<i>vigabatrin oral tablet</i>	5	PA; QL (186 per 31 days); NEDS
<i>vigadrone oral powder in packet</i>	5	PA; QL (186 per 31 days); NEDS
<b>SODIUM CHANNEL AGENTS</b>		
APTIOM ORAL TABLET	5	QL (62 per 31 days); NEDS
BANZEL ORAL SUSPENSION	5	NEDS
BANZEL ORAL TABLET	5	NEDS
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>carbamazepine oral suspension 100 mg/5 ml</i>	2	
<i>carbamazepine oral tablet</i>	2	
<i>carbamazepine oral tablet extended release 12 hr</i>	2	
<i>carbamazepine oral tablet, chewable</i>	2	
DILANTIN 30 MG ORAL CAPSULE	3	
<i>epitol oral tablet</i>	2	
<i>fosphenytoin injection solution 500 mg pe/10 ml</i>	2	
<i>oxcarbazepine oral suspension</i>	2	
<i>oxcarbazepine oral tablet</i>	2	
PEGANONE ORAL TABLET	3	
<i>phenytoin oral suspension</i>	2	
<i>phenytoin oral tablet, chewable</i>	2	
<i>phenytoin sodium extended oral capsule</i>	2	
VIMPAT ORAL SOLUTION	4	QL (3600 per 90 days)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	4	QL (180 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
VIMPAT ORAL TABLET 50 MG	4	QL (360 per 90 days)
<i>zonisamide oral capsule</i>	2	
<b>ANTIDEMENTIA AGENTS</b>		
<b>ANTIDEMENTIA AGENTS, OTHER</b>		
<i>ergoloid oral tablet</i>	2	
NAMZARIC ORAL CAP, SPRINKLE, ER 24HR DOSE PACK	3	
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR	3	
<b>CHOLINESTERASE INHIBITORS</b>		
<i>donepezil oral tablet 10 mg, 5 mg</i>	2	QL (90 per 90 days)
<i>donepezil oral tablet 23 mg</i>	4	QL (90 per 90 days)
<i>donepezil oral tablet, disintegrating</i>	4	QL (90 per 90 days)
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	2	QL (90 per 90 days)
<i>galantamine oral solution</i>	2	
<i>galantamine oral tablet</i>	2	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg</i>	2	QL (270 per 90 days)
<i>rivastigmine tartrate oral capsule 4.5 mg, 6 mg</i>	2	QL (180 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>rivastigmine transdermal patch 24 hour</i>	4	QL (90 per 90 days)
<b>N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST</b>		
<i>memantine oral capsule, sprinkle, er 24hr</i>	4	QL (90 per 90 days)
<i>memantine oral solution</i>	2	QL (1080 per 90 days)
<i>memantine oral tablet</i>	2	QL (180 per 90 days)
MEMANTINE ORAL TABLETS, DOSE PACK	3	QL (147 per 84 days)
NAMENDA TITRATION PAK ORAL TABLETS, DOSE PACK	3	QL (147 per 84 days)
NAMENDA XR ORAL CAP, SPRINKLE, ER 24HR DOSE PACK	4	QL (84 per 84 days)
<b>ANTIDEPRESSANTS</b>		
<b>ANTIDEPRESSANTS, OTHER</b>		
<i>bupropion hcl oral tablet</i>	2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	2	
<i>maprotiline oral tablet</i>	2	
<i>mirtazapine oral tablet</i>	2	
<i>mirtazapine oral tablet, disintegrating</i>	2	
<i>olanzapine-fluoxetine oral capsule</i>	4	
<b>MONOAMINE OXIDASE INHIBITORS</b>		
EMSAM TRANSDERMAL PATCH 24 HOUR	5	QL (31 per 31 days); NEDS
MARPLAN ORAL TABLET	4	
<i>phenelzine oral tablet</i>	2	
<i>tranylcypromine oral tablet</i>	4	
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS</b>		
<i>citalopram oral solution</i>	2	
<i>citalopram oral tablet</i>	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
DESVENLAFAXIN E ORAL TABLET EXTENDED RELEASE 24 HR	4	ST
<i>desvenlafaxine succinate oral tablet extended release 24 hr 100 mg</i>	3	QL (360 per 90 days)
<i>desvenlafaxine succinate oral tablet extended release 24 hr 25 mg, 50 mg</i>	3	QL (90 per 90 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE	4	
<i>duloxetine oral capsule, delayed release(dr/ec)</i>	2	QL (180 per 90 days)
<i>escitalopram oxalate oral solution</i>	2	
<i>escitalopram oxalate oral tablet</i>	2	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	4	ST
FETZIMA ORAL CAPSULE,EXTEN DED RELEASE 24 HR 120 MG, 80 MG	4	ST; QL (90 per 90 days)
FETZIMA ORAL CAPSULE,EXTEN DED RELEASE 24 HR 20 MG, 40 MG	4	ST; QL (180 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>fluoxetine oral capsule</i>	2	
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	2	
<i>fluoxetine oral solution</i>	4	
<i>fluoxetine oral tablet</i>	4	
<i>fluvoxamine oral capsule, extended release 24hr</i>	2	
<i>fluvoxamine oral tablet</i>	2	
<i>nefazodone oral tablet</i>	2	
<i>paroxetine hcl oral tablet</i>	2	HRM
<i>paroxetine hcl oral tablet extended release 24 hr</i>	2	HRM
<i>paroxetine mesylate(menop.sym ) oral capsule</i>	2	HRM
PAXIL ORAL SUSPENSION	4	ST; HRM
<i>sertraline oral concentrate</i>	2	
<i>sertraline oral tablet</i>	1	
<i>trazodone oral tablet</i>	1	
TRINTELLIX ORAL TABLET 10 MG	4	ST; QL (180 per 90 days)

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug  
5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B  
only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day  
Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy  
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This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
TRINTELLIX ORAL TABLET 20 MG	4	ST; QL (90 per 90 days)
TRINTELLIX ORAL TABLET 5 MG	4	ST; QL (360 per 90 days)
<i>venlafaxine oral capsule,extended release 24hr</i>	2	
<i>venlafaxine oral tablet</i>	2	
VIIBRYD ORAL TABLET	4	ST; QL (90 per 90 days)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	4	ST
<b>TRICYCLICS</b>		
<i>amitriptyline oral tablet</i>	2	PA; HRM
<i>amoxapine oral tablet</i>	2	HRM
<i>clomipramine oral capsule</i>	4	PA; HRM
<i>desipramine oral tablet</i>	4	HRM
<i>doxepin oral capsule</i>	3	PA; HRM
<i>doxepin oral concentrate</i>	3	PA; HRM
<i>imipramine hcl oral tablet</i>	2	PA; HRM
<i>imipramine pamoate oral capsule</i>	2	PA; HRM

Drug Name	Drug Tier	Requirements /Limits
<i>nortriptyline oral capsule</i>	2	HRM
<i>nortriptyline oral solution</i>	2	HRM
<i>protriptyline oral tablet</i>	2	HRM
<i>trimipramine oral capsule</i>	2	PA; HRM
<b>ANTIEMETICS</b>		
<b>ANTIEMETICS, OTHER</b>		
<i>compro rectal suppository</i>	2	
<i>droperidol injection solution</i>	2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	HRM
<i>prochlorperazine maleate oral tablet</i>	2	
<i>prochlorperazine rectal suppository</i>	2	
<i>promethazine oral syrup</i>	2	
<i>promethazine oral tablet</i>	2	
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	2	
<i>promethegan rectal suppository 25 mg, 50 mg</i>	2	
<i>scopolamine base transdermal patch 3 day</i>	4	HRM

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<b>EMETOGENIC THERAPY ADJUNCTS</b>		
<i>aprepitant oral capsule</i>	4	B/D PA
<i>aprepitant oral capsule, dose pack</i>	4	B/D PA
<i>dronabinol oral capsule</i>	4	B/D PA
EMEND ORAL SUSPENSION FOR RECONSTITUTION	4	B/D PA
<i>granisetron hcl oral tablet</i>	2	B/D PA
<i>ondansetron hcl oral solution</i>	4	B/D PA
<i>ondansetron hcl oral tablet</i>	2	B/D PA
<i>ondansetron oral tablet, disintegrating</i>	2	B/D PA
<b>ANTIFUNGALS</b>		
<b>ANTIFUNGALS</b>		
ABELCET INTRAVENOUS SUSPENSION	5	B/D PA; NEDS
AMBISOME INTRAVENOUS SUSPENSION FOR RECONSTITUTION	5	B/D PA; NEDS
<i>amphotericin b injection recon soln</i>	4	B/D PA

Drug Name	Drug Tier	Requirements /Limits
<i>caspofungin intravenous recon soln</i>	4	B/D PA
<i>ciclopirox topical cream</i>	2	
<i>ciclopirox topical suspension</i>	2	
<i>clotrimazole mucous membrane troche</i>	2	
<i>clotrimazole topical cream</i>	2	
<i>clotrimazole topical solution</i>	2	
<i>econazole topical cream</i>	3	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	5	NEDS
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	4	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	4	
<i>fluconazole oral suspension for reconstitution</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>fluconazole oral tablet</i>	2	
<i>flucytosine oral capsule</i>	2	
<i>griseofulvin microsize oral suspension</i>	2	
<i>griseofulvin microsize oral tablet</i>	2	
<i>griseofulvin ultramicrosize oral tablet</i>	2	
<i>itraconazole oral capsule</i>	4	
<i>itraconazole oral solution</i>	3	
<i>ketoconazole oral tablet</i>	2	
<i>ketoconazole topical cream</i>	2	QL (270 per 90 days)
<i>ketoconazole topical foam</i>	2	
<i>ketoconazole topical shampoo</i>	2	
<i>ketodan topical foam</i>	2	
MENTAX TOPICAL CREAM	4	
<i>miconazole-3 vaginal suppository</i>	2	
<i>naftifine topical cream</i>	2	
NOXAFIL ORAL SUSPENSION	5	QL (651 per 31 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>nyamyc topical powder</i>	2	
<i>nystatin oral suspension</i>	2	
<i>nystatin oral tablet</i>	2	
<i>nystatin topical cream</i>	2	
<i>nystatin topical ointment</i>	2	
<i>nystatin topical powder</i>	2	
<i>nystop topical powder</i>	2	
<i>oxiconazole topical cream</i>	2	
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	5	QL (93 per 31 days); NEDS
<i>terconazole vaginal cream</i>	2	
<i>terconazole vaginal suppository</i>	2	
<i>voriconazole intravenous recon soln</i>	4	
<i>voriconazole oral suspension for reconstitution</i>	5	NEDS
<i>voriconazole oral tablet</i>	3	

## ANTIGOUT AGENTS

## ANTIGOUT AGENTS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>allopurinol oral tablet</i>	1	
<i>colchicine oral tablet</i>	4	QL (360 per 90 days)
<i>febuxostat oral tablet</i>	3	ST; QL (90 per 90 days)
<i>probenecid oral tablet</i>	2	
<i>probenecid-colchicine oral tablet</i>	2	

## ANTIMIGRAINE AGENTS

### ERGOT ALKALOIDS

<i>dihydroergotamine nasal spray, non-aerosol</i>	5	QL (24 per 90 days); NEDS
<i>migergot rectal suppository</i>	2	

### PROPHYLACTIC

AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	4	PA; QL (3 per 90 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	4	PA; QL (6 per 90 days)
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	3	PA

Drug Name	Drug Tier	Requirements /Limits
AJOVY SYRINGE SUBCUTANEOUS SYRINGE	3	PA

### SEROTONIN (5-HT) RECEPTOR AGONISTS

<i>almotriptan malate oral tablet</i>	4	QL (36 per 90 days)
<i>eletriptan oral tablet</i>	4	QL (18 per 90 days)
<i>frovatriptan oral tablet</i>	4	QL (36 per 90 days)
<i>naratriptan oral tablet</i>	2	QL (54 per 90 days)
<i>rizatriptan oral tablet</i>	2	QL (36 per 90 days)
<i>rizatriptan oral tablet, disintegrating</i>	2	QL (36 per 90 days)
<i>sumatriptan nasal spray, non-aerosol</i>	4	QL (36 per 90 days)
<i>sumatriptan succinate oral tablet</i>	2	QL (36 per 90 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	4	QL (27 per 90 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	4	QL (18 per 90 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	4	QL (27 per 90 days)

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	4	QL (18 per 90 days)
<i>sumatriptan succinate subcutaneous solution</i>	4	QL (18 per 90 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	4	QL (18 per 90 days)
<i>zolmitriptan oral tablet</i>	2	QL (18 per 90 days)
<i>zolmitriptan oral tablet, disintegrating</i>	2	QL (18 per 90 days)

## ANTIMYASTHENIC AGENTS

### PARASYMPATHOMIMETICS

<i>guanidine oral tablet</i>	2	
<i>pyridostigmine bromide oral syrup</i>	2	
<i>pyridostigmine bromide oral tablet 60 mg</i>	2	
<i>pyridostigmine bromide oral tablet extended release</i>	2	

## ANTIMYCOBACTERIALS

### ANTIMYCOBACTERIALS, OTHER

<i>dapsone oral tablet</i>	2	
<i>rifabutin oral capsule</i>	4	

## ANTITUBERCULARS

Drug Name	Drug Tier	Requirements /Limits
<i>ethambutol oral tablet</i>	2	
<i>isoniazid oral solution</i>	2	
<i>isoniazid oral tablet</i>	2	
PASER ORAL GRANULES DR FOR SUSP IN PACKET	4	
PRETOMANID ORAL TABLET	4	
PRIFTIN ORAL TABLET	4	
<i>pyrazinamide oral tablet</i>	2	
<i>rifampin intravenous recon soln</i>	4	
<i>rifampin oral capsule</i>	2	
SIRTURO ORAL TABLET 100 MG	5	PA; NEDS
TRECTOR ORAL TABLET	4	

## ANTINEOPLASTICS, OTHER

### ANTINEOPLASTICS, OTHER

LIBTAYO INTRAVENOUS SOLUTION	5	PA; NEDS
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## ANTINEOPLASTICS

### ALKYLATING AGENTS

<i>cyclophosphamide oral capsule</i>	3	B/D PA
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**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
GLEOSTINE ORAL CAPSULE 10 MG	3	
GLEOSTINE ORAL CAPSULE 100 MG, 40 MG	5	NEDS
LEUKERAN ORAL TABLET	4	
MATULANE ORAL CAPSULE	5	LA; NEDS
<i>melfalan oral tablet</i>	4	B/D PA
VALCHLOR TOPICAL GEL	5	PA; NEDS
<b>ANTIANDROGENS</b>		
<i>abiraterone oral tablet</i>	5	PA; QL (124 per 31 days); NEDS
<i>bicalutamide oral tablet</i>	2	
ERLEADA ORAL TABLET	5	PA; LA; NEDS
<i>flutamide oral capsule</i>	2	
<i>nilutamide oral tablet</i>	5	NEDS
NUBEQA ORAL TABLET	5	PA; NEDS
<i>toremifene oral tablet</i>	5	NEDS
XTANDI ORAL CAPSULE	5	PA; LA; QL (124 per 31 days); NEDS
<b>ANTIANGIOGENIC AGENTS</b>		

Drug Name	Drug Tier	Requirements /Limits
POMALYST ORAL CAPSULE	5	PA; LA; QL (31 per 31 days); NEDS
REVLIMID ORAL CAPSULE	5	PA; LA; QL (31 per 31 days); NEDS
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; LA; QL (31 per 31 days); NEDS
THALOMID ORAL CAPSULE 150 MG, 200 MG	5	PA; LA; QL (62 per 31 days); NEDS
<b>ANTIESTROGENS/MODIFIERS</b>		
EMCYT ORAL CAPSULE	5	NEDS
SOLTAMOX ORAL SOLUTION	5	NEDS
<i>tamoxifen oral tablet</i>	2	
<b>ANTIMETABOLITES</b>		
DROXIA ORAL CAPSULE	4	
<i>hydroxyurea oral capsule</i>	2	
<i>mercaptopurine oral tablet</i>	2	
PURIXAN ORAL SUSPENSION	5	LA; NEDS
TABLOID ORAL TABLET	3	PA
<b>ANTINEOPLASTICS, OTHER</b>		

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
ADRIAMYCIN INTRAVENOUS RECON SOLN 50 MG	3	B/D PA
<i>dexrazoxane hcl intravenous recon soln 500 mg</i>	2	
ENHERTU INTRAVENOUS RECON SOLN	5	PA; NEDS
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION	5	NEDS
IDHIFA ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
KISQALI FEMARA CO-PACK ORAL TABLET	5	PA; NEDS
<i>leucovorin calcium injection recon soln 50 mg, 500 mg</i>	4	
<i>leucovorin calcium oral tablet</i>	2	
LONSURF ORAL TABLET	5	PA; LA; NEDS
LUMOXITI INTRAVENOUS RECON SOLN	5	PA; NEDS
NINLARO ORAL CAPSULE	5	PA; NEDS
PADCEV INTRAVENOUS RECON SOLN	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
POLIVY INTRAVENOUS RECON SOLN	5	PA; NEDS
SYNRIBO SUBCUTANEOUS RECON SOLN	5	PA; NEDS
<i>valrubicin intravesical solution</i>	3	
VELCADE INJECTION RECON SOLN	4	
<i>vincasar pfs intravenous solution 2 mg/2 ml</i>	2	B/D PA
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)	5	PA; NEDS
ZOLINZA ORAL CAPSULE	5	PA; NEDS
<b>AROMATASE INHIBITORS, 3RD GENERATION</b>		
<i>anastrozole oral tablet</i>	2	
<i>exemestane oral tablet</i>	2	
<i>letrozole oral tablet</i>	2	
<b>MOLECULAR TARGET INHIBITORS</b>		

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION	5	PA; NEDS
AFINITOR ORAL TABLET 10 MG	5	PA; QL (31 per 31 days); NEDS
ALECENSA ORAL CAPSULE	5	PA; LA; NEDS
ALUNBRIG ORAL TABLET	5	PA; LA; NEDS
ALUNBRIG ORAL TABLETS,DOSE PACK	5	PA; LA; NEDS
AYVAKIT ORAL TABLET	5	PA; NEDS
BALVERSA ORAL TABLET	5	PA; NEDS
BOSULIF ORAL TABLET	5	PA; LA; NEDS
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; NEDS
BRUKINSA ORAL CAPSULE	5	PA; NEDS
CABOMETYX ORAL TABLET 20 MG, 60 MG	5	PA; LA; QL (31 per 31 days); NEDS
CABOMETYX ORAL TABLET 40 MG	5	PA; LA; QL (62 per 31 days); NEDS
CALQUENCE ORAL CAPSULE	5	PA; LA; NEDS
CAPRELSA ORAL TABLET	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
COMETRIQ ORAL CAPSULE	5	PA; LA; NEDS
COPIKTRA ORAL CAPSULE	5	PA; NEDS
COTELLIC ORAL TABLET	5	PA; LA; NEDS
DAURISMO ORAL TABLET	5	PA; NEDS
ERIVEDGE ORAL CAPSULE	5	PA; LA; NEDS
<i>erlotinib oral tablet 100 mg, 150 mg</i>	5	PA; QL (31 per 31 days); NEDS
<i>erlotinib oral tablet 25 mg</i>	5	PA; QL (93 per 31 days); NEDS
<i>everolimus (antineoplastic) oral tablet</i>	5	PA; QL (31 per 31 days); NEDS
FARYDAK ORAL CAPSULE 10 MG, 20 MG	5	PA; LA; QL (6 per 21 days); NEDS
FARYDAK ORAL CAPSULE 15 MG	5	PA; NEDS
GILOTRIF ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
IBRANCE ORAL CAPSULE	5	PA; LA; QL (21 per 28 days); NEDS
IBRANCE ORAL TABLET	5	PA; LA; QL (21 per 28 days); NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
ICLUSIG ORAL TABLET	5	PA; LA; NEDS
<i>imatinib oral tablet 100 mg</i>	5	PA; QL (186 per 31 days); NEDS
<i>imatinib oral tablet 400 mg</i>	5	PA; QL (62 per 31 days); NEDS
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; LA; QL (124 per 31 days); NEDS
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; LA; QL (31 per 31 days); NEDS
IMBRUVICA ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
INLYTA ORAL TABLET 1 MG	5	PA; LA; QL (186 per 31 days); NEDS
INLYTA ORAL TABLET 5 MG	5	PA; LA; QL (124 per 31 days); NEDS
INREBIC ORAL CAPSULE	5	PA; NEDS
IRESSA ORAL TABLET	5	PA; LA; NEDS
JAKAFI ORAL TABLET	5	PA; LA; QL (62 per 31 days); NEDS
KISQALI ORAL TABLET	5	PA; NEDS
KOSELUGO ORAL CAPSULE	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
LENVIMA ORAL CAPSULE	5	PA; NEDS
LORBRENA ORAL TABLET	5	PA; NEDS
LYNPARZA ORAL TABLET	5	PA; LA; QL (124 per 31 days); NEDS
MEKINIST ORAL TABLET	5	PA; NEDS
MEKTOVI ORAL TABLET	5	PA; NEDS
NERLYNX ORAL TABLET	5	PA; LA; NEDS
NEXAVAR ORAL TABLET	5	PA; LA; NEDS
ODOMZO ORAL CAPSULE	5	PA; LA; NEDS
PEMAZYRE ORAL TABLET	5	PA; NEDS
PIQRAY ORAL TABLET	5	PA; NEDS
QINLOCK ORAL TABLET	5	PA; QL (90 per 30 days); NEDS
RETEVMO ORAL CAPSULE 40 MG	5	PA; QL (186 per 31 days); NEDS
RETEVMO ORAL CAPSULE 80 MG	5	PA; QL (124 per 31 days); NEDS
ROZLYTREK ORAL CAPSULE	5	PA; NEDS
RUBRACA ORAL TABLET	5	PA; LA; NEDS

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Drug Name	Drug Tier	Requirements /Limits
RYDAPT ORAL CAPSULE	5	PA; NEDS
SPRYCEL ORAL TABLET 100 MG, 140 MG, 70 MG	5	PA; QL (31 per 31 days); NEDS
SPRYCEL ORAL TABLET 20 MG, 50 MG	5	PA; QL (93 per 31 days); NEDS
SPRYCEL ORAL TABLET 80 MG	5	PA; QL (62 per 31 days); NEDS
STIVARGA ORAL TABLET	5	PA; LA; NEDS
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 50 MG	5	PA; LA; QL (31 per 31 days); NEDS
SUTENT ORAL CAPSULE 37.5 MG	5	PA; LA; QL (62 per 31 days); NEDS
TABRECTA ORAL TABLET	5	PA; QL (112 per 28 days); NEDS
TAFINLAR ORAL CAPSULE	5	PA; NEDS
TAGRISSE ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
TALZENNA ORAL CAPSULE	5	PA; NEDS
TASIGNA ORAL CAPSULE 150 MG	5	PA; QL (155 per 31 days); NEDS
TASIGNA ORAL CAPSULE 200 MG	5	PA; QL (124 per 31 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
TASIGNA ORAL CAPSULE 50 MG	5	PA; QL (434 per 31 days); NEDS
TAZVERIK ORAL TABLET	5	PA; LA; NEDS
TIBSOVO ORAL TABLET	5	PA; NEDS
TUKYSA ORAL TABLET 150 MG	5	PA; QL (120 per 30 days); NEDS
TUKYSA ORAL TABLET 50 MG	5	PA; QL (300 per 30 days); NEDS
TURALIO ORAL CAPSULE	5	PA; NEDS
TYKERB ORAL TABLET	5	PA; NEDS
VENCLEXTA ORAL TABLET 10 MG, 50 MG	3	PA; LA
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA; NEDS
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK	5	PA; LA; NEDS
VERZENIO ORAL TABLET	5	PA; LA; NEDS
VITRAKVI ORAL CAPSULE	5	PA; NEDS
VITRAKVI ORAL SOLUTION	5	PA; NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
VIZIMPRO ORAL TABLET	5	PA; NEDS
VOTRIENT ORAL TABLET	5	PA; NEDS
XALKORI ORAL CAPSULE	5	PA; LA; QL (62 per 31 days); NEDS
XOSPATA ORAL TABLET	5	PA; NEDS
ZEJULA ORAL CAPSULE	5	PA; LA; NEDS
ZELBORAF ORAL TABLET	5	PA; LA; QL (248 per 31 days); NEDS
ZYDELIG ORAL TABLET	5	PA; LA; QL (62 per 31 days); NEDS
ZYKADIA ORAL TABLET	5	PA; NEDS
<b>MONOCLONAL ANTIBODIES/ANTIBODY-DRUG CONJUGATE</b>		
SARCLISA INTRAVENOUS SOLUTION	5	PA; NEDS
<b>RETINOIDS</b>		
<i>bexarotene oral capsule</i>	5	PA; NEDS
PANRETIN TOPICAL GEL	3	
TARGRETIN TOPICAL GEL	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>tretinoin (antineoplastic) oral capsule</i>	5	NEDS
<b>TREATMENT ADJUNCTS</b>		
MESNEX ORAL TABLET	4	
<b>ANTIPARASITICS</b>		
<b>ANTHELMINTHICS</b>		
<i>albendazole oral tablet</i>	5	NEDS
<i>ivermectin oral tablet</i>	2	
<i>praziquantel oral tablet</i>	2	
<b>ANTIPROTOZOALS</b>		
ALINIA ORAL SUSPENSION FOR RECONSTITUTION	3	
ALINIA ORAL TABLET	5	NEDS
<i>atovaquone oral suspension</i>	5	NEDS
<i>atovaquone-proguanil oral tablet</i>	2	
<i>chloroquine phosphate oral tablet</i>	2	
COARTEM ORAL TABLET	3	
<i>hydroxychloroquine oral tablet</i>	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>mefloquine oral tablet</i>	2	
NEBUPENT INHALATION RECON SOLN	4	B/D PA
<i>pentamidine injection recon soln</i>	4	
PRIMAQUINE ORAL TABLET	3	
<i>pyrimethamine oral tablet</i>	5	NEDS
<i>quinine sulfate oral capsule</i>	2	
<b>ANTIPARKINSON AGENTS</b>		
<b>ANTICHOLINERGICS</b>		
<i>benztropine injection solution</i>	4	HRM
<i>benztropine oral tablet</i>	2	HRM
<i>trihexyphenidyl oral elixir</i>	2	HRM
<i>trihexyphenidyl oral tablet</i>	2	HRM
<b>ANTIPARKINSON AGENTS, OTHER</b>		
<i>amantadine hcl oral capsule</i>	2	
<i>amantadine hcl oral solution</i>	2	
<i>amantadine hcl oral tablet</i>	2	
<i>carbidopa-levodopa-entacapone oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>entacapone oral tablet</i>	2	
<i>tolcapone oral tablet</i>	5	NEDS
<b>DOPAMINE AGONISTS</b>		
APOKYN SUBCUTANEOUS CARTRIDGE	5	PA; LA; QL (93 per 31 days); NEDS
<i>bromocriptine oral capsule</i>	2	
<i>bromocriptine oral tablet</i>	2	
NEUPRO TRANSDERMAL PATCH 24 HOUR	4	
<i>pramipexole oral tablet</i>	2	
<i>pramipexole oral tablet extended release 24 hr</i>	4	
<i>ropinirole oral tablet</i>	2	
<i>ropinirole oral tablet extended release 24 hr</i>	2	
<b>DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS</b>		
<i>carbidopa oral tablet</i>	2	
<i>carbidopa-levodopa oral tablet</i>	2	
<i>carbidopa-levodopa oral tablet extended release</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>carbidopa-levodopa oral tablet, disintegrating</i>	2	
<b>MONOAMINE OXIDASE B (MAO-B) INHIBITORS</b>		
<i>rasagiline oral tablet</i>	2	
<i>selegiline hcl oral capsule</i>	2	
<i>selegiline hcl oral tablet</i>	2	
<b>ANTIPSYCHOTICS</b>		
<b>1ST GENERATION/TYPICAL</b>		
ADASUVE INHALATION AEROSOL POWDR BREATH ACTIVATED	5	HRM; NEDS
<i>chlorpromazine oral tablet</i>	4	HRM
<i>fluphenazine decanoate injection solution</i>	4	HRM
<i>fluphenazine hcl injection solution</i>	4	HRM
<i>fluphenazine hcl oral concentrate</i>	2	HRM
<i>fluphenazine hcl oral elixir</i>	2	HRM
<i>fluphenazine hcl oral tablet</i>	2	HRM

Drug Name	Drug Tier	Requirements /Limits
<i>haloperidol decanoate intramuscular solution</i>	4	HRM
<i>haloperidol lactate injection solution</i>	4	HRM
<i>haloperidol lactate oral concentrate</i>	2	HRM
<i>haloperidol oral tablet</i>	2	HRM
<i>loxapine succinate oral capsule</i>	2	HRM
<i>molindone oral tablet</i>	2	HRM
<i>perphenazine oral tablet</i>	2	HRM
<i>pimozide oral tablet</i>	2	HRM
<i>thioridazine oral tablet</i>	2	PA; HRM
<i>thiothixene oral capsule</i>	2	HRM
<i>trifluoperazine oral tablet</i>	2	HRM
<b>2ND GENERATION/ATYPICAL</b>		
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE RECON	5	ST; HRM; QL (1 per 28 days); NEDS

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Drug Name	Drug Tier	Requirements /Limits
ABILIFY MAINTENANCE INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING	5	ST; HRM; QL (1 per 28 days); NEDS
<i>aripiprazole oral solution</i>	4	HRM; QL (2700 per 90 days)
<i>aripiprazole oral tablet</i>	3	HRM; QL (90 per 90 days)
<i>aripiprazole oral tablet, disintegrating 10 mg</i>	5	HRM; QL (270 per 90 days); NEDS
<i>aripiprazole oral tablet, disintegrating 15 mg</i>	5	HRM; QL (180 per 90 days); NEDS
ARISTADA INITIATION INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING	5	ST; HRM; NEDS
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING	5	ST; HRM; NEDS
CAPLYTA ORAL CAPSULE	5	ST; NEDS
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG	4	ST; HRM; QL (180 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	5	ST; HRM; QL (180 per 90 days); NEDS
FANAPT ORAL TABLETS, DOSE PACK	4	ST; HRM
GEODON INTRAMUSCULAR RECONSTITUTION SOLUTION	4	ST; HRM
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	ST; HRM; QL (0.75 per 28 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	ST; HRM; QL (1 per 28 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	ST; HRM; QL (1.5 per 28 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	4	ST; HRM; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	ST; HRM; QL (0.5 per 28 days); NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML	5	ST; HRM; QL (0.88 per 90 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.315 ML	5	ST; HRM; QL (1.32 per 90 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	ST; HRM; QL (1.75 per 90 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.625 ML	5	ST; HRM; QL (2.63 per 90 days); NEDS
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	5	ST; HRM; QL (31 per 31 days); NEDS
LATUDA ORAL TABLET 80 MG	5	ST; HRM; QL (62 per 31 days); NEDS
NUPLAZID ORAL CAPSULE	5	PA; HRM; QL (31 per 31 days); NEDS
NUPLAZID ORAL TABLET 10 MG	5	PA; HRM; QL (31 per 31 days); NEDS
<i>olanzapine intramuscular recon soln</i>	4	HRM
<i>olanzapine oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	HRM; QL (180 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>olanzapine oral tablet 15 mg, 20 mg, 7.5 mg</i>	2	HRM; QL (90 per 90 days)
<i>olanzapine oral tablet, disintegrating 10 mg</i>	2	HRM; QL (180 per 90 days)
<i>olanzapine oral tablet, disintegrating 15 mg, 20 mg, 5 mg</i>	2	HRM; QL (90 per 90 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	2	HRM; QL (90 per 90 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	2	HRM; QL (180 per 90 days)
PERSERIS ABDOMINAL SUBCUTANEOUS SUSPENSION, EXTEND REL SYR KIT	5	ST; HRM; NEDS
<i>quetiapine oral tablet</i>	2	HRM
<i>quetiapine oral tablet extended release 24 hr</i>	2	HRM
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG	5	ST; HRM; QL (62 per 31 days); NEDS
REXULTI ORAL TABLET 3 MG, 4 MG	5	ST; HRM; QL (31 per 31 days); NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	4	ST; HRM
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	5	ST; HRM; NEDS
<i>risperidone oral solution</i>	2	HRM
<i>risperidone oral tablet</i>	2	HRM
<i>risperidone oral tablet, disintegrating</i>	2	HRM
SAPHRIS SUBLINGUAL TABLET	3	ST; HRM; QL (180 per 90 days)
SECUADO TRANSDERMAL PATCH 24 HOUR	5	ST; QL (31 per 31 days); NEDS
VRAYLAR ORAL CAPSULE 1.5 MG	5	ST; HRM; QL (62 per 31 days); NEDS
VRAYLAR ORAL CAPSULE 3 MG, 4.5 MG, 6 MG	5	ST; HRM; QL (31 per 31 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
VRAYLAR ORAL CAPSULE, DOSE PACK	4	ST; HRM
<i>ziprasidone hcl oral capsule</i>	2	HRM; QL (180 per 90 days)
<i>ziprasidone mesylate intramuscular recon soln</i>	4	HRM
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	ST; HRM
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG, 405 MG	5	ST; HRM; NEDS
<b>TREATMENT-RESISTANT</b>		
<i>clozapine oral tablet</i>	2	HRM
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 25 mg</i>	2	HRM
CLOZAPINE ORAL TABLET, DISINTEGRATING 150 MG	4	HRM

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Drug Name	Drug Tier	Requirements /Limits
CLOZAPINE ORAL TABLET,DISINTEGRATING 200 MG	5	HRM; NEDS

VERSACLOZ ORAL SUSPENSION	5	HRM; NEDS
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### ANTISPASTICITY AGENTS

#### ANTISPASTICITY AGENTS

<i>baclofen intrathecal solution</i>	2	
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<i>baclofen oral tablet 10 mg, 20 mg</i>	2	
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<i>dantrolene oral capsule</i>	2	
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<i>tizanidine oral capsule</i>	2	
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<i>tizanidine oral tablet</i>	2	
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### ANTIVIRALS

#### ANTI-CYTOMEGALOVIRUS (CMV) AGENTS

<i>ganciclovir sodium intravenous solution</i>	4	B/D PA
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PREVYMIS ORAL TABLET	5	NEDS
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<i>valganciclovir oral recon soln</i>	5	NEDS
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<i>valganciclovir oral tablet</i>	3	
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#### ANTI-HEPATITIS B (HBV) AGENTS

<i>adefovir oral tablet</i>	5	NEDS
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<i>entecavir oral tablet</i>	3	
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Drug Name	Drug Tier	Requirements /Limits
<i>lamivudine oral tablet 100 mg</i>	2	

#### ANTI-HEPATITIS C (HCV) AGENTS

EPCLUSA ORAL TABLET	5	PA; QL (31 per 31 days); NEDS
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HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	5	PA; QL (31 per 31 days); NEDS
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HARVONI ORAL PELLETS IN PACKET 45-200 MG	5	PA; QL (62 per 31 days); NEDS
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HARVONI ORAL TABLET	5	PA; QL (31 per 31 days); NEDS
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<i>ribavirin oral capsule</i>	2	
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<i>ribavirin oral tablet 200 mg</i>	2	
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SOVALDI ORAL PELLETS IN PACKET 150 MG	5	PA; QL (31 per 31 days); NEDS
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SOVALDI ORAL PELLETS IN PACKET 200 MG	5	PA; QL (62 per 31 days); NEDS
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SOVALDI ORAL TABLET 200 MG	5	PA; QL (62 per 31 days); NEDS
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SOVALDI ORAL TABLET 400 MG	5	PA; QL (31 per 31 days); NEDS
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**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
VOSEVI ORAL TABLET	5	PA; QL (31 per 31 days); NEDS

### ANTIHERPETIC AGENTS

<i>acyclovir oral capsule</i>	2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	2	
<i>acyclovir oral tablet</i>	2	
<i>acyclovir sodium intravenous solution</i>	4	B/D PA
<i>famciclovir oral tablet</i>	2	
<i>trifluridine ophthalmic (eye) drops</i>	2	
<i>valacyclovir oral tablet</i>	2	

### ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)

BIKTARVY ORAL TABLET	5	QL (31 per 31 days); NEDS
DOVATO ORAL TABLET	5	NEDS
GENVOYA ORAL TABLET	5	QL (31 per 31 days); NEDS
ISENTRESS HD ORAL TABLET	5	NEDS
ISENTRESS ORAL POWDER IN PACKET	5	QL (62 per 31 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
ISENTRESS ORAL TABLET	5	QL (62 per 31 days); NEDS

ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5	QL (186 per 31 days); NEDS
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ISENTRESS ORAL TABLET,CHEWABLE 25 MG	3	QL (186 per 31 days)
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JULUCA ORAL TABLET	5	QL (31 per 31 days); NEDS
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STRIBILD ORAL TABLET	5	NEDS
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TIVICAY ORAL TABLET 10 MG	4	QL (31 per 31 days)
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TIVICAY ORAL TABLET 25 MG	5	QL (31 per 31 days); NEDS
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TIVICAY ORAL TABLET 50 MG	5	QL (62 per 31 days); NEDS
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### ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)

ATRIPLA ORAL TABLET	5	NEDS
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COMPLERA ORAL TABLET	5	NEDS
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DELSTRIGO ORAL TABLET	5	NEDS
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EDURANT ORAL TABLET	5	NEDS
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<i>efavirenz oral capsule 200 mg</i>	4	
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<i>efavirenz oral capsule 50 mg</i>	2	
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**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>efavirenz oral tablet</i>	5	NEDS
INTELENCE ORAL TABLET 100 MG, 200 MG	5	NEDS
INTELENCE ORAL TABLET 25 MG	3	
<i>nevirapine oral suspension</i>	4	
<i>nevirapine oral tablet</i>	2	
<i>nevirapine oral tablet extended release 24 hr</i>	2	
PIFELTRO ORAL TABLET	5	NEDS
SYMFI LO ORAL TABLET	5	NEDS
SYMFI ORAL TABLET	5	NEDS
<b>ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)</b>		
<i>abacavir oral solution</i>	2	
<i>abacavir oral tablet</i>	4	
<i>abacavir-lamivudine oral tablet</i>	3	
<i>abacavir-lamivudine-zidovudine oral tablet</i>	5	NEDS
CIMDUO ORAL TABLET	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
DESCOVY ORAL TABLET	5	NEDS
<i>didanosine oral capsule, delayed release(dr/ec) 250 mg, 400 mg</i>	4	
EMTRIVA ORAL CAPSULE	3	
EMTRIVA ORAL SOLUTION	3	
<i>lamivudine oral solution</i>	2	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	2	
<i>lamivudine-zidovudine oral tablet</i>	2	
ODEFSEY ORAL TABLET	5	NEDS
<i>stavudine oral capsule</i>	2	
TEMIXYS ORAL TABLET	5	NEDS
<i>tenofovir disoproxil fumarate oral tablet</i>	3	
TRIUMEQ ORAL TABLET	5	QL (31 per 31 days); NEDS
TRUVADA ORAL TABLET	5	QL (31 per 31 days); NEDS
VIREAD ORAL POWDER	5	NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	NEDS
<i>zidovudine oral capsule</i>	2	
<i>zidovudine oral syrup</i>	2	
<i>zidovudine oral tablet</i>	2	
<b>ANTI-HIV AGENTS, OTHER</b>		
FUZEON SUBCUTANEOUS RECON SOLN	5	NEDS
SELZENTRY ORAL SOLUTION	5	NEDS
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	5	NEDS
SELZENTRY ORAL TABLET 25 MG	3	
TROGARZO INTRAVENOUS SOLUTION	5	NEDS
TYBOST ORAL TABLET	3	
<b>ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)</b>		
APTIVUS (WITH VITAMIN E) ORAL SOLUTION	5	NEDS
APTIVUS ORAL CAPSULE	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>atazanavir oral capsule</i>	4	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	3	
EVOTAZ ORAL TABLET	5	NEDS
<i>fosamprenavir oral tablet</i>	5	NEDS
INVIRASE ORAL TABLET	5	NEDS
KALETRA ORAL TABLET 100-25 MG	4	
KALETRA ORAL TABLET 200-50 MG	5	NEDS
LEXIVA ORAL SUSPENSION	4	
<i>lopinavir-ritonavir oral solution</i>	5	NEDS
NORVIR ORAL POWDER IN PACKET	3	
NORVIR ORAL SOLUTION	3	
PREZCOBIX ORAL TABLET	5	QL (31 per 31 days); NEDS
PREZISTA ORAL SUSPENSION	5	QL (414 per 31 days); NEDS
PREZISTA ORAL TABLET 150 MG	4	QL (720 per 90 days)

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
PREZISTA ORAL TABLET 600 MG	5	QL (62 per 31 days); NEDS
PREZISTA ORAL TABLET 75 MG	4	QL (1440 per 90 days)
PREZISTA ORAL TABLET 800 MG	5	QL (31 per 31 days); NEDS
REYATAZ ORAL POWDER IN PACKET	5	NEDS
<i>ritonavir oral tablet</i>	2	
SYMTUZA ORAL TABLET	5	NEDS
VIRACEPT ORAL TABLET	5	NEDS
<b>ANTI-INFLUENZA AGENTS</b>		
<i>oseltamivir oral capsule 30 mg</i>	2	QL (168 per 180 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	2	QL (84 per 180 days)
<i>oseltamivir oral suspension for reconstitution</i>	2	QL (1050 per 180 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE	4	QL (180 per 90 days)
<i>rimantadine oral tablet</i>	2	
<b>ANXIOLYTICS</b>		
<b>ANXIOLYTICS, OTHER</b>		
<i>bupirone oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>meprobamate oral tablet</i>	4	HRM
<b>BENZODIAZEPINES</b>		
<i>alprazolam intensol oral concentrate</i>	2	HRM
<i>alprazolam oral tablet</i>	2	HRM; QL (450 per 90 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	HRM; QL (360 per 90 days)
<i>clonazepam oral tablet 2 mg</i>	2	HRM; QL (900 per 90 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	2	HRM; QL (360 per 90 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	2	HRM; QL (900 per 90 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	2	HRM; QL (540 per 90 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	2	HRM; QL (2160 per 90 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	2	HRM; QL (1080 per 90 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	HRM

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>diazepam oral tablet</i>	2	HRM; QL (360 per 90 days)
<i>lorazepam intensol oral concentrate</i>	2	HRM; QL (450 per 90 days)
<i>lorazepam oral concentrate</i>	2	HRM; QL (450 per 90 days)
<i>lorazepam oral tablet</i>	2	HRM; QL (450 per 90 days)

## BIPOLAR AGENTS

### MOOD STABILIZERS

<i>lithium carbonate oral capsule</i>	2	
<i>lithium carbonate oral tablet</i>	2	
<i>lithium carbonate oral tablet extended release</i>	2	
<i>lithium citrate oral solution 8 meq/5 ml</i>	2	

## BLOOD GLUCOSE REGULATORS

### ANTIDIABETIC AGENTS

<i>acarbose oral tablet</i>	6	
<i>alcohol pads topical pads, medicated</i>	1	
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR	3	QL (10.2 per 84 days)

Drug Name	Drug Tier	Requirements /Limits
BYDUREON SUBCUTANEOUS PEN INJECTOR	3	QL (12 per 84 days)
CYCLOSET ORAL TABLET	4	QL (540 per 90 days)
FARXIGA ORAL TABLET	3	QL (90 per 90 days)
GAUZE PADS 2 X 2	2	
<i>glimepiride oral tablet</i>	6	HRM
<i>glipizide oral tablet</i>	6	
<i>glipizide oral tablet extended release 24hr 10 mg</i>	6	QL (180 per 90 days)
<i>glipizide oral tablet extended release 24hr 2.5 mg, 5 mg</i>	6	QL (270 per 90 days)
<i>glipizide-metformin oral tablet</i>	6	
<i>glyburide micronized oral tablet</i>	6	HRM
<i>glyburide oral tablet</i>	6	HRM
<i>glyburide-metformin oral tablet</i>	6	
INSULIN PEN NEEDLE	1	
INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG	3	QL (180 per 90 days)
INVOKAMET ORAL TABLET 50-500 MG	3	QL (360 per 90 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG	3	QL (180 per 90 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 50-500 MG	3	QL (360 per 90 days)
INVOKANA ORAL TABLET 100 MG	3	QL (180 per 90 days)
INVOKANA ORAL TABLET 300 MG	3	QL (90 per 90 days)
JANUMET ORAL TABLET	3	QL (180 per 90 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	QL (90 per 90 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	QL (180 per 90 days)
JANUVIA ORAL TABLET	3	QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	3	QL (180 per 90 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	3	QL (90 per 90 days)
<i>metformin oral tablet</i>	6	
<i>metformin oral tablet extended release 24 hr 500 mg</i>	6	QL (360 per 90 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	6	QL (180 per 90 days)
<i>metformin oral tablet extended release (osm) 24 hr 1,000 mg</i>	6	QL (180 per 90 days)
<i>metformin oral tablet extended release (osm) 24 hr 500 mg</i>	6	QL (450 per 90 days)
<i>miglitol oral tablet</i>	6	
<i>nateglinide oral tablet</i>	6	
NEEDLES, INSULIN DISP.,SAFETY	1	
NOVOFINE 32 NEEDLE	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
NOVOFINE PLUS NEEDLE	1	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN	1	
NOVOTWIST NEEDLE 32 GAUGE X 1/5"	1	
ONGLYZA ORAL TABLET	3	QL (90 per 90 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	3	QL (1.5 per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML)	3	QL (3 per 28 days)
<i>pioglitazone oral tablet</i>	6	QL (90 per 90 days)
<i>pioglitazone-glimepiride oral tablet</i>	1	QL (90 per 90 days)
<i>pioglitazone-metformin oral tablet</i>	6	QL (270 per 90 days)
<i>repaglinide oral tablet</i>	6	
RYBELSUS ORAL TABLET 14 MG	3	QL (90 per 90 days)
RYBELSUS ORAL TABLET 3 MG	3	QL (420 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
RYBELSUS ORAL TABLET 7 MG	3	QL (180 per 90 days)
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
V-GO 20 DEVICE	1	
V-GO 30 DEVICE	1	
V-GO 40 DEVICE	1	
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR	3	QL (27 per 90 days)
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR	3	QL (27 per 90 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	QL (90 per 90 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	3	QL (180 per 90 days)
<b>GLYCEMIC AGENTS</b>		
BAQSIMI NASAL SPRAY, NON-AEROSOL	3	
<i>diazoxide oral suspension</i>	4	

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Drug Name	Drug Tier	Requirements /Limits
GLUCAGEN HYPOKIT INJECTION RECON SOLN	3	
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN	3	
GLUCAGON EMERGENCY KIT (HUMAN) INJECTION RECON SOLN	3	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR	3	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR	3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE	3	
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE	3	
KORLYM ORAL TABLET	5	PA; LA; NEDS
<b>INSULINS</b>		

Drug Name	Drug Tier	Requirements /Limits
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN	4	ST
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION	4	ST
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS PEN	3	
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	3	
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT	4	ST
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN	4	ST

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Drug Name	Drug Tier	Requirements /Limits
HUMALOG MIX 50-50 INSULN U-100 SUBCUTANEOUS SUSPENSION	4	ST
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION	4	ST
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE	4	ST
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION	4	ST
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION	4	ST
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST

Drug Name	Drug Tier	Requirements /Limits
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION	4	ST
HUMULIN R REGULAR U-100 INSULN INJECTION SOLUTION	4	ST
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION	5	NEDS
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN	5	NEDS
INSULIN LISPRO PROTAMIN-LISPRO SUBCUTANEOUS INSULIN PEN	4	ST
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN	4	ST
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN, HALF-UNIT	4	ST
INSULIN LISPRO SUBCUTANEOUS SOLUTION	4	ST

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS PEN	3	
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION	3	
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION	3	
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN R REGULAR U-100 INSULIN INJECTION SOLUTION	3	

Drug Name	Drug Tier	Requirements /Limits
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS PEN	3	
NOVOLOG MIX 70-30 U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	3	
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	3	
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION	3	
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN	3	
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS PEN	3	

## BLOOD PRODUCTS AND MODIFIERS

### ANTICOAGULANTS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
BEVYXXA ORAL CAPSULE	4	
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	3	QL (74 per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	3	QL (180 per 90 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (194 per 90 days)
<i>enoxaparin subcutaneous syringe</i>	4	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	5	NEDS
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	4	
FRAGMIN SUBCUTANEOUS SOLUTION	4	
FRAGMIN SUBCUTANEOUS SYRINGE	4	
<i>heparin (porcine) injection solution</i>	2	
<i>jantoven oral tablet</i>	1	
PRADAXA ORAL CAPSULE	4	QL (180 per 90 days)
<i>warfarin oral tablet</i>	1	

Drug Name	Drug Tier	Requirements /Limits
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	3	QL (51 per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (90 per 90 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (180 per 90 days)
<b>BLOOD PRODUCTS AND MODIFIERS, OTHER</b>		
<i>anagrelide oral capsule</i>	2	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML	5	PA; NEDS
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	4	PA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	4	PA

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	5	PA; NEDS
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	4	PA
NEULASTA SUBCUTANEOUS SYRINGE	5	QL (1.2 per 28 days); NEDS
NEULASTA SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR	5	QL (1.2 per 28 days); NEDS
NIVESTYM INJECTION SOLUTION	5	NEDS
NIVESTYM SUBCUTANEOUS SYRINGE	5	NEDS
OXBRYTA ORAL TABLET	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	5	PA; NEDS
PROMACTA ORAL TABLET 12.5 MG, 25 MG	5	PA; QL (31 per 31 days); NEDS
PROMACTA ORAL TABLET 50 MG, 75 MG	5	PA; QL (62 per 31 days); NEDS
ZARXIO INJECTION SYRINGE	5	NEDS
<b>HEMOSTASIS AGENTS</b>		
<i>tranexamic acid oral tablet</i>	2	QL (90 per 63 days)
<b>PLATELET MODIFYING AGENTS</b>		
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr</i>	4	
BRILINTA ORAL TABLET 60 MG	3	QL (180 per 90 days)
BRILINTA ORAL TABLET 90 MG	3	QL (182 per 90 days)
CABLIVI INJECTION KIT	5	PA; NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>cilostazol oral tablet</i>	2	
<i>clopidogrel oral tablet 75 mg</i>	1	QL (90 per 90 days)
DOPTELET (10 TAB PACK) ORAL TABLET	5	PA; NEDS
DOPTELET (15 TAB PACK) ORAL TABLET	5	PA; NEDS
DOPTELET (30 TAB PACK) ORAL TABLET	5	PA; NEDS
<i>prasugrel oral tablet</i>	3	

## CARDIOVASCULAR AGENTS

### ALPHA-ADRENERGIC AGONISTS

<i>clonidine hcl oral tablet</i>	2	HRM
<i>clonidine transdermal patch weekly</i>	1	HRM; QL (12 per 84 days)
<i>midodrine oral tablet</i>	2	
NORTHERA ORAL CAPSULE 100 MG	5	LA; QL (93 per 31 days); NEDS
NORTHERA ORAL CAPSULE 200 MG, 300 MG	5	LA; QL (186 per 31 days); NEDS

### ALPHA-ADRENERGIC BLOCKING AGENTS

<i>doxazosin oral tablet</i>	2	HRM
<i>prazosin oral capsule</i>	2	HRM

Drug Name	Drug Tier	Requirements /Limits
<i>terazosin oral capsule</i>	2	HRM

## ANGIOTENSIN II RECEPTOR ANTAGONISTS

<i>candesartan oral tablet</i>	6	
EDARBI ORAL TABLET	4	
<i>irbesartan oral tablet</i>	6	
<i>losartan oral tablet 100 mg, 50 mg</i>	6	QL (180 per 90 days)
<i>losartan oral tablet 25 mg</i>	6	QL (270 per 90 days)
<i>olmesartan oral tablet</i>	6	
<i>telmisartan oral tablet</i>	6	
<i>valsartan oral tablet</i>	6	

## ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

<i>benazepril oral tablet</i>	6	
<i>captopril oral tablet</i>	6	
<i>enalapril maleate oral tablet</i>	6	
<i>fosinopril oral tablet</i>	6	
<i>lisinopril oral tablet</i>	6	
<i>moexipril oral tablet</i>	6	
<i>perindopril erbumine oral tablet</i>	6	
<i>quinapril oral tablet</i>	6	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>ramipril oral capsule</i>	6	
<i>trandolapril oral tablet</i>	6	
<b>ANTIARRHYTHMICS</b>		
<i>amiodarone oral tablet</i>	2	HRM
<i>dofetilide oral capsule</i>	2	
<i>flecainide oral tablet</i>	2	
<i>mexiletine oral capsule</i>	2	
MULTAQ ORAL TABLET	3	HRM; QL (180 per 90 days)
NORPACE CR ORAL CAPSULE, EXTENDED RELEASE 100 MG	4	HRM
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	2	HRM
<i>propafenone oral capsule, extended release 12 hr</i>	2	
<i>propafenone oral tablet</i>	2	
<i>quinidine gluconate oral tablet extended release</i>	2	
<i>quinidine sulfate oral tablet</i>	2	
<i>sorine oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>sotalol af oral tablet</i>	2	
<i>sotalol oral tablet</i>	2	
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol oral capsule</i>	2	
<i>atenolol oral tablet</i>	1	
<i>betaxolol oral tablet</i>	1	
<i>bisoprolol fumarate oral tablet</i>	1	
BYSTOLIC ORAL TABLET 10 MG	4	ST; QL (360 per 90 days)
BYSTOLIC ORAL TABLET 2.5 MG, 5 MG	4	ST; QL (90 per 90 days)
BYSTOLIC ORAL TABLET 20 MG	4	ST; QL (180 per 90 days)
<i>carvedilol oral tablet</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr</i>	2	QL (90 per 90 days)
<i>labetalol oral tablet</i>	1	
<i>metoprolol succinate oral tablet extended release 24 hr</i>	1	QL (180 per 90 days)
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nadolol oral tablet</i>	1	
<i>pindolol oral tablet</i>	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>propranolol oral capsule,extended release 24 hr</i>	1	
<i>propranolol oral solution</i>	2	
<i>propranolol oral tablet</i>	1	
<i>timolol maleate oral tablet</i>	1	
<b>CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES</b>		
<i>amlodipine oral tablet</i>	1	
<i>felodipine oral tablet extended release 24 hr</i>	1	QL (90 per 90 days)
<i>isradipine oral capsule</i>	2	
<i>nicardipine oral capsule</i>	1	
<i>nifedipine oral tablet extended release</i>	1	QL (90 per 90 days)
<i>nifedipine oral tablet extended release 24hr</i>	1	QL (90 per 90 days)
<i>nimodipine oral capsule</i>	4	
<i>nisoldipine oral tablet extended release 24 hr</i>	4	
<b>CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYROPYRIDINES</b>		

Drug Name	Drug Tier	Requirements /Limits
<i>cartia xt oral capsule,extended release 24hr</i>	1	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	1	
<i>diltiazem hcl oral capsule,extended release 24 hr</i>	1	
<i>diltiazem hcl oral capsule,extended release 24hr</i>	1	
<i>diltiazem hcl oral tablet</i>	1	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	1	
<i>dilt-xr oral capsule,ext.rel 24h degradable</i>	1	
<i>matzim la oral tablet extended release 24 hr</i>	1	
<i>taztia xt oral capsule,extended release 24 hr</i>	1	
<i>tiadylt er oral capsule,extended release 24 hr</i>	1	
<i>verapamil oral capsule, 24 hr er pellet ct</i>	1	
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>verapamil oral tablet</i>	1	
<i>verapamil oral tablet extended release</i>	1	
<b>CARDIOVASCULAR AGENTS, OTHER</b>		
<i>acetazolamide oral tablet</i>	2	
<i>aliskiren oral tablet</i>	3	QL (90 per 90 days)
<i>amiloride-hydrochlorothiazide oral tablet</i>	1	
<i>amlodipine-atorvastatin oral tablet</i>	6	
<i>amlodipine-benazepril oral capsule</i>	6	
<i>amlodipine-olmesartan oral tablet</i>	6	
<i>amlodipine-valsartan oral tablet</i>	6	
<i>amlodipine-valsartan-hcthiazyd oral tablet</i>	6	
<i>atenolol-chlorthalidone oral tablet</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet</i>	6	

Drug Name	Drug Tier	Requirements /Limits
<i>bisoprolol-hydrochlorothiazide oral tablet</i>	1	
<i>candesartan-hydrochlorothiazid oral tablet</i>	6	
<i>captopril-hydrochlorothiazide oral tablet</i>	6	
CORLANOR ORAL SOLUTION	4	QL (1350 per 90 days)
CORLANOR ORAL TABLET	4	QL (180 per 90 days)
DEMSEER ORAL CAPSULE	5	NEDS
<i>digitek oral tablet 125 mcg (0.125 mg)</i>	2	HRM; QL (90 per 90 days)
<i>digitek oral tablet 250 mcg (0.25 mg)</i>	2	HRM
<i>digox oral tablet 125 mcg (0.125 mg)</i>	2	HRM; QL (90 per 90 days)
<i>digox oral tablet 250 mcg (0.25 mg)</i>	2	HRM
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	2	HRM
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	2	HRM; QL (90 per 90 days)
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	2	HRM
EDARBYCLOR ORAL TABLET	4	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>enalapril-hydrochlorothiazide oral tablet</i>	6	
ENTRESTO ORAL TABLET	3	QL (180 per 90 days)
<i>fosinopril-hydrochlorothiazide oral tablet</i>	6	
<i>irbesartan-hydrochlorothiazide oral tablet</i>	6	
<i>isoproterenol hcl injection solution</i>	4	
<i>lisinopril-hydrochlorothiazide oral tablet</i>	6	
<i>losartan-hydrochlorothiazide oral tablet</i>	6	
<i>methyldopa-hydrochlorothiazide oral tablet</i>	2	
<i>metoprolol ta-hydrochlorothiaz oral tablet</i>	1	
<i>nadolol-bendroflumethiazide oral tablet 80-5 mg</i>	1	
<i>olmesartan-amlodipin-hcthiazyd oral tablet</i>	6	
<i>olmesartan-hydrochlorothiazide oral tablet</i>	6	

Drug Name	Drug Tier	Requirements /Limits
<i>pentoxifylline oral tablet extended release</i>	2	
<i>propranolol-hydrochlorothiazid oral tablet</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet</i>	6	
<i>ranolazine oral tablet extended release 12 hr</i>	4	
<i>spironolacton-hydrochlorothiaz oral tablet</i>	1	
TEKTURNA HCT ORAL TABLET	3	QL (90 per 90 days)
<i>telmisartan-amlodipine oral tablet</i>	6	
<i>telmisartan-hydrochlorothiazid oral tablet</i>	6	
<i>trandolapril-verapamil oral tablet, ir - er, biphasic 24hr</i>	6	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hydrochlorothiazid oral tablet</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>valsartan-hydrochlorothiazide oral tablet</i>	6	
<b>DIURETICS, LOOP</b>		
<i>bumetanide injection solution</i>	4	
<i>bumetanide oral tablet</i>	1	
<i>furosemide injection solution</i>	4	
<i>furosemide injection syringe</i>	4	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	
<i>furosemide oral tablet</i>	1	
<i>toremide oral tablet</i>	2	
<b>DIURETICS, POTASSIUM-SPARING</b>		
<i>amiloride oral tablet</i>	2	
<i>eplerenone oral tablet</i>	2	
<i>spironolactone oral tablet</i>	1	
<b>DIURETICS, THIAZIDE</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>hydrochlorothiazide oral capsule</i>	1	
<i>hydrochlorothiazide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>indapamide oral tablet</i>	1	
<i>metolazone oral tablet</i>	2	
<b>DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES</b>		
<i>fenofibrate micronized oral capsule</i>	2	QL (90 per 90 days)
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	2	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	2	QL (90 per 90 days)
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 135 mg</i>	2	QL (90 per 90 days)
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 45 mg</i>	2	QL (270 per 90 days)
<i>fenofibric acid oral tablet</i>	2	
<i>gemfibrozil oral tablet</i>	2	
<b>DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS</b>		
<i>atorvastatin oral tablet 10 mg, 20 mg</i>	6	QL (360 per 90 days)
<i>atorvastatin oral tablet 40 mg</i>	6	QL (180 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>atorvastatin oral tablet 80 mg</i>	6	QL (90 per 90 days)
EZALLOR SPRINKLE ORAL CAPSULE, SPRINKLE	4	QL (90 per 90 days)
<i>fluvastatin oral capsule 20 mg</i>	6	QL (360 per 90 days)
<i>fluvastatin oral capsule 40 mg</i>	6	QL (180 per 90 days)
<i>fluvastatin oral tablet extended release 24 hr</i>	1	QL (90 per 90 days)
LIVALO ORAL TABLET 1 MG	4	QL (360 per 90 days)
LIVALO ORAL TABLET 2 MG	4	QL (180 per 90 days)
LIVALO ORAL TABLET 4 MG	4	QL (90 per 90 days)
<i>lovastatin oral tablet 10 mg, 20 mg</i>	6	QL (360 per 90 days)
<i>lovastatin oral tablet 40 mg</i>	6	QL (180 per 90 days)
<i>pravastatin oral tablet 10 mg, 20 mg</i>	6	QL (360 per 90 days)
<i>pravastatin oral tablet 40 mg</i>	6	QL (180 per 90 days)
<i>pravastatin oral tablet 80 mg</i>	6	QL (90 per 90 days)
<i>rosuvastatin oral tablet 10 mg, 5 mg</i>	6	QL (360 per 90 days)
<i>rosuvastatin oral tablet 20 mg</i>	6	QL (180 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>rosuvastatin oral tablet 40 mg</i>	6	QL (90 per 90 days)
<i>simvastatin oral tablet 10 mg, 20 mg, 5 mg</i>	6	QL (360 per 90 days)
<i>simvastatin oral tablet 40 mg</i>	6	QL (180 per 90 days)
<i>simvastatin oral tablet 80 mg</i>	6	QL (90 per 90 days)
<b>DYSLIPIDEMICS, OTHER</b>		
<i>cholestyramine (with sugar) oral powder</i>	2	
<i>cholestyramine (with sugar) oral powder in packet</i>	2	
<i>cholestyramine light oral powder</i>	2	
<i>cholestyramine light oral powder in packet</i>	2	
<i>colesevelam oral powder in packet</i>	3	
<i>colesevelam oral tablet</i>	3	
<i>colestipol oral granules</i>	2	
<i>colestipol oral packet</i>	2	
<i>colestipol oral tablet</i>	2	
<i>ezetimibe oral tablet</i>	2	QL (90 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>ezetimibe-simvastatin oral tablet</i>	2	QL (90 per 90 days)
<i>niacin oral tablet 500 mg</i>	2	
<i>niacin oral tablet extended release 24 hr</i>	2	
<i>omega-3 acid ethyl esters oral capsule</i>	2	
<i>prevalite oral powder</i>	2	
<i>prevalite oral powder in packet</i>	2	
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR	3	PA; QL (3.5 per 28 days)
REPATHA SUBCUTANEOUS SYRINGE	3	PA; QL (3 per 28 days)
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR	3	PA; QL (3 per 28 days)
VASCEPA ORAL CAPSULE 1 GRAM	4	
<b>VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS</b>		
<i>isosorbide dinitrate oral tablet</i>	2	
<i>isosorbide mononitrate oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>isosorbide mononitrate oral tablet extended release 24 hr</i>	2	
<i>nitro-bid transdermal ointment</i>	2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	4	
<i>nitroglycerin sublingual tablet</i>	2	
<i>nitroglycerin transdermal patch 24 hour</i>	2	
<i>nitroglycerin translingual spray, non-aerosol</i>	4	
RECTIV RECTAL OINTMENT	4	
<b>VASODILATORS, DIRECT-ACTING ARTERIAL</b>		
<i>hydralazine oral tablet</i>	2	
<i>minoxidil oral tablet</i>	2	
<b>CENTRAL NERVOUS SYSTEM AGENTS</b>		
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES</b>		
<i>dextroamphetamine oral tablet</i>	2	QL (540 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	2	QL (270 per 90 days)
<i>dextroamphetamine-amphetamine oral tablet 30 mg</i>	2	QL (180 per 90 days)
<i>zenzedi oral tablet 10 mg, 5 mg</i>	2	QL (540 per 90 days)
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES</b>		
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg</i>	4	QL (180 per 90 days)
<i>atomoxetine oral capsule 100 mg, 80 mg</i>	4	QL (90 per 90 days)
<i>clonidine hcl oral tablet extended release 12 hr</i>	2	HRM; QL (360 per 90 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 20 mg</i>	2	
<i>methylphenidate hcl oral capsule, er biphasic 30-70 40 mg</i>	2	QL (90 per 90 days)
<i>methylphenidate hcl oral solution</i>	2	
<i>methylphenidate hcl oral tablet</i>	2	QL (270 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<b>CENTRAL NERVOUS SYSTEM, OTHER</b>		
<i>FIRDAPSE ORAL TABLET</i>	5	PA; NEDS
<i>NEOSTIGMINE METHYLSULFATE INTRAVENOUS SYRINGE 3 MG/3 ML (1 MG/ML)</i>	3	
<i>NUEDEXTA ORAL CAPSULE</i>	4	PA; QL (180 per 90 days)
<i>riluzole oral tablet</i>	2	
<i>RUZURGI ORAL TABLET</i>	5	PA; NEDS
<i>tetrabenazine oral tablet 12.5 mg</i>	5	PA; QL (248 per 31 days); NEDS
<i>tetrabenazine oral tablet 25 mg</i>	5	PA; QL (124 per 31 days); NEDS
<b>FIBROMYALGIA AGENTS</b>		
<i>SAVELLA ORAL TABLET</i>	3	PA; QL (180 per 90 days)
<i>SAVELLA ORAL TABLETS,DOSE PACK</i>	3	PA; QL (165 per 84 days)
<b>MULTIPLE SCLEROSIS AGENTS</b>		
<i>BETASERON SUBCUTANEOUS KIT</i>	5	PA; QL (14 per 28 days); NEDS
<i>dalfampridine oral tablet extended release 12 hr</i>	5	PA; QL (62 per 31 days); NEDS

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Drug Name	Drug Tier	Requirements /Limits
GILENYA ORAL CAPSULE 0.5 MG	5	PA; QL (31 per 31 days); NEDS
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	5	PA; QL (31 per 31 days); NEDS
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	5	PA; QL (12 per 28 days); NEDS
<i>glatopa subcutaneous syringe 20 mg/ml</i>	5	PA; QL (31 per 31 days); NEDS
<i>glatopa subcutaneous syringe 40 mg/ml</i>	5	PA; QL (12 per 28 days); NEDS
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE	5	PA; NEDS
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE	5	PA; NEDS
TECFIDERA ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	5	PA; LA; QL (62 per 31 days); NEDS
<b>DENTAL AND ORAL AGENTS</b>		
<b>DENTAL AND ORAL AGENTS</b>		
<i>cevimeline oral capsule</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>chlorhexidine gluconate mucous membrane mouthwash</i>	2	
<i>oralone dental paste</i>	2	
<i>paroex oral rinse mucous membrane mouthwash</i>	2	
<i>periogard mucous membrane mouthwash</i>	2	
<i>pilocarpine hcl oral tablet</i>	2	
<i>triamcinolone acetonide dental paste</i>	2	
<b>DERMATOLOGICAL AGENTS</b>		
<b>ACNE AND ROSACEA AGENTS</b>		
<i>acitretin oral capsule 10 mg, 25 mg</i>	4	
<i>acitretin oral capsule 17.5 mg</i>	5	NEDS
<i>adapalene topical cream</i>	2	
<i>adapalene topical gel</i>	2	
<i>adapalene topical gel with pump</i>	2	
<i>amnesteem oral capsule</i>	4	PA
<i>avita topical cream</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>azelaic acid topical gel</i>	4	
<i>claravis oral capsule</i>	4	PA
<i>clindamycin-benzoyl peroxide topical gel</i>	2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i>	2	
<i>erythromycin-benzoyl peroxide topical gel</i>	2	
<i>isotretinoin oral capsule</i>	4	PA
<i>myorisan oral capsule</i>	4	PA
<i>neuac topical gel</i>	2	
<i>tazarotene topical cream</i>	4	
TAZORAC TOPICAL CREAM 0.05 %	4	
<i>tretinoin topical cream</i>	2	
<i>tretinoin topical gel</i>	2	
<i>zenatane oral capsule</i>	4	PA
<b>DERMATITIS AND PRURITUS AGENTS</b>		
<i>alclometasone topical cream</i>	2	
<i>alclometasone topical ointment</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>amcinonide topical cream</i>	4	
<i>amcinonide topical lotion</i>	4	
<i>amcinonide topical ointment</i>	4	
<i>ammonium lactate topical cream</i>	2	
<i>ammonium lactate topical lotion</i>	2	
<i>apexicon e topical cream</i>	4	
<i>betamethasone dipropionate topical cream</i>	2	
<i>betamethasone dipropionate topical lotion</i>	2	
<i>betamethasone valerate topical cream</i>	2	
<i>betamethasone valerate topical lotion</i>	2	
<i>betamethasone valerate topical ointment</i>	2	
<i>betamethasone, augmented topical gel</i>	2	
<i>betamethasone, augmented topical lotion</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>betamethasone, augmented topical ointment</i>	2	
<i>clobetasol scalp solution</i>	3	
<i>clobetasol topical cream</i>	3	
<i>clobetasol topical foam</i>	4	
<i>clobetasol topical gel</i>	4	
<i>clobetasol topical lotion</i>	4	
<i>clobetasol topical ointment</i>	3	
<i>clobetasol topical shampoo</i>	4	
<i>clobetasol topical spray, non-aerosol</i>	4	
<i>clobetasol-emollient topical cream</i>	4	
<i>clobetasol-emollient topical foam</i>	4	
<i>clodan topical shampoo</i>	4	
<i>desonide topical cream</i>	4	
<i>desonide topical lotion</i>	4	
<i>desonide topical ointment</i>	4	
<i>desoximetasone topical cream</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>desoximetasone topical gel</i>	2	
<i>desoximetasone topical ointment</i>	4	
<i>diflorasone topical cream</i>	4	
<i>diflorasone topical ointment</i>	4	
<i>fluocinolone and shower cap scalp oil</i>	2	
<i>fluocinolone topical cream</i>	2	
<i>fluocinolone topical ointment</i>	2	
<i>fluocinolone topical solution</i>	2	
<i>fluocinonide topical cream 0.1 %</i>	3	
<i>fluocinonide topical gel</i>	4	
<i>fluocinonide topical ointment</i>	4	
<i>fluocinonide topical solution</i>	3	
<i>fluocinonide-e topical cream</i>	4	
<i>fluocinonide-emollient topical cream</i>	4	
<i>fluticasone propionate topical cream</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>fluticasone propionate topical ointment</i>	2	
<i>halobetasol propionate topical cream</i>	2	
<i>halobetasol propionate topical ointment</i>	2	
<i>hydrocortisone butyrate topical cream</i>	2	
<i>hydrocortisone butyrate topical ointment</i>	2	
<i>hydrocortisone butyrate topical solution</i>	2	
<i>hydrocortisone topical cream 2.5 %</i>	2	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	2	
<i>hydrocortisone topical lotion 2.5 %</i>	2	
<i>hydrocortisone topical ointment 2.5 %</i>	2	
<i>hydrocortisone valerate topical cream</i>	2	
<i>hydrocortisone valerate topical ointment</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>mometasone topical cream</i>	2	
<i>mometasone topical ointment</i>	2	
<i>mometasone topical solution</i>	2	
<i>nolix topical cream</i>	4	
<i>prednicarbate topical ointment</i>	2	
<i>procto-med hc topical cream with perineal applicator</i>	2	
<i>proctosol hc topical cream with perineal applicator</i>	2	
<i>proctozone-hc topical cream with perineal applicator</i>	2	
<i>selenium sulfide topical lotion</i>	2	
<i>tacrolimus topical ointment</i>	4	
<i>tovet emollient topical foam</i>	4	
<i>triamcinolone acetonide topical cream</i>	2	
<i>triamcinolone acetonide topical lotion</i>	2	
<i>triamcinolone acetonide topical ointment</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>triderm topical cream</i>	2	
<b>DERMATOLOGICAL AGENTS, OTHER</b>		
<i>calcipotriene scalp solution</i>	2	PA; QL (180 per 90 days)
<i>calcipotriene topical cream</i>	2	PA; QL (360 per 90 days)
<i>calcipotriene topical ointment</i>	2	PA; QL (360 per 90 days)
<i>calcitriol topical ointment</i>	4	
<i>clotrimazole-betamethasone topical cream</i>	2	
<i>clotrimazole-betamethasone topical lotion</i>	2	
DUOBRII TOPICAL LOTION	5	NEDS
<i>fluorouracil topical cream 5 %</i>	2	
<i>fluorouracil topical solution</i>	2	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	4	
<i>imiquimod topical cream in packet</i>	2	
<i>methoxsalen oral capsule,liqd-filled,rapid rel</i>	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>nystatin-triamcinolone topical cream</i>	2	
<i>nystatin-triamcinolone topical ointment</i>	2	
PICATO TOPICAL GEL 0.015 %	5	QL (3 per 31 days); NEDS
PICATO TOPICAL GEL 0.05 %	5	QL (2 per 31 days); NEDS
<i>podofilox topical solution</i>	2	
SANTYL TOPICAL OINTMENT	3	
<i>silver sulfadiazine topical cream</i>	2	
<i>ssd topical cream</i>	2	
<b>PEDICULICIDES/SCABICIDES</b>		
<i>crotan topical lotion</i>	4	
<i>lindane topical shampoo</i>	2	
<i>malathion topical lotion</i>	4	
<i>permethrin topical cream</i>	2	
SKLICE TOPICAL LOTION	4	
<b>TOPICAL ANTI-INFECTIVES</b>		
<i>acyclovir topical ointment</i>	4	
<i>ciclodan topical solution</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>ciclopirox topical gel</i>	2	
<i>ciclopirox topical shampoo</i>	2	
<i>ciclopirox topical solution</i>	2	
<i>clindacin etz topical swab</i>	2	
<i>clindacin p topical swab</i>	2	
<i>clindamycin phosphate topical gel</i>	2	
<i>clindamycin phosphate topical lotion</i>	2	
<i>clindamycin phosphate topical solution</i>	2	
<i>clindamycin phosphate topical swab</i>	2	
<i>clindamycin phosphate vaginal cream</i>	2	
<i>ery pads topical swab</i>	2	
<i>erygel topical gel</i>	2	
<i>erythromycin with ethanol topical gel</i>	2	
<i>erythromycin with ethanol topical solution</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>mupirocin calcium topical cream</i>	2	
<i>mupirocin topical ointment</i>	2	
<b>ELECTROLYTES/MINERALS/ METALS/VITAMINS</b>		
<b>ELECTROLYTE/MINERAL REPLACEMENT</b>		
<i>calcium chloride intravenous solution</i>	4	
<i>calcium chloride intravenous syringe</i>	4	
<i>calcium gluconate intravenous solution</i>	4	
<i>d10 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>d2.5 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>d5 % and 0.9 % sodium chloride intravenous parenteral solution</i>	4	
<i>d5 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>denta 5000 plus dental cream</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>dextrose 10 % in water (d10w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose 20 % in water (d20w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose 30 % in water (d30w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose 40 % in water (d40w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	4	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	4	
<i>dextrose 5%-0.2 % sod chloride intravenous parenteral solution</i>	4	
<i>dextrose 5%-0.3 % sod.chloride intravenous parenteral solution</i>	4	
<i>dextrose 50 % in water (d50w) intravenous parenteral solution</i>	2	B/D PA

Drug Name	Drug Tier	Requirements /Limits
<i>dextrose 70 % in water (d70w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose with sodium chloride intravenous parenteral solution</i>	4	
<i>fluoride (sodium) oral tablet</i>	2	
<i>fluoride (sodium) oral tablet, chewable 1 mg (2.2 mg sod. fluoride)</i>	2	
<i>fluoritab oral tablet, chewable 1 mg (2.2 mg sod. fluoride)</i>	2	
FREAMINE HBC 6.9 % INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
<i>freamine iii 10 % intravenous parenteral solution</i>	2	B/D PA
<i>intralipid intravenous emulsion 20 %</i>	4	B/D PA
INTRALIPID INTRAVENOUS EMULSION 30 %	4	B/D PA
ISOLYTE-P IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION	4	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>klor-con 10 oral tablet extended release</i>	2	
<i>klor-con 8 oral tablet extended release</i>	2	
<i>klor-con m10 oral tablet,er particles/crystals</i>	2	
<i>klor-con m15 oral tablet,er particles/crystals</i>	2	
<i>klor-con m20 oral tablet,er particles/crystals</i>	2	
<i>k-tab oral tablet extended release 8 meq</i>	2	
<i>levocarnitine (with sugar) oral solution</i>	2	
<i>levocarnitine oral solution 100 mg/ml</i>	2	
<i>levocarnitine oral tablet</i>	2	
<i>ludent fluoride oral tablet,chewable 1 mg (2.2 mg sod. fluoride)</i>	2	
<i>magnesium sulfate injection syringe</i>	4	
NEPHRAMINE 5.4 % INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA

Drug Name	Drug Tier	Requirements /Limits
PLASMA-LYTE 148 INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
<i>potassium acetate intravenous solution 2 meq/ml</i>	4	
<i>potassium chlorid-d5-0.45%nacl intravenous parenteral solution</i>	4	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	4	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 30 meq/l, 40 meq/l</i>	4	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	4	
<i>potassium chloride in water intravenous piggyback</i>	4	
<i>potassium chloride oral capsule, extended release</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride oral liquid</i>	2	
<i>potassium chloride oral tablet extended release</i>	2	
<i>potassium chloride oral tablet, er particles/crystals</i>	2	
<i>potassium chloride-0.45 % nacl intravenous parenteral solution</i>	4	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l, 30 meq/l, 40 meq/l</i>	4	
<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	4	
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution</i>	4	
<i>potassium citrate oral tablet extended release</i>	2	
<i>potassium phosphate m-/d-basic intravenous solution 3 mmol/ml</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>premasol 10 % intravenous parenteral solution</i>	4	B/D PA
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE	4	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE	4	
PREVIDENT 5000 SENSITIVE DENTAL PASTE	4	
<i>sf 5000 plus dental cream</i>	2	
<i>sodium acetate intravenous solution</i>	4	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	4	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	4	
<i>sodium chloride 0.9 % intravenous piggyback</i>	4	
<i>sodium chloride 3 % intravenous parenteral solution</i>	4	
<i>sodium chloride 5 % intravenous parenteral solution</i>	4	
<i>sodium chloride intravenous parenteral solution</i>	4	

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Drug Name	Drug Tier	Requirements /Limits
<i>sodium chloride irrigation solution</i>	4	
<i>sodium phosphate intravenous solution</i>	4	
<i>travasol 10 % intravenous parenteral solution</i>	4	B/D PA
<b>ELECTROLYTE/MINERAL/METAL MODIFIERS</b>		
CHEMET ORAL CAPSULE	3	
<i>deferasirox oral tablet</i>	5	PA; NEDS
<i>deferasirox oral tablet, dispersible</i>	5	NEDS
D-PENAMINE ORAL TABLET	4	
JYNARQUE ORAL TABLET	5	PA; NEDS
JYNARQUE ORAL TABLETS, SEQUENTIAL	5	PA; NEDS
SAMSCA ORAL TABLET	5	PA; NEDS
<i>sps (with sorbitol) rectal enema</i>	2	
<i>trientine oral capsule</i>	5	PA; NEDS
<b>PHOSPHATE BINDERS</b>		
AURYXIA ORAL TABLET	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>calcium acetate(phosphat bind) oral capsule</i>	2	
<i>calcium acetate(phosphat bind) oral tablet</i>	2	
<i>lanthanum oral tablet, chewable</i>	4	
<i>sevelamer carbonate oral powder in packet</i>	2	
<i>sevelamer carbonate oral tablet</i>	2	QL (1620 per 90 days)
<b>POTASSIUM BINDERS</b>		
<i>kionex (with sorbitol) oral suspension</i>	2	
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sps (with sorbitol) oral suspension</i>	2	
VELTASSA ORAL POWDER IN PACKET	4	
<b>GASTROINTESTINAL AGENTS</b>		
<b>ANTI-CONSTIPATION AGENTS</b>		
<i>constulose oral solution</i>	2	
<i>enulose oral solution</i>	2	
<i>generlac oral solution</i>	2	
<i>lactulose oral packet</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>lactulose oral solution</i>	2	
LINZESS ORAL CAPSULE	3	QL (90 per 90 days)
MOVANTIK ORAL TABLET	4	PA
RELISTOR ORAL TABLET	5	PA; NEDS
RELISTOR SUBCUTANEOUS SOLUTION	5	PA; QL (16.8 per 28 days); NEDS
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	5	PA; QL (16.8 per 28 days); NEDS
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	5	PA; QL (11.2 per 28 days); NEDS
TRULANCE ORAL TABLET	3	QL (90 per 90 days)
<b>ANTI-DIARRHEAL AGENTS</b>		
<i>alosetron oral tablet</i>	5	PA; QL (62 per 31 days); NEDS
<i>diphenoxylate-atropine oral liquid</i>	2	HRM
<i>diphenoxylate-atropine oral tablet</i>	2	HRM
<i>loperamide oral capsule</i>	2	
<b>ANTISPASMODICS, GASTROINTESTINAL</b>		

Drug Name	Drug Tier	Requirements /Limits
<i>dicyclomine oral capsule</i>	2	HRM
<i>dicyclomine oral solution</i>	2	HRM
<i>dicyclomine oral tablet</i>	2	HRM
<i>glycopyrrolate oral tablet</i>	2	
<i>methscopolamine oral tablet</i>	2	
<b>GASTROINTESTINAL AGENTS, OTHER</b>		
<i>atropine injection solution 0.4 mg/ml</i>	4	
GATTEX 30-VIAL SUBCUTANEOUS KIT	5	PA; LA; NEDS
GATTEX ONE-VIAL SUBCUTANEOUS KIT	5	PA; NEDS
<i>gavilyte-c oral recon soln</i>	2	
<i>gavilyte-g oral recon soln</i>	2	
<i>gavilyte-n oral recon soln</i>	2	
<i>metoclopramide hcl oral solution</i>	2	HRM
<i>metoclopramide hcl oral tablet</i>	2	HRM
MYALEPT SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS

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Drug Name	Drug Tier	Requirements /Limits
OSMOPREP ORAL TABLET	4	
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	2	
<i>peg-electrolyte oral recon soln</i>	2	
<i>polyethylene glycol 3350 oral powder</i>	2	
SUPREP BOWEL PREP KIT ORAL RECON SOLN	4	
<i>trilyte with flavor packets oral recon soln</i>	2	
<i>ursodiol oral capsule</i>	2	
<i>ursodiol oral tablet</i>	2	
<b>HISTAMINE2 (H2) RECEPTOR ANTAGONISTS</b>		
<i>famotidine oral suspension</i>	1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	
<i>nizatidine oral capsule</i>	2	
<i>nizatidine oral solution</i>	2	
<b>PROTECTANTS</b>		
<i>misoprostol oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>sucralfate oral tablet</i>	2	
<b>PROTON PUMP INHIBITORS</b>		
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec)</i>	3	
<i>lansoprazole oral capsule,delayed release(dr/ec)</i>	2	
<i>omeprazole oral capsule,delayed release(dr/ec) 10 mg</i>	2	QL (180 per 90 days)
<i>omeprazole oral capsule,delayed release(dr/ec) 20 mg, 40 mg</i>	1	QL (180 per 90 days)
<i>pantoprazole oral tablet,delayed release (dr/ec)</i>	2	QL (180 per 90 days)
<i>rabeprazole oral tablet,delayed release (dr/ec)</i>	2	
<b>GENETIC OR ENZYME DISORDER: REPLACEMENT, MODIFIERS, TREATMENT</b>		
<b>GENETIC OR ENZYME: REPLACEMENT, MODIFIERS, TREATMENT</b>		
<i>nitisinone oral capsule</i>	5	NEDS

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Drug Name	Drug Tier	Requirements /Limits
<b>GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT</b>		
<b>GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT</b>		
CERDELGA ORAL CAPSULE	5	LA; NEDS
CHOLBAM ORAL CAPSULE	5	PA; NEDS
CREON ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	3	
<i>cromolyn oral concentrate</i>	2	
CYSTADANE ORAL POWDER	5	NEDS
CYSTAGON ORAL CAPSULE	4	LA
CYSTARAN OPHTHALMIC (EYE) DROPS	5	LA; NEDS
ENDARI ORAL POWDER IN PACKET	5	LA; NEDS
GALAFOLD ORAL CAPSULE	5	PA; NEDS
KUVAN ORAL POWDER IN PACKET	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
KUVAN ORAL TABLET,SOLUBL E	5	PA; LA; NEDS
<i>miglustat oral capsule</i>	5	PA; LA; NEDS
NITYR ORAL TABLET	5	PA; NEDS
ORFADIN ORAL CAPSULE 20 MG	5	LA; NEDS
ORFADIN ORAL SUSPENSION	5	LA; NEDS
PANCREAZE ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 10,500-35,500-61,500 UNIT, 16,800-56,800-98,400 UNIT, 2,600-6,200- 10,850 UNIT, 21,000-54,700-83,900 UNIT, 4,200-14,200- 24,600 UNIT	4	ST
PERTZYE ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 24,000-86,250-90,750 UNIT	4	
<i>plenamine intravenous parenteral solution</i>	4	B/D PA
PROLASTIN-C INTRAVENOUS RECON SOLN	5	PA; LA; NEDS

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Drug Name	Drug Tier	Requirements /Limits
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; NEDS
RAVICTI ORAL LIQUID	5	PA; LA; NEDS
REVCIVI INTRAMUSCULAR SOLUTION	5	PA; NEDS
<i>sodium phenylbutyrate oral powder</i>	5	NEDS
<i>sodium phenylbutyrate oral tablet</i>	5	NEDS
TEGSEDI SUBCUTANEOUS SYRINGE	5	PA; NEDS
VYNDAMAX ORAL CAPSULE	5	PA; QL (31 per 31 days); NEDS
VYNDAQEL ORAL CAPSULE	5	PA; QL (124 per 31 days); NEDS
ZEMAIRA INTRAVENOUS RECON SOLN	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000-105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 5,000-17,000-24,000 UNIT	4	ST
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40,000-126,000-168,000 UNIT	5	ST; NEDS

## GENITOURINARY AGENTS

### ANTISPASMODICS, URINARY

<i>flavoxate oral tablet</i>	2	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	3	QL (90 per 90 days)
<i>oxybutynin chloride oral syrup</i>	2	
<i>oxybutynin chloride oral tablet</i>	2	
<i>oxybutynin chloride oral tablet extended release 24hr</i>	2	QL (180 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>solifenacin oral tablet</i>	3	
<i>tolterodine oral capsule, extended release 24hr</i>	2	QL (90 per 90 days)
<i>tolterodine oral tablet</i>	2	QL (180 per 90 days)
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR	3	
<i>trospium oral capsule, extended release 24hr</i>	2	QL (90 per 90 days)
<i>trospium oral tablet</i>	2	
<b>BENIGN PROSTATIC HYPERTROPHY AGENTS</b>		
<i>alfuzosin oral tablet extended release 24 hr</i>	2	QL (90 per 90 days)
<i>dutasteride oral capsule</i>	2	QL (90 per 90 days)
<i>finasteride oral tablet 5 mg</i>	2	
<i>tamsulosin oral capsule</i>	2	QL (180 per 90 days)
<b>GENITOURINARY AGENTS, OTHER</b>		
<i>bethanechol chloride oral tablet</i>	2	
DEPEN TITRATABS ORAL TABLET	4	

Drug Name	Drug Tier	Requirements /Limits
ELMIRON ORAL CAPSULE	3	
<i>penicillamine oral tablet</i>	4	
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)</b>		
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)</b>		
<i>betamethasone dipropionate topical ointment</i>	2	
<i>betamethasone, augmented topical cream</i>	2	
<i>cortisone oral tablet</i>	2	
<i>decadron oral tablet</i>	1	
<i>dexamethasone intensol oral drops</i>	2	
<i>dexamethasone oral elixir</i>	1	
<i>dexamethasone oral solution</i>	1	
<i>dexamethasone oral tablet</i>	1	
<i>fludrocortisone oral tablet</i>	2	
<i>fluocinolone topical oil</i>	2	
<i>fluocinonide topical cream 0.05 %</i>	3	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocortisone butyr-emollient topical cream</i>	2	
<i>methylprednisolone oral tablet</i>	1	
<i>methylprednisolone oral tablets,dose pack</i>	1	
<i>prednisolone oral solution 15 mg/5 ml</i>	2	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml</i>	4	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 15 mg/5 ml (5 ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	2	
<i>prednisolone sodium phosphate oral tablet,disintegrating 15 mg, 30 mg</i>	2	
<i>prednisone intensol oral concentrate</i>	2	
<i>prednisone oral solution</i>	2	
<i>prednisone oral tablet</i>	2	
<i>prednisone oral tablets,dose pack</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)</b>		
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)</b>		
<i>desmopressin injection solution</i>	2	HRM
<i>desmopressin nasal spray with pump</i>	4	HRM
<i>desmopressin nasal spray,non-aerosol</i>	4	HRM
<i>desmopressin oral tablet</i>	2	HRM
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	5	NEDS
EGRIFTA SV SUBCUTANEOUS RECON SOLN	5	NEDS
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	5	PA; HRM; NEDS
HUMATROPE INJECTION RECON SOLN	5	PA; HRM; NEDS
INCRELEX SUBCUTANEOUS SOLUTION	5	PA; LA; NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR	5	PA; HRM; NEDS
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR	5	PA; LA; HRM; NEDS
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	5	PA; HRM; NEDS
STIMATE NASAL SPRAY, NON-AEROSOL	4	HRM
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)</b>		
<b>ANABOLIC STEROIDS</b>		
ANADROL-50 ORAL TABLET	5	PA; NEDS
<i>oxandrolone oral tablet</i>	2	PA
<b>ANDROGENS</b>		
<i>danazol oral capsule</i>	2	
METHITEST ORAL TABLET	4	HRM
<i>methyltestosterone oral capsule</i>	5	HRM; NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	3	HRM
<i>testosterone enanthate intramuscular oil</i>	3	HRM
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	3	PA; HRM; QL (450 per 90 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i>	2	PA; HRM; QL (900 per 90 days)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	3	PA; HRM; QL (225 per 90 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	3	PA; HRM; QL (450 per 90 days)
<b>ESTROGENS</b>		
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.03-0.451 mg (21) (7)</i>	2	
<i>estradiol oral tablet</i>	2	
<i>estradiol vaginal cream</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>estradiol vaginal tablet</i>	2	
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	4	
ESTRING VAGINAL RING	3	QL (1 per 90 days)
FEMRING VAGINAL RING	3	QL (1 per 90 days)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT	3	
IMVEXXY STARTER PACK VAGINAL INSERT, DOSE PACK	3	
MENEST ORAL TABLET 1.25 MG, 2.5 MG	4	HRM
<i>norethindrone ac-eth estradiol oral tablet 1.5-30 mg-mcg</i>	2	
PREMARIN VAGINAL CREAM	3	HRM
<i>yuvafem vaginal tablet</i>	2	
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS), OTHER</b>		
<i>amethia oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)

Drug Name	Drug Tier	Requirements /Limits
<i>apri oral tablet</i>	2	
<i>ashlyna oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<i>camrese lo oral tablets,dose pack,3 month</i>	2	QL (91 per 91 days)
<i>cyred eq oral tablet</i>	2	
<i>cyred oral tablet</i>	2	
<i>desogestrel-ethinyl estradiol oral tablet</i>	2	
<i>eluryng vaginal ring</i>	4	QL (3 per 84 days)
<i>emoquette oral tablet</i>	2	
<i>enskyce oral tablet</i>	2	
<i>estarylla oral tablet</i>	2	
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	2	
<i>etonogestrel-ethinyl estradiol vaginal ring</i>	4	QL (3 per 84 days)
<i>femynor oral tablet</i>	2	
<i>fyavolv oral tablet 0.5-2.5 mg-mcg</i>	2	
<i>isibloom oral tablet</i>	2	
<i>jasmiel (28) oral tablet</i>	2	
<i>juleber oral tablet</i>	2	
<i>junel 1/20 (21) oral tablet</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<i>kelnor 1-50 oral tablet</i>	2	
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)</i>	2	QL (91 per 91 days)
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)</i>	4	QL (91 per 91 days)
<i>lojaimiess oral tablets,dose pack,3 month</i>	2	QL (91 per 91 days)
<i>microgestin 1/20 (21) oral tablet</i>	2	
<i>mili oral tablet</i>	2	
<i>mono-linyah oral tablet</i>	2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg</i>	2	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28), 0.25-35 mg-mcg</i>	2	
<i>previfem oral tablet</i>	2	
<i>reclipsen (28) oral tablet</i>	2	
<i>sprintec (28) oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>tri femynor oral tablet</i>	2	
<i>tri-estarylla oral tablet</i>	2	
<i>tri-linyah oral tablet</i>	2	
<i>tri-mili oral tablet</i>	2	
<i>tri-previfem (28) oral tablet</i>	2	
<i>tri-sprintec (28) oral tablet</i>	2	
<i>tri-vylibra oral tablet</i>	2	
<i>vylibra oral tablet</i>	2	
<i>xulane transdermal patch weekly</i>	2	
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)</b>		
<i>aurovela 1/20 (21) oral tablet</i>	2	
<i>camrese oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<i>daysee oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<i>jaimiess oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<b>PROGESTINS</b>		
<i>camila oral tablet</i>	2	
<i>deblitane oral tablet</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	4	
<i>errin oral tablet</i>	2	
<i>heather oral tablet</i>	2	
<i>incassia oral tablet</i>	2	
<i>jencycla oral tablet</i>	2	
<i>lyza oral tablet</i>	2	
<i>medroxyprogesterone intramuscular suspension</i>	3	
<i>medroxyprogesterone intramuscular syringe</i>	3	
<i>medroxyprogesterone oral tablet</i>	2	
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	4	PA; HRM
<i>megestrol oral tablet</i>	2	PA; HRM
<i>nora-be oral tablet</i>	2	
<i>norethindrone (contraceptive) oral tablet</i>	2	
<i>norethindrone acetate oral tablet</i>	2	
<i>norlyda oral tablet</i>	2	
<i>progesterone micronized oral capsule</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>sharobel oral tablet</i>	2	
<i>tulana oral tablet</i>	2	
<b>SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS</b>		
<i>clomiphene citrate oral tablet</i>	2	PA
DUAVEE ORAL TABLET	3	
<i>raloxifene oral tablet</i>	1	QL (90 per 90 days)
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)</b>		
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)</b>		
<i>euthyrox oral tablet</i>	3	
<i>levothyroxine oral tablet</i>	1	
<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</i>	1	
<i>liothyronine oral tablet</i>	2	
SYNTHROID ORAL TABLET	4	
<i>thyroid (pork) oral tablet 30 mg, 60 mg, 90 mg</i>	2	HRM
<i>unithroid oral tablet</i>	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL)</b>		
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL)</b>		
LYSODREN ORAL TABLET	3	
<b>HORMONAL AGENTS, SUPPRESSANT (PITUITARY)</b>		
<b>HORMONAL AGENTS, SUPPRESSANT (PITUITARY)</b>		
<i>cabergoline oral tablet</i>	2	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	NEDS
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	
<i>leuprolide subcutaneous kit</i>	5	NEDS
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT	5	NEDS
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT	5	NEDS
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	5	NEDS
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	5	PA; NEDS
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA
SIGNIFOR SUBCUTANEOUS SOLUTION	5	PA; LA; NEDS
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE	5	NEDS
SOMAVERT SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
SYNAREL NASAL SPRAY, NON-AEROSOL	5	NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	5	NEDS

**HORMONAL AGENTS, SUPPRESSANT (THYROID)**

**ANTITHYROID AGENTS**

<i>methimazole oral tablet 10 mg, 5 mg</i>	2	
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<i>propylthiouracil oral tablet</i>	2	
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**IMMUNOLOGICAL AGENTS**

**ANGIOEDEMA AGENTS**

HAEGARDA SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
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<i>icatibant subcutaneous syringe</i>	5	PA; QL (279 per 31 days); NEDS
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**IMMUNOGLOBULINS**

GAMMAGARD LIQUID INJECTION SOLUTION	5	B/D PA; NEDS
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GAMMAPLEX INTRAVENOUS SOLUTION	5	B/D PA; NEDS
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Drug Name	Drug Tier	Requirements /Limits
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), 40 GRAM/400 ML (10 %)	5	B/D PA; NEDS

HYPERHEP B S/D INTRAMUSCULAR SOLUTION	4	
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HYPERHEP B S/D INTRAMUSCULAR SYRINGE	4	
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HYPERHEP B S-D NEONATAL INTRAMUSCULAR SYRINGE	4	
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HYQVIA SUBCUTANEOUS SOLUTION 2.5 GRAM /25 ML (10 %)	5	B/D PA; NEDS
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NABI-HB INTRAMUSCULAR SOLUTION	4	
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OCTAGAM INTRAVENOUS SOLUTION	5	B/D PA; NEDS
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PRIVIGEN INTRAVENOUS SOLUTION	5	B/D PA; NEDS
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VARIZIG INTRAMUSCULAR SOLUTION	3	
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**IMMUNOLOGICAL AGENTS, OTHER**

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
ARCALYST SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR	5	PA; LA; NEDS
BENLYSTA SUBCUTANEOUS SYRINGE	5	PA; LA; NEDS
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE	5	PA; LA; NEDS
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR	5	PA; LA; NEDS
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
COSENTYX SUBCUTANEOUS SYRINGE	5	PA; NEDS
RIDAURA ORAL CAPSULE	5	NEDS
STELARA SUBCUTANEOUS SOLUTION	5	PA; QL (0.5 per 28 days); NEDS
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; QL (0.5 per 28 days); NEDS
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; QL (1 per 28 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML	5	NEDS
XELJANZ ORAL TABLET 10 MG	5	PA; QL (62 per 31 days); NEDS
XELJANZ ORAL TABLET 5 MG	5	PA; QL (60 per 30 days); NEDS
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR	5	PA; QL (30 per 30 days); NEDS
XOLAIR SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
XOLAIR SUBCUTANEOUS SYRINGE	5	PA; NEDS
<b>IMMUNOSTIMULANTS</b>		
ACTIMMUNE SUBCUTANEOUS SOLUTION	5	LA; NEDS
INTRON A INJECTION RECON SOLN	5	LA; NEDS
INTRON A INJECTION SOLUTION	5	LA; NEDS
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	5	QL (4 per 28 days); NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG	5	PA; NEDS
<b>IMMUNOSUPPRESSANTS</b>		
ASTAGRAF XL ORAL CAPSULE,EXTEN DED RELEASE 24HR 0.5 MG, 1 MG	4	B/D PA
ASTAGRAF XL ORAL CAPSULE,EXTEN DED RELEASE 24HR 5 MG	5	B/D PA; NEDS
<i>azathioprine oral tablet</i>	2	B/D PA
<i>cyclosporine modified oral capsule</i>	2	B/D PA
<i>cyclosporine modified oral solution</i>	2	B/D PA
<i>cyclosporine oral capsule</i>	2	B/D PA
ENBREL MINI SUBCUTANEOUS CARTRIDGE	5	PA; QL (8 per 28 days); NEDS
ENBREL SUBCUTANEOUS RECON SOLN	5	PA; QL (16 per 28 days); NEDS
ENBREL SUBCUTANEOUS SYRINGE	5	PA; QL (8 per 28 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR	5	PA; QL (8 per 28 days); NEDS
<i>everolimus (immunosuppressive ) oral tablet 0.25 mg</i>	4	B/D PA
<i>everolimus (immunosuppressive ) oral tablet 0.5 mg, 0.75 mg</i>	5	B/D PA; NEDS
<i>gengraf oral capsule 100 mg, 25 mg</i>	2	B/D PA
<i>gengraf oral solution</i>	2	B/D PA
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS INJECTOR KIT	5	PA; QL (6 per 28 days); NEDS
HUMIRA PEN PSOR-UEVITS- ADOL HS SUBCUTANEOUS INJECTOR KIT	5	PA; QL (6 per 28 days); NEDS
HUMIRA PEN SUBCUTANEOUS INJECTOR KIT	5	PA; QL (6 per 28 days); NEDS
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	5	PA; QL (2 per 28 days); NEDS
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (6 per 28 days); NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	5	PA; LA; QL (4 per 28 days); NEDS
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; LA; QL (2 per 28 days); NEDS
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS INJECTOR KIT	5	PA; QL (4 per 28 days); NEDS
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS INJECTOR KIT	5	PA; QL (2 per 28 days); NEDS
HUMIRA(CF) PEN SUBCUTANEOUS INJECTOR KIT 40 MG/0.4 ML	5	PA; QL (6 per 28 days); NEDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5	PA; QL (2 per 28 days); NEDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (6 per 28 days); NEDS
<i>leflunomide oral tablet</i>	2	QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>methotrexate sodium (pf) injection solution</i>	3	
<i>methotrexate sodium injection solution</i>	3	
<i>methotrexate sodium oral tablet</i>	1	B/D PA
<i>mycophenolate mofetil oral capsule</i>	2	B/D PA
<i>mycophenolate mofetil oral suspension for reconstitution</i>	5	B/D PA; NEDS
<i>mycophenolate mofetil oral tablet</i>	2	B/D PA
<i>mycophenolate sodium oral tablet, delayed release (dr/ec)</i>	4	B/D PA
OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML	4	
PROGRAF ORAL GRANULES IN PACKET	3	B/D PA

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	4	
SANDIMMUNE ORAL SOLUTION	4	B/D PA
SIMULECT INTRAVENOUS RECON SOLN 10 MG	5	B/D PA; NEDS
<i>sirolimus oral solution</i>	5	B/D PA; NEDS
<i>sirolimus oral tablet 0.5 mg, 1 mg</i>	4	B/D PA
<i>sirolimus oral tablet 2 mg</i>	5	B/D PA; NEDS
<i>tacrolimus oral capsule</i>	2	B/D PA
XATMEP ORAL SOLUTION	4	B/D PA
ZORTRESS ORAL TABLET 1 MG	5	B/D PA; NEDS
<b>VACCINES</b>		
ACTHIB (PF) INTRAMUSCULA R RECON SOLN	3	

Drug Name	Drug Tier	Requirements /Limits
ADACEL(TDAP ADOLESN/ADULT ) (PF) INTRAMUSCULA R SUSPENSION	3	
ADACEL(TDAP ADOLESN/ADULT ) (PF) INTRAMUSCULA R SYRINGE	3	
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTIO N	3	
BEXSERO INTRAMUSCULA R SYRINGE	3	
BOOSTRIX TDAP INTRAMUSCULA R SUSPENSION	3	
BOOSTRIX TDAP INTRAMUSCULA R SYRINGE	3	
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULA R SUSPENSION	3	
ENGERIX-B (PF) INTRAMUSCULA R SUSPENSION	3	B/D PA
ENGERIX-B (PF) INTRAMUSCULA R SYRINGE	3	B/D PA

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	3	B/D PA
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION	3	
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE	3	
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE	3	
HIBERIX (PF) INTRAMUSCULAR RECON SOLN	3	
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN	3	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	3	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	3	
IPOL INJECTION SUSPENSION	3	

Drug Name	Drug Tier	Requirements /Limits
IXIARO (PF) INTRAMUSCULAR SYRINGE	3	
KINRIX (PF) INTRAMUSCULAR SUSPENSION	3	
KINRIX (PF) INTRAMUSCULAR SYRINGE	3	
MENACTRA (PF) INTRAMUSCULAR SOLUTION	3	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	3	
M-M-R II (PF) SUBCUTANEOUS RECON SOLN	3	
PEDIARIX (PF) INTRAMUSCULAR SYRINGE	3	
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION	3	
PENTACEL (PF) INTRAMUSCULAR KIT	3	
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	3	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION	3	B/D PA
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	3	B/D PA
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION	3	
ROTATEQ VACCINE ORAL SOLUTION	3	
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	QL (2 per 999 days)
STAMARIL (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
TDVAX INTRAMUSCULAR SUSPENSION	3	

Drug Name	Drug Tier	Requirements /Limits
TENIVAC (PF) INTRAMUSCULAR SUSPENSION	3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	3	
TETANUS,DIPHTHERIA TOX PED(PF) INTRAMUSCULAR SUSPENSION	3	
TICE BCG INTRA VESICAL SUSPENSION FOR RECONSTITUTION	3	
TRUMENBA INTRAMUSCULAR SYRINGE	3	
TWINRIX (PF) INTRAMUSCULAR SYRINGE	3	
TYPHIM VI INTRAMUSCULAR SOLUTION	3	
TYPHIM VI INTRAMUSCULAR SYRINGE	3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION	3	
VAQTA (PF) INTRAMUSCULAR SYRINGE	3	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug  
5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B  
only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day  
Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy  
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Drug Name	Drug Tier	Requirements /Limits
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
ZOSTAVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	QL (1 per 999 days)

## INFLAMMATORY BOWEL DISEASE AGENTS

### AMINOSALICYLATES

<i>balsalazide oral capsule</i>	2	
<i>mesalamine oral capsule (with del rel tablets)</i>	3	
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	4	
<i>mesalamine oral tablet, delayed release (dr/ec) 800 mg</i>	3	
<i>mesalamine rectal enema</i>	4	QL (5400 per 90 days)
<i>mesalamine rectal suppository</i>	3	

Drug Name	Drug Tier	Requirements /Limits
<i>mesalamine with cleansing wipe rectal enema kit</i>	4	QL (5400 per 90 days)
PENTASA ORAL CAPSULE, EXTENDED RELEASE	4	
<i>sulfasalazine oral tablet</i>	1	
<i>sulfasalazine oral tablet, delayed release (dr/ec)</i>	2	

### GLUCOCORTICOIDS

<i>budesonide oral capsule, delayed, extended release</i>	3	
<i>budesonide oral tablet, delayed and ext. release</i>	5	NEDS
<i>hydrocortisone oral tablet</i>	1	
<i>hydrocortisone rectal enema</i>	2	

## METABOLIC BONE DISEASE AGENTS

### METABOLIC BONE DISEASE AGENTS

<i>alendronate oral solution</i>	2	
<i>alendronate oral tablet 10 mg, 5 mg</i>	1	QL (90 per 90 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	QL (12 per 84 days)

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>calcitonin (salmon) nasal spray, non-aerosol</i>	2	
<i>calcitriol oral capsule</i>	2	
<i>calcitriol oral solution</i>	2	
<i>cinacalcet oral tablet 30 mg</i>	3	QL (360 per 90 days)
<i>cinacalcet oral tablet 60 mg</i>	5	QL (62 per 31 days); NEDS
<i>cinacalcet oral tablet 90 mg</i>	5	QL (124 per 31 days); NEDS
FORTEO SUBCUTANEOUS PEN INJECTOR	5	PA; QL (3 per 28 days); NEDS
FOSAMAX PLUS D ORAL TABLET	4	QL (12 per 84 days)
<i>ibandronate oral tablet</i>	2	QL (3 per 84 days)
NATPARA SUBCUTANEOUS CARTRIDGE	5	PA; LA; NEDS
<i>paricalcitol oral capsule</i>	2	
PROLIA SUBCUTANEOUS SYRINGE	4	PA; QL (1 per 180 days)
<i>risedronate oral tablet 150 mg</i>	2	QL (3 per 84 days)
<i>risedronate oral tablet 30 mg, 5 mg</i>	2	QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	2	QL (12 per 84 days)
<i>risedronate oral tablet, delayed release (dr/ec)</i>	2	QL (12 per 84 days)
TYMLOS SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
XGEVA SUBCUTANEOUS SOLUTION	5	PA; NEDS

## MISCELLANEOUS THERAPEUTIC AGENTS

### MISCELLANEOUS THERAPEUTIC AGENTS

CALCIUM DISODIUM VERSENATE INJECTION SOLUTION	4	
<i>methylergonovine oral tablet</i>	4	

## OPHTHALMIC AGENTS

### OPHTHALMIC AGENTS, OTHER

<i>ak-poly-bac ophthalmic (eye) ointment</i>	2	
<i>atropine ophthalmic (eye) drops</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>bacitracin-polymyxin b ophthalmic (eye) ointment</i>	2	
BLEPHAMIDE S.O.P. OPHTHALMIC (EYE) OINTMENT	3	
COMBIGAN OPHTHALMIC (EYE) DROPS	3	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	4	
<i>dorzolamide-timolol ophthalmic (eye) drops</i>	1	
<i>neomycin-bacitracin-poly-hc ophthalmic (eye) ointment</i>	2	
<i>neomycin-bacitracin-polymyxin ophthalmic (eye) ointment</i>	2	
<i>neomycin-polymyxin-gamicidin ophthalmic (eye) drops</i>	2	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension</i>	2	

Drug Name	Drug Tier	Requirements /Limits
OXERVATE OPHTHALMIC (EYE) DROPS	5	PA; NEDS
<i>polycin ophthalmic (eye) ointment</i>	2	
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops</i>	2	
PRED-G OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
PRED-G S.O.P. OPHTHALMIC (EYE) OINTMENT	4	
RESTASIS MULTIDOSE OPHTHALMIC (EYE) DROPS	3	QL (16.5 per 90 days)
RESTASIS OPHTHALMIC (EYE) DROPPERETTE	3	QL (180 per 90 days)
ROCKLATAN OPHTHALMIC (EYE) DROPS	3	
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION	4	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>sulfacetamide-prednisolone ophthalmic (eye) drops</i>	1	
TOBRADEX OPTHALMIC (EYE) OINTMENT	3	
TOBRADEX ST OPTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension</i>	2	
<b>OPHTHALMIC ANTI-ALLERGY AGENTS</b>		
<i>azelastine ophthalmic (eye) drops</i>	2	
<i>cromolyn ophthalmic (eye) drops</i>	2	
<i>epinastine ophthalmic (eye) drops</i>	2	
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	2	
PAZEO OPTHALMIC (EYE) DROPS	3	
<b>OPHTHALMIC ANTI-INFECTIVES</b>		

Drug Name	Drug Tier	Requirements /Limits
AZASITE OPTHALMIC (EYE) DROPS	4	
<i>bacitracin ophthalmic (eye) ointment</i>	2	
<i>ciprofloxacin hcl ophthalmic (eye) drops</i>	2	
<i>erythromycin ophthalmic (eye) ointment</i>	2	
<i>gatifloxacin ophthalmic (eye) drops</i>	2	
<i>gentak ophthalmic (eye) ointment</i>	2	
<i>gentamicin ophthalmic (eye) drops</i>	2	
<i>levofloxacin ophthalmic (eye) drops</i>	2	
<i>moxifloxacin ophthalmic (eye) drops</i>	2	
<i>moxifloxacin ophthalmic (eye) drops, viscous</i>	2	
NATACYN OPTHALMIC (EYE) DROPS,SUSPENSION	3	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>ofloxacin ophthalmic (eye) drops</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	2	
<i>tobramycin ophthalmic (eye) drops</i>	1	
ZIRGAN OPHTHALMIC (EYE) GEL	3	
<b>OPHTHALMIC ANTI-INFLAMMATORIES</b>		
<i>dexamethasone sodium phosphate ophthalmic (eye) drops</i>	2	
DUREZOL OPHTHALMIC (EYE) DROPS	3	
<i>fluorometholone ophthalmic (eye) drops,suspension</i>	2	
<i>flurbiprofen sodium ophthalmic (eye) drops</i>	2	
FML FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION	4	

Drug Name	Drug Tier	Requirements /Limits
FML S.O.P. OPHTHALMIC (EYE) OINTMENT	4	
ILEVRO OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
<i>ketorolac ophthalmic (eye) drops</i>	2	HRM
NEVANAC OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>prednisolone acetate ophthalmic (eye) drops,suspension</i>	2	
<i>prednisolone sodium phosphate ophthalmic (eye) drops</i>	2	
<b>OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>betaxolol ophthalmic (eye) drops</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
BETOPTIC S OPTHALMIC (EYE) DROPS,SUSPENSION	4	
<i>carteolol ophthalmic (eye) drops</i>	2	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>timolol maleate ophthalmic (eye) drops</i>	1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	1	
<b>OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER</b>		
<i>acetazolamide oral capsule, extended release</i>	2	
ALPHAGAN P OPTHALMIC (EYE) DROPS 0.1 %	3	
<i>apraclonidine ophthalmic (eye) drops</i>	2	
AZOPT OPTHALMIC (EYE) DROPS,SUSPENSION	4	

Drug Name	Drug Tier	Requirements /Limits
<i>brimonidine ophthalmic (eye) drops</i>	2	
<i>dorzolamide ophthalmic (eye) drops</i>	2	
<i>methazolamide oral tablet</i>	4	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	2	
<b>OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS</b>		
<i>bimatoprost ophthalmic (eye) drops</i>	4	
<i>latanoprost ophthalmic (eye) drops</i>	2	
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	3	
<i>travoprost ophthalmic (eye) drops</i>	3	
ZIOPTAN (PF) OPTHALMIC (EYE) DROPPERETTE	3	
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS</b>		

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
CIPRO HC OTIC (EAR) DROPS,SUSPENSION	4	
CIPRODEX OTIC (EAR) DROPS,SUSPENSION	3	
<i>ciprofloxacin hcl otic (ear) dropperette</i>	2	
<i>flac oil otic (ear) drops</i>	2	
<i>fluocinolone acetonide oil otic (ear) drops</i>	2	
<i>hydrocortisone-acetic acid otic (ear) drops</i>	2	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension</i>	2	
<i>neomycin-polymyxin-hc otic (ear) solution</i>	2	
<i>ofloxacin otic (ear) drops</i>	2	
<b>RESPIRATORY TRACT/PULMONARY AGENTS</b>		
<b>ANTI-HISTAMINES</b>		
<i>azelastine nasal aerosol,spray</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>azelastine nasal spray,non-aerosol</i>	2	
<i>cetirizine oral solution 1 mg/ml</i>	2	
<i>cyproheptadine oral syrup</i>	2	HRM
<i>cyproheptadine oral tablet</i>	2	HRM
<i>desloratadine oral tablet</i>	2	QL (90 per 90 days)
<i>desloratadine oral tablet,disintegrating</i>	2	QL (90 per 90 days)
<i>dexchlorpheniramine maleate oral solution</i>	2	HRM
<i>diphenhydramine hcl injection syringe</i>	4	
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	2	HRM
<i>hydroxyzine hcl oral tablet</i>	2	HRM
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	2	HRM
<i>levocetirizine oral solution</i>	2	
<i>levocetirizine oral tablet</i>	2	QL (90 per 90 days)
<i>olopatadine nasal spray,non-aerosol</i>	2	
<b>ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS</b>		

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
BECONASE AQ NASAL SPRAY, NON-AEROSOL	4	
<i>budesonide inhalation suspension for nebulization</i>	4	B/D PA
<i>budesonide nasal spray, non-aerosol</i>	2	
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE	3	QL (360 per 90 days)
FLOVENT HFA AEROSOL INHALER	3	QL (72 per 90 days)
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	2	
<i>fluticasone propionate nasal spray, suspension</i>	2	QL (48 per 90 days)
<i>mometasone nasal spray, non-aerosol</i>	2	
OMNARIS NASAL SPRAY, NON-AEROSOL	4	ST
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL (6 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
QVAR REDHALER INHALATION HFA AEROSOL BREATH ACTIVATED	3	QL (64 per 90 days)
<b>ANTILEUKOTRIENES</b>		
<i>montelukast oral granules in packet</i>	4	QL (90 per 90 days)
<i>montelukast oral tablet</i>	2	QL (90 per 90 days)
<i>montelukast oral tablet, chewable</i>	2	QL (90 per 90 days)
<i>zafirlukast oral tablet</i>	4	QL (180 per 90 days)
<i>zileuton oral tablet, er multiphase 12 hr</i>	4	QL (360 per 90 days)
<b>BRONCHODILATORS, ANTICHOLINERGIC</b>		
ATROVENT HFA AEROSOL INHALER	3	QL (77.4 per 90 days)
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE	3	
<i>ipratropium bromide inhalation solution</i>	1	B/D PA
<i>ipratropium bromide nasal spray, non-aerosol</i>	1	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
SPIRIVA RESPIMAT INHALATION MIST	3	QL (12 per 90 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE	3	QL (90 per 90 days)
<b>BRONCHODILATORS, SYMPATHOMIMETIC</b>		
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	3	QL (102 per 90 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	3	QL (81 per 90 days)
ALBUTEROL SULFATE INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION (NDA020983)	3	QL (216 per 90 days)
<i>albuterol sulfate inhalation solution for nebulization</i>	1	B/D PA
<i>albuterol sulfate oral syrup</i>	1	
<i>albuterol sulfate oral tablet</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>albuterol sulfate oral tablet extended release 12 hr</i>	1	
BROVANA INHALATION SOLUTION FOR NEBULIZATION	4	B/D PA; QL (360 per 90 days)
EPINEPHRINE INJECTION AUTO- INJECTOR 0.15 MG/0.15 ML, 0.3 MG/0.3 ML	3	
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	3	
EPIPEN 2-PAK INJECTION AUTO- INJECTOR	4	
EPIPEN INJECTION AUTO- INJECTOR	4	
<i>levalbuterol hcl inhalation solution for nebulization</i>	2	B/D PA
LEVALBUTEROL TARTRATE INHALATION HFA AEROSOL INHALER	4	QL (90 per 90 days)
<i>metaproterenol oral syrup</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL (12 per 90 days)
PROVENTIL HFA AEROSOL INHALER	3	QL (81 per 90 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
SYMJEPI INJECTION SYRINGE	3	
<i>terbutaline oral tablet</i>	2	
VENTOLIN HFA AEROSOL INHALER	3	QL (216 per 90 days)
<b>CYSTIC FIBROSIS AGENTS</b>		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION	5	PA; LA; QL (84 per 28 days); NEDS
KALYDECO ORAL GRANULES IN PACKET 25 MG	5	PA; NEDS
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	5	PA; LA; NEDS
KALYDECO ORAL TABLET	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
ORKAMBI ORAL GRANULES IN PACKET	5	PA; NEDS
ORKAMBI ORAL TABLET	5	PA; LA; NEDS
PULMOZYME INHALATION SOLUTION	5	B/D PA; NEDS
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization</i>	5	B/D PA; NEDS
TRIKAFTA ORAL TABLETS, SEQUENTIAL	5	PA; NEDS
<b>MAST CELL STABILIZERS</b>		
<i>cromolyn inhalation solution for nebulization</i>	2	B/D PA
<b>PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE</b>		
<i>aminophylline intravenous solution 500 mg/20 ml</i>	4	
DALIRESP ORAL TABLET	4	PA
<i>theophylline oral tablet extended release 12 hr 300 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr</i>	2	
<b>PULMONARY ANTIHYPERTENSIVES</b>		

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2020.

Drug Name	Drug Tier	Requirements /Limits
ADEMPAS ORAL TABLET	5	PA; LA; QL (93 per 31 days); NEDS
<i>alyq oral tablet</i>	5	PA; QL (62 per 31 days); NEDS
<i>ambrisentan oral tablet</i>	5	PA; NEDS
<i>bosentan oral tablet</i>	5	PA; NEDS
OPSUMIT ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	4	PA; LA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG	5	PA; LA; NEDS
<i>sildenafil (pulmonary arterial hypertension) oral suspension for reconstitution 10 mg/ml</i>	5	PA; QL (180 per 30 days); NEDS
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	2	PA; QL (270 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	5	PA; QL (62 per 31 days); NEDS
TRACLEER ORAL TABLET FOR SUSPENSION	5	PA; LA; NEDS
<i>treprostinil sodium injection solution</i>	4	B/D PA
TYVASO INHALATION SOLUTION FOR NEBULIZATION	5	B/D PA; NEDS
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION	5	B/D PA; NEDS
VENTAVIS INHALATION SOLUTION FOR NEBULIZATION	5	B/D PA; LA; NEDS
<b>PULMONARY FIBROSIS AGENTS</b>		
ESBRIET ORAL TABLET 267 MG	5	PA; LA; QL (279 per 31 days); NEDS
ESBRIET ORAL TABLET 801 MG	5	PA; LA; QL (93 per 31 days); NEDS
OFEV ORAL CAPSULE	5	PA; LA; QL (62 per 31 days); NEDS
<b>RESPIRATORY TRACT AGENTS, OTHER</b>		
<i>acetylcysteine intravenous solution</i>	2	

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
<i>acetylcysteine solution</i>	2	B/D PA
ADVAIR HFA AEROSOL INHALER	3	QL (36 per 90 days)
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
COMBIVENT RESPIMAT INHALATION MIST	4	QL (24 per 90 days)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED	5	QL (1 per 31 days); NEDS
DULERA INHALATION HFA AEROSOL INHALER	3	QL (39 per 90 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	2	QL (180 per 90 days)
<i>ipratropium-albuterol inhalation solution for nebulization</i>	2	B/D PA

Drug Name	Drug Tier	Requirements /Limits
NUCALA SUBCUTANEOUS AUTO-INJECTOR	5	PA; NEDS
NUCALA SUBCUTANEOUS RECON SOLN	5	PA; NEDS
NUCALA SUBCUTANEOUS SYRINGE	5	PA; NEDS
STIOLTO RESPIMAT INHALATION MIST	3	QL (12 per 90 days)
SYMBICORT INHALATION HFA AEROSOL INHALER	3	QL (30.6 per 90 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE	3	QL (60 per 30 days)
<i>wixela inhub inhalation blister with device</i>	2	QL (180 per 90 days)

## SKELETAL MUSCLE RELAXANTS

### SKELETAL MUSCLE RELAXANTS

<i>cyclobenzaprine oral tablet</i>	2	HRM
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<i>methocarbamol oral tablet</i>	2	HRM
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## SLEEP DISORDER AGENTS

### SLEEP PROMOTING AGENTS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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Drug Name	Drug Tier	Requirements /Limits
HETLIOZ ORAL CAPSULE	5	PA; LA; QL (31 per 31 days); NEDS
<i>ramelteon oral tablet</i>	3	QL (90 per 90 days)
<i>triazolam oral tablet</i>	3	HRM
<i>zaleplon oral capsule</i>	2	HRM; QL (90 per 90 days)
<i>zolpidem oral tablet</i>	3	HRM; QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>zolpidem oral tablet,ext release multiphase</i>	3	HRM; QL (90 per 90 days)
<b>WAKEFULLNESS PROMOTING AGENTS</b>		
<i>armodafinil oral tablet</i>	3	PA; QL (90 per 90 days)
<i>modafinil oral tablet</i>	4	PA; QL (180 per 90 days)
XYREM ORAL SOLUTION	5	PA; LA; QL (558 per 31 days); NEDS

**Drug Tier:** 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier 6-Select Care Drugs **Requirements/Limits:** B/D - Prior Authorization, Part D vs. Part B only HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy **Brand-name** drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

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REBIF TITRATION PACK	56	scopolamine base .....	18	ssd.....	60
reclipsen (28).....	74	SECUADO .....	33	STAMARIL (PF) .....	83
RECOMBIVAX HB (PF)....	83	selegiline hcl.....	30	stavudine.....	36
RECTIV .....	54	selenium sulfide .....	59	STELARA .....	78
RELENZA DISKHALER....	38	SELZENTRY .....	37	STIMATE.....	72
RELISTOR .....	66	SEREVENT DISKUS .....	93	STIOLTO RESPIMAT .....	95
repaglinide.....	41	SEROSTIM .....	72	STIVARGA.....	27
REPATHA.....	54	sertraline.....	17	STRIBILD .....	35
REPATHA PUSHTRONEX	54	sevelamer carbonate .....	65	subvenite.....	13
REPATHA SURECLICK....	54	sf 5000 plus.....	64	subvenite starter (blue) kit ..	13
RESTASIS.....	86	sharobel.....	75	subvenite starter (green) kit.	13
RESTASIS MULTIDOSE ...	86	SHINGRIX (PF) .....	83	subvenite starter (orange) kit	13
RETEVMO.....	26	SIGNIFOR.....	76	sucralfate .....	67
REVCovi.....	69	sildenafil (pulmonary arterial		sulfacetamide sodium.....	88
REVLIMID.....	23	hypertension).....	94	sulfacetamide sodium (acne)	11
REXULTI.....	32	silver sulfadiazine .....	60	sulfacetamide-prednisolone .	87
REYATAZ .....	38	SIMBRINZA .....	86	sulfadiazine.....	11
ribavirin.....	34	SIMULECT .....	81	sulfamethoxazole-trimethoprim	
RIDAURA.....	78	simvastatin.....	53	.....	11
rifabutin.....	22	sirolimus.....	81	sulfasalazine.....	84
rifampin.....	22	SIRTURO.....	22	sulindac .....	2
riluzole .....	55	SKLICE.....	60	sumatriptan .....	21
rimantadine.....	38	sodium acetate .....	64	sumatriptan succinate ....	21, 22
risedronate.....	85	sodium chloride.....	64, 65	SUPREP BOWEL PREP KIT	
RISPERDAL CONSTA.....	33	sodium chloride 0.45 % .....	64	.....	67

SUTENT.....	27	testosterone enanthate.....	72	tretinoin (antineoplastic).....	28
SYLATRON.....	79	TETANUS,DIPHThERIA		tretinoin topical.....	57
SYMBICORT.....	95	TOX PED(PF).....	83	tri femynor.....	74
SYMFI.....	36	tetrabenazine.....	55	triamcinolone acetonide. 56, 59	
SYMFI LO.....	36	tetracycline.....	12	triamterene-hydrochlorothiazid	
SYMJEPI.....	93	THALOMID.....	23	.....	51
SYMLINPEN 120.....	41	theophylline.....	93	triazolam.....	96
SYMLINPEN 60.....	41	thioridazine.....	30	triderm.....	60
SYMPAZAN.....	14	thiothixene.....	30	trientine.....	65
SYMTUZA.....	38	thyroid (pork).....	75	tri-estarylla.....	74
SYNAGIS.....	78	tiadylt er.....	49	trifluoperazine.....	30
SYNAREL.....	76	tiagabine.....	14	trifluridine.....	35
SYNRIBO.....	24	TIBSOVO.....	27	trihexyphenidyl.....	29
SYNTHROID.....	75	TICE BCG.....	83	TRIKAFTA.....	93
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TABLOID.....	23	tinidazole.....	7	trilyte with flavor packets....	67
TABRECTA.....	27	TIVICAY.....	35	trimethoprim.....	7
tacrolimus.....	59, 81	tizanidine.....	34	tri-mili.....	74
tadalafil (pulmonary arterial		TOBRADEX.....	87	trimipramine.....	18
hypertension) oral tablet 20		TOBRADEX ST.....	87	TRINTELLIX.....	17, 18
mg.....	94	tobramycin.....	88	tri-previfem (28).....	74
TAFINLAR.....	27	tobramycin in 0.225 % nacl. 93		tri-sprintec (28).....	74
TAGRISSE.....	27	tobramycin sulfate.....	6	TRIUMEQ.....	36
TALZENNA.....	27	tobramycin-dexamethasone. 87		tri-vylibra.....	74
tamoxifen.....	23	tolcapone.....	29	TROGARZO.....	37
tamsulosin.....	70	tolmetin.....	2	trospium.....	70
TARGRETIN.....	28	tolterodine.....	70	TRULANCE.....	66
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tenofovir disoproxil fumarate		travasol 10 %.....	65	valacyclovir.....	35
.....	36	travoprost.....	89	VALCHLOR.....	23
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terconazole.....	20	TRELEGY ELLIPTA.....	95	valproic acid (as sodium salt)	
testosterone.....	72	TRELSTAR.....	77	.....	13
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VANCOMYCIN.....	7	VOSEVI.....	35	YF-VAX (PF).....	84
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This formulary was updated on September 1, 2020. For more recent information or other questions, please contact us, **Medicare Plus Blue PPO** Customer Service, at 1-877-241-2583 or, for TTY users, 711, Monday through Friday, 8 a.m. to 9 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m. Eastern time, seven days a week, or visit [www.bcbsm.com/medicare](http://www.bcbsm.com/medicare).

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