PRESBYTERIAN
Health Plan, Inc.

Presbyterian Federal Employees Plan Formulary, Therapeutic Class Listing

This list is in order by therapeutic class. To find a specific drug, use the search feature available in Adobe Acrobat Reader (keyboard shortcut: Ctrl+F).

What Is A Formulary?

A drug Formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

The primary purpose of the Formulary is to encourage the use of safe, effective and most affordable medications. Presbyterian Health Plan administers a “closed Formulary,” which means that non-Formulary drugs are not routinely reimbursed by the plan. Medical exceptions policies provide access to non-Formulary medication when medical necessity is established.

The medications listed on the Formulary are subject to change per the management activities of Presbyterian Health Plan Pharmacy and Therapeutics Committee pursuant to N.M.S.A. 1978, §59A-23-7.13.

How Is the Formulary Managed?

Presbyterian Health Plan Pharmacy Services applies utilization management tools to Formulary drugs such as prior authorization, step therapy and quantity limits.

“Prior authorization” is a clinical evaluation process to determine if the requested healthcare service is medically necessary, a covered benefit, and if it is being delivered in the most appropriate healthcare setting. Our Medical Director or other clinical professional will review the requested healthcare service and, if it meets our requirements for coverage and medical necessity, it is authorized (approved) before those services are provided.

The prior authorization process and requirements are regularly reviewed and updated based on various factors including evidence-based practice guidelines, medical trends, practitioner/provider participation, state and federal regulations, and our policies and procedures.

“Step therapy” promotes the appropriate use of equally effective but lower-cost Formulary drugs first. With this program, prior use of one or more “prerequisite” drugs is required before a step-therapy medication will be covered. Prerequisite drugs are Food and Drug Administration (FDA)-approved and treat the same condition as the corresponding step-therapy drugs.
Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your provider and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian Health Plan uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following:

- **Maximum Daily Dose** limits quantities to a maximum number of dosage units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a single day. Limits are based on daily dosages shown to be safe and effective, and that are approved by FDA.
- **Quantity Limits Over Time** limits quantities to number of units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time.

For the most up-to-date Formulary drug information, visit your searchable formulary found at **https://client.formularynavigator.com/Search.aspx?siteCode=0322075909**.

You may obtain more information by calling our local Pharmacy Services team, Monday through Friday, 8 a.m. to 5 p.m. at:

Presbyterian Health Plan Commercial HMO: (505) 923-5678 or 1-800-356-2219

You can also send pharmacy inquires to **AskPharmacy@phs.org**.

Some medications may be excluded as determined by benefit.

Definition of Status

Icon	Status	Definition
	Tier 1	Tier 1 Preferred Generic.
	Tier 2	Tier 2 Preferred Brand.
	Tier 3	Tier 3 Non-Preferred Drug.
	Tier 4	Tier 4 Self-Administered Specialty Pharmaceutical.
	Medical Benefit	A medical drug is any drug administered by a healthcare professional and is typically given in the member's home, provider's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical drugs may require a prior authorization and some must be obtained through the Specialty Pharmacy network. For a complete list of medical drugs to determine which require prior authorization please see the Presbyterian Health Plan Pharmacy Services website at **www.phs.org**.
	$0	Zero Dollar Copay
	Medical Exception	A process to request an exception to Formulary/Preferred Drug List (PDL) drug limitations and restrictions such as coverage of a non-Formulary drug, quantity limits and step-therapy requirements. The request can be made by a prescriber, a member or their appointed representative. The prescriber must

Icon	Status	Definition
		provide information to support the medical exception request by fax, phone or mail.
BE Benefit Exclusion	Benefit Exclusion	Benefit Exclusion not a covered benefit.
NF Non-Formulary	Non-Formulary	Non-Formulary drugs require an exception to the Formulary due to allergy, adverse reactions or no response to all Formulary drugs. Medical exception policies provide access to non-formulary medications when Medical Necessity is established.

Definition of Restrictions

Icon	Restriction	Definition
AL Age Limit	Age Restriction	A coverage limit based on minimum or maximum age of the member in order to ensure safety and effectiveness of treatments and drug dosage.
BH Behavioral Health	Behavioral Health	Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.
STI Sexually Transmitted Infections	Sexually Transmitted Infections	Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.
DX Diagnosis Code	Diagnosis Code	Diagnosis Code.
EX Excluded Drug	Excluded Drug	Benefit Exclusion Not a Covered Benefit.
G Generic	Generic Indicator	A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand name drug. Generally, generic drugs cost less than brand name drugs.
CB Capped Benefit	Insulin for Diabetes Cost Sharing Cap	The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances will be applied towards the deductible, ***but your copay*** will not exceed a total $25.00* per thirty-day supply.

Icon	Restriction	Definition
	Limited Access	Limited Access.
	Non-Extended Day Supply	This drug is limited to a one-month supply.
	Note	Note
	Prior Authorization	Prior authorization is a clinical evaluation process to determine if the requested healthcare service is medically necessary, a covered benefit and if it is being delivered in the most appropriate health care setting. Our Medical Director or other clinical professional will review the requested healthcare service and, if it meets our requirements for coverage and medical necessity, it is authorized (approved) before those services are provided.
	Quantity Limit	Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your doctor and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian Health Plan uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following: • **Maximum Daily Dose** limits quantities to a maximum number of dosage units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a single day. Limits are based on daily dosages shown to be safe and effective, and that are approved by the FDA.
	Quantity Limit (Over Time)	**Quantity Limits Over Time** limits quantities to number of units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time
	Schedule II Max Days	Schedule II maximum of 30-day supply.
	Specialty Pharmacy	Most Specialty pharmaceuticals require prior authorization and must be obtained through the Specialty Pharmacy network. Specialty pharmaceuticals are often high cost, typically greater than $600 for up to a 30-day supply. Specialty pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply. Certain Specialty pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.
	Split Fill - New Starts	Certain specialty pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.
	Step Therapy	Step therapy promotes the appropriate use of equally effective but lower-cost Formulary drugs first. With this program, prior use

Icon	Restriction	Definition
		of one or more "prerequisite" drugs is required before a Step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drug.

Can the Formulary change during the year?

The Formulary can change throughout the year. Some reasons why it can change include:

- New drugs are approved
- Existing drugs are removed from the market
- Prescription drugs are removed from the market
- Prescription drugs may become available over the counter (without a prescription)
- Brand-name drugs lose patent protection and generic versions become available
- Changes based on new clinical guidelines

If we remove drugs from our Formulary, add quantity limits, prior authorization, 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 60 days before the change becomes effective.

What if my drug is not Covered?

You or your doctor can ask us to make an exception (**prior authorization**) to our coverage rules. We will work with your prescriber to get additional information to support your request. 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.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit 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 more.

Our review of a prior authorization request will determine if the proposed care involves a covered service, is medically necessary and whether an alternative type of prescription medication should be pursued instead of, or before, the requested prescription medication. Our decisions concerning medical necessity and Formulary alternatives will be guided by current clinical guidelines and will be made by an appropriate medical professional. Prior authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

Prior Authorization Request Processing Times

Standard Pharmacy Prior Authorization Requests

When all necessary information is provided with the Drug Prior Authorization request, standard requests are processed as expeditiously as the member's health requires, within **72 hours** after the request is received.

Expedited Pharmacy Prior Authorization Requests

When a member or their provider believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in jeopardy, a prior authorization can be expedited. These requests are processed within **24 hours** after the request is received.

If additional information is required in order to decide on a prior authorization, Presbyterian Pharmacy Services team will contact your prescriber by phone and, if necessary, by fax.

Once a decision has been made, you will receive a notification with either an approval or adverse determination.

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services at https:/www.phs.org/nondiscrimination.

Disclaimers

Please be sure a prescription drug benefit is part of your specific coverage before consulting this list. If you do not know which list is correct, you may obtain more information by calling our local Pharmacy Services team, Monday through Friday, 7 a.m. to 6 p.m.

Presbyterian Health Plan Commercial HMO: (505) 923-5678 or 1-800-356-2219

You can also send your pharmacy inquires to **AskPharmacy@phs.org**.

Coverage for some drugs may be limited to specific dosage forms and/or strengths. Your benefit design determines what is covered for you and what your copayment will be. Please refer to your benefit materials for your specific coverage information.

This list is not all-inclusive, nor does it imply a guarantee of coverage. In addition, coverage for some drugs listed may be limited to specific dosage forms and/or strengths. Substitution of a generic product for a brand-name drug is mandatory when a generic equivalent is available. If a member requests the brand-name drug in this situation, a pharmacy exception (prior authorization) may be required, and the member must pay the difference in cost between the generic and branded versions. Non-Formulary medications are not considered for coverage unless trial and failure of Formulary alternatives are documented.

Please see your Subscriber and Guide to Your Managed Care Plan (GSA) for further details.

Drug Name	Tier	Notes
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS**		
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR**		
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
AMPHETAMINE MIXTURES**		
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 3 Years)
amphetamine-dextroamphetamine oral tablet 30 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 3 Years)
AMPHETAMINES**		
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	1	PA required for age 19 years and older.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 6 Years and Max 18 Years)

Drug Name	Tier	Notes
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	1	PA required for age 19 years and older.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 3 Years and Max 18 Years)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	1	PA required for age 19 years and older.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years and Max 18 Years)
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 3 Years)
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg	3	QL (30 EA per 30 days); AL (Min 6 Years); NDS
ANALEPTICS**		
caffeine citrate intravenous solution 60 mg/3ml	1	
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	1	
ANOREXIANTS NON-AMPHETAMINE**		
benzphetamine hcl oral tablet 50 mg	3	PA; QL (90 EA per 30 days)
diethylpropion hcl oral tablet 25 mg	3	PA; QL (90 EA per 30 days)
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	3	PA; QL (30 EA per 30 days)
phendimetrazine tartrate oral tablet 35 mg	3	PA; QL (180 EA per 30 days)
phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg	3	QL (1 EA per 1 day)

Drug Name	Tier	Notes
ANTI-OBESITY - GLP-1 RECEPTOR AGONISTS**		
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML	4	PA; QL (2 ML per 28 days); NDS
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML	4	PA; QL (3 ML per 28 days); NDS
ANTI-OBESITY AGENT COMBINATIONS*		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG	3	QL (120 EA per 30 days)
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)**		
SUNOSI ORAL TABLET 150 MG, 75 MG	4	PA; QL (30 EA per 30 days); AL (Min 18 Years)
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS**		
WAKIX ORAL TABLET 17.8 MG	4	PA; LA; QL (60 EA per 30 days); AL (Min 6 Years); NDS
WAKIX ORAL TABLET 4.45 MG	4	PA; LA; QL (14 EA per 7 days); AL (Min 6 Years); NDS
STIMULANTS - MISC.**		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	1	PA; QL (30 EA per 30 days)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	1	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg	1	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er (osm) oral tablet extended release 36 mg	1	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 10 mg	1	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 20 mg	1	QL (90 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 36 mg, 54 mg	1	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er(diffus) oral tablet extended release 27 mg, 54 mg	1	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er(diffus) oral tablet extended release 36 mg	1	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl oral solution 10 mg/5ml	1	PA; QL (450 ML per 30 days); AL (Min 6 Years and Max 12 Years)
methylphenidate hcl oral solution 5 mg/5ml	1	PA; QL (180 ML per 30 days); AL (Min 6 Years and Max 12 Years)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	1	QL (90 EA per 30 days); AL (Min 3 Years)
modafinil oral tablet 100 mg, 200 mg	1	QL (30 EA per 30 days)
AMINOGLYCOSIDES		
AMINOGLYCOSIDES**		
neomycin sulfate oral tablet 500 mg	1	
tobramycin inhalation nebulization solution 300 mg/5ml	4	NDS; SP
tobramycin sulfate injection solution reconstituted 1.2 gm	MB	
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS**		
RINVOQ LQ ORAL SOLUTION 1 MG/ML	4	PA; QL (360 ML per 30 days); NDS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG	4	PA; QL (30 EA per 30 days); NDS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG	4	PA; QL (90 EA per 365 days); NDS; SP
tofacitinib citrate er oral tablet extended release 24 hour 11 mg	4	PA; QL (30 EA per 30 days); SP
tofacitinib citrate er oral tablet extended release 24 hour 22 mg	4	PA; QL (112 EA per 180 days); SP
tofacitinib citrate oral solution 1 mg/ml	4	PA; QL (300 ML per 30 days); SP

Drug Name	Tier	Notes
tofacitinib citrate oral tablet 10 mg, 5 mg	4	PA; QL (60 EA per 30 days); SP
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES**		
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	4	PA; Coverage applies to approved products only. Covered NDCs: 55513-0482-01 and 555130482-02; QL (1.6 ML per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML	4	PA; Coverage applies to approved products only. Covered NDCs: 72511-0400-01 and 72511-0400-02.; QL (3.2 EA per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	4	PA; Coverage applies to approved products only. Covered NDCs: 55513-0481-01 and 55513-0481-02; QL (1.6 ML per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	4	PA; Coverage applies to approved products only. Covered NDCs: 55513-0479-01 and 55513-0479-02; QL (1.6 ML per 28 days); NDS; SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML	4	PA; QL (0.4 ML per 28 days); NDS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	4	PA; QL (1.6 ML per 28 days); NDS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML	4	PA; QL (3.2 ML per 28 days); NDS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	4	PA; QL (1.6 ML per 28 days); NDS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML	4	PA; QL (3.2 ML per 28 days); NDS; SP
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (1 Kit per 28 days); NDS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	4	PA; QL (2 EA per 28 days); NDS; SP
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	4	PA; QL (4 EA per 28 days); NDS; SP
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (1 EA per 28 days); NDS; SP

Drug Name	Tier	Notes
YUFLYMA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	4	PA; QL (2 EA per 28 days); NDS; SP
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	4	PA; QL (2 EA per 29 days); NDS; SP
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	4	PA; QL (2 EA per 28 days); NDS; SP
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
CYCLOOXYGENASE 2 (COX-2) INHIBITORS**		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	1	QL (60 EA per 30 days)
GOLD COMPOUNDS**		
RIDAURA ORAL CAPSULE 3 MG	2	
INTERLEUKIN-6 RECEPTOR INHIBITORS**		
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML	4	PA; QL (2.28 ML per 28 days); NDS; SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	4	PA; QL (2.28 ML per 28 days); NDS; SP
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML	MB	PA; SP
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	4	PA; QL (3.6 ML per 28 days); NDS; SP
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	4	PA; QL (3.6 ML per 28 days); NDS; SP
NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS**		
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	3	
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)**		
diclofenac sodium er oral tablet extended release 24 hour 100 mg	1	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	1	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	1	
etodolac oral capsule 200 mg, 300 mg	1	
etodolac oral tablet 400 mg, 500 mg	1	
flurbiprofen oral tablet 100 mg, 50 mg	1	
ibuprofen junior strength oral tablet chewable 100 mg	1	

Drug Name	Tier	Notes
ibuprofen lysine intravenous solution 10 mg/ml	MB	
ibuprofen oral suspension 100 mg/5ml	1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin er oral capsule extended release 75 mg	1	
indomethacin oral capsule 25 mg, 50 mg	1	
ketoprofen er oral capsule extended release 24 hour 200 mg	1	
ketorolac tromethamine oral tablet 10 mg	1	QL (20 EA per 30 days)
meclofenamate sodium oral capsule 100 mg	2	
MECLOFENAMATE SODIUM ORAL CAPSULE 50 MG	2	
meloxicam oral tablet 15 mg, 7.5 mg	1	
MOTRIN IB ORAL TABLET 200 MG	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen oral suspension 125 mg/5ml	1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen sodium oral tablet 275 mg, 550 mg	1	
oxaprozin oral tablet 600 mg	1	
piroxicam oral capsule 10 mg, 20 mg	1	
sulindac oral tablet 150 mg, 200 mg	1	
TOLECTIN DS ORAL CAPSULE 400 MG	2	
TOLMETIN SODIUM ORAL CAPSULE 400 MG	2	
TOLMETIN SODIUM ORAL TABLET 600 MG	2	
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**		
OTEZLA ORAL TABLET 30 MG	4	PA; QL (60 EA per 30 days); NDS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	4	PA; QL (60 EA per 30 days); NDS; SP
PYRIMIDINE SYNTHESIS INHIBITORS**		
leflunomide oral tablet 10 mg, 20 mg	1	
SELECTIVE COSTIMULATION MODULATORS**		
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	4	PA; QL (4 ML per 30 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML	4	PA; QL (4 ML per 28 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML	4	PA; QL (1.6 ML per 28 days); NDS; SP

Drug Name	Tier	Notes
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML	4	PA; QL (2.8 ML per 28 days); NDS; SP
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS**		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	4	PA; QL (4 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	4	PA; QL (2 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML	4	PA; QL (2 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML	4	PA; QL (4 ML per 28 days); NDS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	4	PA; QL (4 ML per 28 days)
ANALGESICS - NONNARCOTIC		
ANALGESICS OTHER**		
DURACLON EPIDURAL SOLUTION 100 MCG/ML	MB	
ANALGESICS-SEDATIVES**		
butalbital-apap-caffeine oral tablet 50-325-40 mg	1	QL (6 EA per 1 day)
SALICYLATES**		
aspirin 81 oral tablet chewable 81 mg	$0	AL (Min 45 Years)
aspirin oral tablet 325 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
aspirin oral tablet chewable 81 mg	1	AL (Min 45 Years and Max 79 Years)
aspirin oral tablet delayed release 325 mg, 81 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
Bayer Aspirin Oral Tablet 325 MG	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
childrens aspirin oral tablet chewable 81 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
cvs aspirin oral tablet 325 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
diflunisal oral tablet 500 mg	1	
eq aspirin oral tablet 325 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
gnp aspirin oral tablet 325 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
gnp aspirin oral tablet delayed release 325 mg, 81 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
kp aspirin oral tablet delayed release 81 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
Medi-First Aspirin Oral Tablet 325 MG	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)

Drug Name	Tier	Notes
Medique Aspirin Oral Tablet 325 MG	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
qc aspirin oral tablet 325 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
qc aspirin oral tablet delayed release 325 mg	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
qc childrens aspirin oral tablet chewable 81 mg	$0	AL (Min 45 Years)
salsalate oral tablet 500 mg, 750 mg	1	
sb aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
sb childrens aspirin oral tablet chewable 81 mg	$0	AL (Min 45 Years)
St Joseph Aspirin Oral Tablet Delayed Release 81 MG	$0	$0 copay per PPACA guidelines.; AL (Min 45 Years)
ANALGESICS - OPIOID		
CODEINE COMBINATIONS**		
acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (166 ML per 1 day); AL (Min 12 Years)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (13 EA per 1 day); AL (Min 12 Years)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (6 EA per 1 day); AL (Min 12 Years)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (6 EA per 1 day); AL (Min 12 Years)
HYDROCODONE COMBINATIONS**		
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	1	QL (180 ML per 1 day)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	QL (12 EA per 1 day)
OPIOID AGONISTS**		
codeine sulfate oral tablet 15 mg, 30 mg	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (180 EA per 30 days); AL (Min 12 Years)

Drug Name	Tier	Notes
CODEINE SULFATE ORAL TABLET 60 MG	2	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (180 EA per 30 days); AL (Min 12 Years)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	QL (10 EA per 30 days)
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	1	QL (180 EA per 30 days)
levorphanol tartrate oral tablet 2 mg	3	QL (180 EA per 30 days)
MEPERIDINE HCL ORAL SOLUTION 50 MG/5ML	2	QL (2000 ML per 30 days)
meperidine hcl oral tablet 50 mg	1	
methadone hcl injection solution 10 mg/ml	MB	
METHADONE HCL ORAL SOLUTION 10 MG/5ML, 5 MG/5ML	2	
methadone hcl oral tablet 10 mg, 5 mg	1	QL (180 EA per 30 days)
morphine sulfate (concentrate) oral solution 20 mg/ml	1	QL (180 ML per 30 days)
morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	3	ST; QL (30 EA per 30 days)
morphine sulfate er oral capsule extended release 24 hour 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg	3	ST; Schedule II medications are limited to a 34 day supply maximum; QL (60 EA per 30 days)
morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg	1	QL (180 EA per 30 days)
morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml	1	QL (1000 ML per 30 days)
morphine sulfate oral tablet 15 mg, 30 mg	1	QL (180 EA per 30 days)
oxycodone hcl oral concentrate 100 mg/5ml	1	QL (180 ML per 30 days)
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	1	QL (180 EA per 30 days)
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg	3	ST; QL (60 EA per 30 days)
tramadol hcl er oral tablet extended release 24 hour 100 mg	3	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (90 EA per 30 days); AL (Min 12 Years)
tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg	3	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (30 EA per 30 days); AL (Min 12 Years)
tramadol hcl oral tablet 50 mg	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (240 EA per 30 days); AL (Min 12 Years)

Drug Name	Tier	Notes
OPIOID COMBINATIONS**		
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	QL (12 EA per 1 day)
OPIOID PARTIAL AGONISTS**		
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.28 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 24 MG/0.48ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.92 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32 MG/0.64ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.56 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.16ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.64 ML per 28 days)

Drug Name	Tier	Notes
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.36 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 64 MG/0.18ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.18 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 96 MG/0.27ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.27 ML per 28 days)
buprenorphine hcl sublingual tablet sublingual 2 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3 EA per 1 day); AL (Min 16 Years)

Drug Name	Tier	Notes
buprenorphine hcl sublingual tablet sublingual 8 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (4 EA per 1 day); AL (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 16 Years)

Drug Name	Tier	Notes
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 16 Years)
butorphanol tartrate injection solution 1 mg/ml	MB	
butorphanol tartrate nasal solution 10 mg/ml	3	
nalbuphine hcl injection solution 10 mg/ml, 20 mg/ml	1	
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.5 ML per 30 days); NDS
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/1.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.5 ML per 30 days); NDS
TRAMADOL COMBINATIONS**		
tramadol-acetaminophen oral tablet 37.5-325 mg	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (300 EA per 30 days); AL (Min 12 Years)
ANDROGENS-ANABOLIC		
ANDROGENS**		
danazol oral capsule 100 mg, 200 mg, 50 mg	1	

Drug Name	Tier	Notes
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	1	
testosterone enanthate intramuscular solution 200 mg/ml	2	
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%)	3	QL (150 GM per 30 days)
testosterone transdermal gel 10 mg/act (2%)	3	QL (120 GM per 30 days)
testosterone transdermal gel 12.5 mg/act (1%), 50 mg/5gm (1%)	1	QL (300 GM per 30 days)
testosterone transdermal gel 20.25 mg/1.25gm (1.62%)	3	QL (75 GM per 30 days)
testosterone transdermal gel 25 mg/2.5gm (1%)	1	QL (75 GM per 30 days)
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS**		
hydrocortisone rectal enema 100 mg/60ml	1	
RECTAL ANESTHETIC/STEROIDS**		
lidocaine-hydrocort (perianal) external cream 3-0.5 %	1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 %	2	
RECTAL STEROIDS**		
hydrocortisone (perianal) external cream 2.5 %	1	
PROCTO-MED HC EXTERNAL CREAM 2.5 %	1	
PROCTOZONE-HC EXTERNAL CREAM 2.5 %	1	
ANTHELMINTICS		
ANTHELMINTICS**		
albendazole oral tablet 200 mg	4	
BILTRICIDE ORAL TABLET 600 MG	3	
ivermectin oral tablet 3 mg	3	QL (30 EA per 90 days)
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER**		
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	3	ST
NITRATES**		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 5 mg	1	
isosorbide dinitrate oral tablet 30 mg	2	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
NITRO-BID TRANSDERMAL OINTMENT 2 %	2	

Drug Name	Tier	Notes
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg	1	
nitroglycerin sublingual tablet sublingual 0.6 mg	2	
nitroglycerin transdermal ointment 2 %	2	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr	1	
ANTIANXIETY AGENTS		
ANTIANXIETY AGENTS - MISC.**		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
hydroxyzine hcl oral syrup 10 mg/5ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
meprobamate oral tablet 200 mg, 400 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
BENZODIAZEPINES**		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
alprazolam er oral tablet extended release 24 hour 3 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
alprazolam oral tablet 2 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (135 EA per 30 days)
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
alprazolam xr oral tablet extended release 24 hour 3 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)

Drug Name	Tier	Notes
diazepam oral tablet 10 mg, 2 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
diazepam oral tablet 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); NDS
lorazepam injection solution 2 mg/ml, 4 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.5 ML per 1 day)
lorazepam oral concentrate 2 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
oxazepam oral capsule 10 mg, 15 mg, 30 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A**		
disopyramide phosphate oral capsule 100 mg, 150 mg	1	
quinidine gluconate er oral tablet extended release 324 mg	1	
QUINIDINE SULFATE ORAL TABLET 200 MG, 300 MG	1	
ANTIARRHYTHMICS TYPE I-B**		
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	1	
ANTIARRHYTHMICS TYPE I-C**		
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	1	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	1	
ANTIARRHYTHMICS TYPE III**		
amiodarone hcl intravenous solution 150 mg/3ml	1	
amiodarone hcl oral tablet 200 mg, 400 mg	1	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	3	
MULTAQ ORAL TABLET 400 MG	3	PA; QL (60 EA per 30 days)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
5-LIPOXYGENASE INHIBITORS**		
zileuton er oral tablet extended release 12 hour 600 mg	4	PA; QL (120 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
ADRENERGIC COMBINATIONS**		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	2	QL (60 EA per 30 days)
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	2	QL (20.4 GM per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	3	QL (8 GM per 30 days)
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT	3	ST; QL (13 GM per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	3	QL (60 EA per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act	2	QL (1 EA per 30 days)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	2	QL (4 GM per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	2	PA; QL (60 EA per 30 days)
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	3	QL (60 EA per 30 days)
ANTI-IGE MONOCLONAL ANTIBODIES**		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; NDS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; NDS; SP
ANTI-INFLAMMATORY AGENTS**		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	1	
BETA ADRENERGICS**		
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	1	Formulary NDCs/Manufactures: Ventolin HFA: 00173-0682-20 (Glaxo Smith Kline)Generic Proventil HFA: 69097-0142-60 (Cipla US); 00254-1007-52 (PAR Pharmaceutical) / Generic Proair HFA: 00093-3174-31(Teva); 68180-0963-01 (Lupin Pharmaceuticals); 45802-0088-01 (Perrigo Pharmaceuticals)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml	1	
albuterol sulfate oral syrup 2 mg/5ml	1	

Drug Name	Tier	Notes
albuterol sulfate oral tablet 2 mg, 4 mg	1	
isoproterenol hcl injection solution 0.2 mg/ml	MB	
levalbuterol tartrate inhalation aerosol 45 mcg/act	3	QL (30 GM per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	2	
terbutaline sulfate injection solution 1 mg/ml	1	
terbutaline sulfate oral tablet 2.5 mg, 5 mg	1	
VENTOLIN HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION	2	Formulary NDCs/Manufactures: Ventolin HFA: 00173-0682-20 (Glaxo Smith Kline)Generic Proventil HFA: 69097-0142-60 (Cipla US); 00254-1007-52 (PAR Pharmaceutical) / Generic Proair HFA: 00093-3174-31(Teva); 68180-0963-01 (Lupin Pharmaceuticals); 45802-0088-01 (Perrigo Pharmaceuticals)
BRONCHODILATORS - ANTICHOLINERGICS**		
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	2	
ipratropium bromide inhalation solution 0.02 %	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	2	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	2	
LEUKOTRIENE RECEPTOR ANTAGONISTS**		
montelukast sodium oral tablet 10 mg	1	QL (30 EA per 30 days)
montelukast sodium oral tablet chewable 4 mg, 5 mg	1	QL (30 EA per 30 days)
zafirlukast oral tablet 10 mg, 20 mg	1	
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**		
roflumilast oral tablet 500 mcg	2	PA; QL (30 EA per 30 days)
STEROID INHALANTS**		
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT	2	QL (12.2 GM per 30 days)
ALVESCO INHALATION AEROSOL SOLUTION 80 MCG/ACT	2	QL (6.1 GM per 30 days)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	2	QL (30 EA per 30 days)
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT, 220 MCG/INH	2	QL (1 EA per 30 days)

Drug Name	Tier	Notes
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 110 MCG/INH, 220 MCG/ACT, 220 MCG/INH	2	QL (1 EA per 30 days)
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT, 220 MCG/INH	2	QL (1 EA per 30 days)
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	2	QL (13 GM per 30 days)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	1	QL (120 ML per 30 days)
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act	2	
fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act	2	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT	3	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT	3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT	3	QL (21.2 GM per 30 days)
XANTHINES**		
aminophylline intravenous solution 25 mg/ml	MB	
ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML	2	
theophylline er oral tablet extended release 12 hour 300 mg	2	
theophylline er oral tablet extended release 12 hour 450 mg	1	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS**		
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
DIRECT FACTOR XA INHIBITORS**		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	2	QL (74 EA per 365 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	2	QL (60 EA per 30 days)
rivaroxaban oral tablet 2.5 mg	2	QL (2 EA per 1 Day)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	2	
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	2	QL (30 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG	2	QL (60 EA per 30 days)

Drug Name	Tier	Notes
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	2	QL (102 EA per 365 days)
HEPARINS AND HEPARINOID-LIKE AGENTS**		
BD HEPARIN POSIFLUSH INTRAVENOUS SOLUTION 10 UNIT/ML, 100 UNIT/ML	1	
heparin na (pork) lock flsh pf intravenous solution 1 unit/ml, 10 unit/ml, 100 unit/ml	1	
heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml	1	
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml	1	
heparin sodium (porcine) injection solution 20000 unit/ml	3	
heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml	1	
LOW MOLECULAR WEIGHT HEPARINS**		
enoxaparin sodium injection solution 300 mg/3ml	1	PA
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	1	PA
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML	4	PA; QL (30 ML per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML	4	PA; QL (30 Syringes per 30 days)
SYNTHETIC HEPARINOID-LIKE AGENTS**		
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	4	PA
THROMBIN INHIBITORS - SELECTIVE DIRECT & REVERSIBLE**		
argatroban in sodium chloride intravenous solution 50-0.9 mg/50ml-%	MB	
ANTICONVULSANTS		
ANTICONVULSANTS - BENZODIAZEPINES**		
clobazam oral suspension 2.5 mg/ml	3	QL (8 ML per 1 day)
clobazam oral tablet 10 mg, 20 mg	3	QL (2 EA per 1 day)
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	QL (90 EA per 30 days)

Drug Name	Tier	Notes
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	2	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (5 EA per 30 days); AL (Max 17 Years)
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	4	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (10 Delivery Systems per 30 days)
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	4	ST; QL (10 EA per 30 days); AL (Min 2 Years)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML	4	ST; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML	4	ST; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	4	ST; QL (10 EA per 30 days); AL (Min 2 Years)
ANTICONVULSANTS - MISC.**		
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
carbamazepine oral suspension 100 mg/5ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
carbamazepine oral tablet 200 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
carbamazepine oral tablet chewable 100 mg, 200 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
gabapentin oral capsule 100 mg, 300 mg, 400 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
gabapentin oral solution 250 mg/5ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
gabapentin oral tablet 600 mg, 800 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lacosamide oral solution 10 mg/ml	4	ST; QL (1200 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	QL (60 EA per 30 days)
lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
lamotrigine er oral tablet extended release 24 hour 200 mg, 250 mg, 300 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lamotrigine oral tablet chewable 25 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	3	QL (120 EA per 30 days)
levetiracetam oral solution 100 mg/ml, 500 mg/5ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
oxcarbazepine oral suspension 300 mg/5ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
primidone oral tablet 250 mg, 50 mg	1	
topiramate oral capsule sprinkle 15 mg, 25 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
CARBAMATES**		
felbamate oral suspension 600 mg/5ml	3	QL (900 ML per 30 days)
felbamate oral tablet 400 mg	3	QL (90 EA per 30 days)
felbamate oral tablet 600 mg	4	QL (180 EA per 30 days)
GABA MODULATORS**		
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	3	
HYDANTOINS**		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG	2	
DILANTIN ORAL CAPSULE 30 MG	3	
phenytoin oral suspension 125 mg/5ml	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
SUCCINIMIDES**		
ethosuximide oral capsule 250 mg	1	
ethosuximide oral solution 250 mg/5ml	1	
VALPROIC ACID**		
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
valproic acid oral capsule 250 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)**		
mirtazapine oral tablet 15 mg, 30 mg, 45 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDEPRESSANTS - MISC.**		

Drug Name	Tier	Notes
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
bupropion hcl oral tablet 100 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
MONOAMINE OXIDASE INHIBITORS (MAOIS)**		

Drug Name	Tier	Notes
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
phenelzine sulfate oral tablet 15 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
tranylcypromine sulfate oral tablet 10 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS**		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	MB	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); NDS

Drug Name	Tier	Notes
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	MB	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); NDS
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**		
citalopram hydrobromide oral solution 10 mg/5ml, 20 mg/10ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (600 ML per 30 days)
citalopram hydrobromide oral tablet 10 mg, 20 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
citalopram hydrobromide oral tablet 40 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
escitalopram oxalate oral solution 5 mg/5ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (600 ML per 30 days)
escitalopram oxalate oral tablet 10 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
fluoxetine hcl oral solution 20 mg/5ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
paroxetine hcl oral suspension 10 mg/5ml	3	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)

Drug Name	Tier	Notes
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
paroxetine hcl oral tablet 40 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
sertraline hcl oral concentrate 20 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
sertraline hcl oral tablet 100 mg, 25 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
sertraline hcl oral tablet 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
SEROTONIN MODULATORS**		
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)**		
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 37.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 EA per 1 day)
venlafaxine hcl er oral tablet extended release 24 hour 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3 EA per 1 day)

Drug Name	Tier	Notes
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
TRICYCLIC AGENTS**		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
doxepin hcl oral concentrate 10 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS**		
acarbose oral tablet 100 mg, 25 mg, 50 mg	1	
BIGUANIDES**		
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	1	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	
DIABETIC OTHER**		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	2	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	2	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML	2	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS**		
alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg	2	ST; QL (30 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	2	ST; QL (30 EA per 30 days)
saxagliptin hcl oral tablet 2.5 mg, 5 mg	3	PA; QL (30 EA per 30 days)
DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS**		
alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg	2	ST; QL (60 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	2	ST; QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	2	ST; QL (30 EA per 30 days)

Drug Name	Tier	Notes
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	2	ST; QL (60 EA per 30 days)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	3	PA; QL (60 EA per 60 days)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	3	PA; QL (30 EA per 30 days)
DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS**		
alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg	2	ST; QL (30 EA per 30 days)
HUMAN INSULIN**		
HUMALOG INJECTION SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	ST; QL (45 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	ST; QL (50 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	ST; QL (45 ML per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	ST; QL (50 ML per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	3	ST; QL (50 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	3	PA; QL (18 ML per 30 days)
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin aspart injection solution 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)

Drug Name	Tier	Notes
insulin aspart penfill subcutaneous solution cartridge 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
insulin glargine-yfgn subcutaneous solution 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin lispro injection solution 100 unit/ml	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)

Drug Name	Tier	Notes
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)

Drug Name	Tier	Notes
NOVOLOG MIX 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG RELION SOLUTION 100 UNIT/ML INJECTION	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)

Drug Name	Tier	Notes
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
INCRETIN MIMETIC AGENTS (GIP & GLP-1 RECEPTOR AGONISTS)**		
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML	2	PA; QL (2 ML per 28 days); NDS
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)**		
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	2	PA; QL (2 ML per 28 days); NDS
MEGLITINIDE ANALOGUES**		
nateglinide oral tablet 120 mg, 60 mg	1	
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	3	
SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS**		
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG	2	ST; QL (30 EA per 30 days)

Drug Name	Tier	Notes
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS**		
dapagliflozin oral tablet 10 mg, 5 mg	2	ST; QL (30 EA per 30 days)
dapagliflozin propanediol oral tablet 10 mg, 5 mg	2	ST; QL (30 EA per 30 days)
STEGLATRO ORAL TABLET 15 MG, 5 MG	2	ST; QL (30 EA per 30 days)
SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB**		
dapaglifloz base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-500 mg	2	ST; QL (30 EA per 30 days)
dapaglifloz base-metformin er oral tablet extended release 24 hour 5-1000 mg	2	ST; QL (60 EA per 30 days)
dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg	2	ST; QL (30 EA per 30 days)
dapagliflozin pro-metformin er oral tablet extended release 24 hour 5-1000 mg	2	ST; QL (60 EA per 30 days)
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG	2	ST; QL (60 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	2	ST; QL (60 EA per 30 days)
SULFONYLUREA-BIGUANIDE COMBINATIONS**		
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	1	
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	1	
SULFONYLUREAS**		
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
glipizide oral tablet 10 mg, 5 mg	1	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	1	
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	1	
SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS**		
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	1	ST
THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS**		
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	1	ST
THIAZOLIDINEDIONES**		
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	QL (30 EA per 30 days)

Drug Name	Tier	Notes
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS**		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	2	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES AND SPECIFIC ANTAGONISTS**		
ACETADOTE INTRAVENOUS SOLUTION 200 MG/ML	MB	
ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	
DESFERAL INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
DIGIFAB INTRAVENOUS SOLUTION RECONSTITUTED 40 MG	MB	
fomepizole intravenous solution 1.5 gm/1.5ml	MB	
OPIOID ANTAGONISTS**		
naloxone hcl injection solution 0.4 mg/ml	1	Naloxone injectable used with nasal atomizer is covered.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 ML per 30 days)
naloxone hcl injection solution prefilled syringe 2 mg/2ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
naloxone hcl nasal liquid 4 mg/0.1ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
naltrexone hcl oral tablet 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 28 days); NDS
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS**		
ANZEMET ORAL TABLET 50 MG	3	PA; QL (4 EA per 30 days)
granisetron hcl oral tablet 1 mg	1	ST; QL (20 EA per 30 days)
ondansetron hcl oral solution 4 mg/5ml	1	AL (Max 4 Years)
ondansetron hcl oral tablet 4 mg, 8 mg	1	QL (90 EA per 30 days)
ondansetron oral tablet dispersible 4 mg, 8 mg	1	QL (90 EA per 30 days)
palonosetron hcl intravenous solution 0.25 mg/2ml	MB	QL (2 ML per 5 days)
ANTIEMETICS - ANTICHOLINERGIC**		
scopolamine transdermal patch 72 hour 1 mg/3days	3	
trimethobenzamide hcl oral capsule 300 mg	1	
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS**		
aprepitant oral capsule 125 mg, 40 mg	3	PA; QL (1 EA per 30 days)

Drug Name	Tier	Notes
aprepitant oral capsule 80 & 125 mg, 80 mg	3	PA; QL (3 EA per 30 days)
aprepitant oral capsule therapy pack 80 & 125 mg	3	PA; QL (3 EA per 30 days)
CINVANTI INTRAVENOUS EMULSION 130 MG/18ML	MB	PA
EMEND INTRAVENOUS SOLUTION RECONSTITUTED 150 MG	MB	PA
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML	4	PA; QL (6 EA per 28 days)
ANTIFUNGALS		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)**		
caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg	MB	
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG	MB	
micafungin sodium intravenous solution reconstituted 100 mg	MB	
ANTIFUNGALS**		
AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG	MB	
amphotericin b liposome intravenous suspension reconstituted 50 mg	MB	
griseofulvin microsize oral suspension 125 mg/5ml	1	
nystatin oral tablet 500000 unit	1	
terbinafine hcl oral tablet 250 mg	1	QL (90 EA per 365 days)
IMIDAZOLES**		
ketoconazole oral tablet 200 mg	1	
TRIAZOLES**		
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%	MB	
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	1	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
itraconazole oral capsule 100 mg	3	ST; QL (168 EA per 365 days)

Drug Name	Tier	Notes
voriconazole oral suspension reconstituted 40 mg/ml	3	PA; QL (150 ML per 14 days)
voriconazole oral tablet 200 mg	3	PA; QL (60 EA per 30 days)
voriconazole oral tablet 50 mg	1	PA; QL (60 EA per 30 days)
ANTIHISTAMINES		
ANTIHISTAMINES - ETHANOLAMINES**		
diphenhydramine hcl injection solution 50 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIHISTAMINES - PHENOTHIAZINES**		
promethazine hcl injection solution 25 mg/ml, 50 mg/ml	1	
promethazine hcl oral solution 6.25 mg/5ml	1	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
promethazine hcl rectal suppository 12.5 mg, 25 mg	1	
ANTIHISTAMINES - PIPERIDINES**		
cyproheptadine hcl oral syrup 2 mg/5ml	1	
cyproheptadine hcl oral tablet 4 mg	1	
ANTIHYPERLIPIDEMICS		
ANTIHYPERLIPIDEMICS - MISC.**		
omega-3-acid ethyl esters oral capsule 1 gm	3	QL (120 EA per 30 days)
BILE ACID SEQUESTRANTS**		
cholestyramine light oral packet 4 gm	1	
cholestyramine light oral powder 4 gm/dose	1	
cholestyramine oral packet 4 gm	1	
cholestyramine oral powder 4 gm/dose	1	
colesevelam hcl oral packet 3.75 gm	4	QL (30 EA per 30 days)
colesevelam hcl oral tablet 625 mg	1	
PREVALITE ORAL PACKET 4 GM	1	
PREVALITE ORAL POWDER 4 GM/DOSE	1	
FIBRIC ACID DERIVATIVES**		
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg	1	

Drug Name	Tier	Notes
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	1	
gemfibrozil oral tablet 600 mg	1	
HMG COA REDUCTASE INHIBITORS**		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	$0	QL (30 EA per 30 days)
fluvastatin sodium oral capsule 20 mg, 40 mg	3	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	$0	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	$0	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	$0	
INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB**		
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	3	
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS**		
ezetimibe oral tablet 10 mg	1	
NICOTINIC ACID DERIVATIVES**		
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
PCSK9 INHIBITORS**		
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	2	PA; QL (2 ML per 28 days); NDS
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	2	PA; QL (2 ML per 30 days); NDS
ANTIHYPERTENSIVES		
ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS**		
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	
ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE**		
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
CAPTOPRIL-HYDROCHLOROTHIAZIDE ORAL TABLET 25-15 MG, 25-25 MG, 50-15 MG, 50-25 MG	2	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	

Drug Name	Tier	Notes
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
ACE INHIBITORS**		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
enalapril maleate oral solution 1 mg/ml	3	PA; AL (Max 12 Years)
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
moexipril hcl oral tablet 15 mg, 7.5 mg	1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	3	
QBRELIS ORAL SOLUTION 1 MG/ML	4	PA; AL (Min 1 Years and Max 12 Years)
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
AGENTS FOR PHEOCHROMOCYTOMA**		
phenoxybenzamine hcl oral capsule 10 mg	3	
ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE**		
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	3	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	3	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS**		
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	3	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	

Drug Name	Tier	Notes
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	3	QL (30 EA per 30 days)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	1	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	3	QL (60 EA per 30 days)
ANTIADRENERGICS - CENTRALLY ACTING**		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	1	
guanfacine hcl oral tablet 1 mg, 2 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
methyldopa oral tablet 250 mg, 500 mg	1	
ANTIADRENERGICS - PERIPHERALLY ACTING**		
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
BETA BLOCKER & DIURETIC COMBINATIONS**		
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
VASODILATORS**		
hydralazine hcl injection solution 20 mg/ml	1	

Drug Name	Tier	Notes
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	1	
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.**		
CONTEPO INTRAVENOUS SOLUTION RECONSTITUTED 6 GM	MB	
metronidazole oral tablet 250 mg, 500 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
PENTAM INJECTION SOLUTION RECONSTITUTED 300 MG	4	NDS
pentamidine isethionate inhalation solution reconstituted 300 mg	3	QL (1 Vial per 28 days)
trimethoprim oral tablet 100 mg	1	
XIFAXAN ORAL TABLET 200 MG	4	PA; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	4	PA; QL (60 EA per 30 days)
ANTI-INFECTIVE MISC. - COMBINATIONS**		
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIPROTOZOAL AGENTS**		
atovaquone oral suspension 750 mg/5ml	1	
CARBAPENEM COMBINATIONS**		
PRIMAXIN IV INTRAVENOUS SOLUTION RECONSTITUTED 500-500 MG	MB	
CARBAPENEMS**		
ertapenem sodium injection solution reconstituted 1 gm	MB	
CHLORAMPHENICALS**		
chloramphenicol sod succinate intravenous solution reconstituted 1 gm	MB	
GLYCOPEPTIDES**		
vancomycin hcl intravenous solution reconstituted 500 mg	1	
vancomycin hcl oral capsule 125 mg	3	QL (56 EA per 14 days)
vancomycin hcl oral capsule 250 mg	3	PA; QL (80 EA per 30 days)
vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml	2	QL (300 ML per 14 days)
LEPROSTATICS**		
dapsone oral tablet 100 mg, 25 mg	2	
LINCOSAMIDES**		
clindamycin hcl oral capsule 150 mg, 300 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
clindamycin hcl oral capsule 75 mg	1	

Drug Name	Tier	Notes
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	1	
MONOBACTAMS**		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	4	PA; QL (84 ML per 56 days); SP
OXAZOLIDINONES**		
linezolid oral suspension reconstituted 100 mg/5ml	3	PA
linezolid oral tablet 600 mg	3	PA
POLYMYXINS**		
colistimethate sodium (cba) injection solution reconstituted 150 mg	MB	
URINARY ANTI-INFECTIVES**		
methenamine hippurate oral tablet 1 gm	1	
METHENAMINE MANDELATE ORAL TABLET 0.5 GM	2	
methenamine mandelate oral tablet 1 gm	1	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	1	
nitrofurantoin monohyd macro oral capsule 100 mg	1	
nitrofurantoin oral suspension 25 mg/5ml	3	QL (560 ML per 7 days); AL (Max 12 Years)
ANTIMALARIALS		
ANTIMALARIALS**		
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
hydroxychloroquine sulfate oral tablet 200 mg	1	
primaquine phosphate oral tablet 26.3 (15 base) mg	2	
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS**		
FIRDAPSE ORAL TABLET 10 MG	4	PA; LA; QL (240 EA per 30 days); NDS; SP
pyridostigmine bromide oral solution 60 mg/5ml	3	
pyridostigmine bromide oral tablet 60 mg	1	
ANTIMYCOBACTERIAL AGENTS		
ANTIMYCOBACTERIAL AGENTS**		
ISONIAZID ORAL SYRUP 50 MG/5ML	2	
isoniazid oral tablet 100 mg	1	
isoniazid oral tablet 300 mg	2	

Drug Name	Tier	Notes
PRIFTIN ORAL TABLET 150 MG	3	
pyrazinamide oral tablet 500 mg	2	
rifabutin oral capsule 150 mg	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS**		
MYLERAN ORAL TABLET 2 MG	4	PA; NDS; SP
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED 4 MG	MB	PA; NDS
ANDROGEN BIOSYNTHESIS INHIBITORS**		
abiraterone acetate oral tablet 250 mg	3	QL (120 EA per 30 days)
ANTIADRENALS**		
LYSODREN ORAL TABLET 500 MG	4	
ANTIANDROGENS**		
bicalutamide oral tablet 50 mg	1	
ERLEADA ORAL TABLET 240 MG	4	PA; QL (1 EA per 1 day); SP
ERLEADA ORAL TABLET 60 MG	4	PA; QL (120 EA per 30 days)
NUBEQA ORAL TABLET 300 MG	4	PA; QL (120 EA per 30 days)
XTANDI ORAL CAPSULE 40 MG	4	PA; QL (120 EA per 30 days); SP
XTANDI ORAL TABLET 40 MG	4	PA; QL (120 EA per 30 days); NDS; SP
XTANDI ORAL TABLET 80 MG	4	PA; QL (60 EA per 30 days); SP
ANTIESTROGENS**		
FARESTON ORAL TABLET 60 MG	4	PA; QL (30 EA per 30 days); NDS; SP
tamoxifen citrate oral tablet 10 mg, 20 mg	1	DX (Diagnosis Code at point of sale accepted)
ANTIMETABOLITES**		
capecitabine oral tablet 150 mg, 500 mg	3	NDS
FOLOTYN INTRAVENOUS SOLUTION 20 MG/ML, 40 MG/2ML	MB	
mercaptopurine oral tablet 50 mg	1	
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	1	
methotrexate sodium injection solution reconstituted 1 gm	1	
methotrexate sodium oral tablet 2.5 mg	1	
pralatrexate intravenous solution 20 mg/ml, 40 mg/2ml	MB	

Drug Name	Tier	Notes
TABLOID ORAL TABLET 40 MG	4	PA; NDS; SP
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	2	
XATMEP ORAL SOLUTION 2.5 MG/ML	4	PA; AL (Max 12 Years)
ANTINEOPLASTIC - ALK INHIBITORS**		
ALECENSA ORAL CAPSULE 150 MG	4	PA; LA; QL (240 EA per 30 days); NDS
ALUNBRIG ORAL TABLET 180 MG, 90 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ALUNBRIG ORAL TABLET 30 MG	4	PA; QL (60 EA per 30 days); NDS; SP
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	4	PA; LA; QL (30 EA per 30 days); NDS
LORBRENA ORAL TABLET 100 MG, 25 MG	4	PA; QL (30 EA per 30 days); NDS; SP
XALKORI ORAL CAPSULE 200 MG, 250 MG	4	PA; QL (60 EA per 30 days); SP
ANTINEOPLASTIC - ANTI-BCMA ANTIBODY-DRUG COMPLEX**		
BLENREP INTRAVENOUS SOLUTION RECONSTITUTED 70 MG	MB	PA
ANTINEOPLASTIC - ANTI-CCR4 ANTIBODIES**		
POTELIGEO INTRAVENOUS SOLUTION 20 MG/5ML	MB	PA; NDS
ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES**		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	PA; NDS
ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES**		
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA
TRUXIMA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA
ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX**		
BESPONSA INTRAVENOUS SOLUTION RECONSTITUTED 0.9 MG	MB	PA; NDS
ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX**		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED 4.5 MG	MB	PA; NDS
ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES**		
DARZALEX INTRAVENOUS SOLUTION 100 MG/5ML, 400 MG/20ML	MB	PA

Drug Name	Tier	Notes
SARCLISA INTRAVENOUS SOLUTION 100 MG/5ML, 500 MG/25ML	MB	PA; NDS
ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX**		
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 140 MG	MB	PA
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 30 MG	MB	PA; NDS
ANTINEOPLASTIC - ANTI-HER2 AGENTS**		
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	MB	
TUKYSA ORAL TABLET 150 MG, 50 MG	4	PA; LA; QL (120 EA per 30 days); NDS
ANTINEOPLASTIC - ANTI-NECTIN-4 ANTIBODY-DRUG COMPLEX**		
PADCEV INTRAVENOUS SOLUTION RECONSTITUTED 20 MG, 30 MG	MB	PA; NDS
ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES**		
OPDIVO INTRAVENOUS SOLUTION 120 MG/12ML, 240 MG/24ML	MB	PA
TEVIMBRA INTRAVENOUS SOLUTION 100 MG/10ML	MB	PA
ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES**		
BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML	MB	PA; NDS
IMFINZI INTRAVENOUS SOLUTION 120 MG/2.4ML, 500 MG/10ML	MB	PA; NDS
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML	MB	PA; NDS
ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES**		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED 300 MG, 400 MG	MB	PA
ANTINEOPLASTIC - BCL-2 INHIBITORS**		
VENCLEXTA ORAL TABLET 10 MG	4	PA; LA; QL (60 EA per 30 days)
VENCLEXTA ORAL TABLET 100 MG	4	PA; LA; QL (120 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	4	PA; LA; QL (30 EA per 30 days)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	4	PA; LA; QL (1 PK per 28 days); NDS

Drug Name	Tier	Notes
ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS**		
BOSULIF ORAL CAPSULE 100 MG	4	PA; QL (3 EA per 1 day); SP
bosutinib oral tablet 100 mg	4	PA; QL (90 EA per 30 days); SP
bosutinib oral tablet 400 mg, 500 mg	4	PA; QL (30 EA per 30 days); SP
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg	4	PA; QL (30 EA per 30 days); NDS; SP
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	4	PA; LA; QL (30 EA per 30 days); NDS; SP
imatinib mesylate oral tablet 100 mg, 400 mg	4	PA; QL (60 EA per 30 days); NDS; SP
nilotinib d-tartrate oral capsule 150 mg, 200 mg, 50 mg	4	PA; QL (4 EA per 1 day); NDS; SP
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	4	PA; QL (120 EA per 30 days); NDS; SP
ANTINEOPLASTIC - BISPECIFIC T-CELL ENGAGERS**		
LUNSUMIO VELO SUBCUTANEOUS SOLUTION 45 MG/ML, 5 MG/0.5ML	MB	
ANTINEOPLASTIC - BRAF KINASE INHIBITORS**		
BRAFTOVI ORAL CAPSULE 75 MG	4	PA; QL (180 EA per 30 days); NDS; SP
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	4	PA; QL (120 EA per 30 days); NDS; SP
ZELBORAF ORAL TABLET 240 MG	4	PA; QL (240 EA per 30 days); NDS; SP
ANTINEOPLASTIC - BTK INHIBITORS**		
BRUKINSA ORAL CAPSULE 80 MG	4	PA; QL (120 EA per 30 days); NDS; SP
BRUKINSA ORAL TABLET 160 MG	4	PA; QL (60 EA per 30 days); NDS; SP
CALQUENCE ORAL TABLET 100 MG	4	PA; QL (60 EA per 30 days); NDS; SP
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	4	PA; LA; QL (1 EA per 1 day); NDS
IMBRUVICA ORAL SUSPENSION 70 MG/ML	4	PA; LA; QL (6 ML per 1 day); NDS
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	4	PA; LA; QL (28 EA per 28 days); NDS
JAYPIRCA ORAL TABLET 100 MG	4	PA; QL (60 EA per 30 days); SP
JAYPIRCA ORAL TABLET 50 MG	4	PA; QL (30 EA per 30 days); SP
ANTINEOPLASTIC - EGFR INHIBITORS**		
ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML, 200 MG/100ML	MB	PA
erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	4	PA; QL (60 EA per 30 days); NDS; SP
gefitinib oral tablet 250 mg	4	PA; LA; QL (30 EA per 30 days); NDS
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	4	PA; LA; QL (30 EA per 30 days); NDS

Drug Name	Tier	Notes
TAGRISSO ORAL TABLET 40 MG, 80 MG	4	PA; QL (30 EA per 30 days); NDS; SP
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	4	PA; QL (30 EA per 30 days); SP
ANTINEOPLASTIC - FGFR KINASE INHIBITORS**		
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	4	PA; NDS; SP
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	4	PA; LA; QL (14 EA per 21 days); NDS
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS**		
DAURISMO ORAL TABLET 100 MG	4	PA; QL (30 EA per 30 days); SP
DAURISMO ORAL TABLET 25 MG	4	PA; QL (60 EA per 30 days); SP
ERIVEDGE ORAL CAPSULE 150 MG	4	PA; QL (30 EA per 30 days); SP
ODOMZO ORAL CAPSULE 200 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS**		
ZOLINZA ORAL CAPSULE 100 MG	4	PA; QL (120 EA per 30 days); SP
ANTINEOPLASTIC - IMMUNOMODULATORS**		
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	4	PA; QL (21 EA per 28 days); NDS; SP
ANTINEOPLASTIC - KRAS INHIBITORS**		
KRAZATI ORAL TABLET 200 MG	4	PA; LA; QL (180 EA per 30 days); NDS
LUMAKRAS ORAL TABLET 120 MG	4	PA; QL (240 EA per 30 days); NDS; SP
LUMAKRAS ORAL TABLET 320 MG	4	PA; QL (3 EA per 1 day); SP
ANTINEOPLASTIC - MEK INHIBITORS**		
MEKINIST ORAL TABLET 0.5 MG	4	PA; QL (90 EA per 30 days); NDS; SP
MEKINIST ORAL TABLET 2 MG	4	PA; QL (30 EA per 30 days); NDS; SP
MEKTOVI ORAL TABLET 15 MG	4	PA; LA; QL (180 EA per 30 days); NDS
ANTINEOPLASTIC - MET INHIBITORS**		
TABRECTA ORAL TABLET 150 MG, 200 MG	4	PA; QL (120 EA per 30 days); NDS; SP
ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS**		
TAZVERIK ORAL TABLET 200 MG	4	PA; LA; QL (240 EA per 30 days); NDS
ANTINEOPLASTIC - MTOR KINASE INHIBITORS**		
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	4	PA; SP
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	4	PA; NDS; SP
temsirolimus intravenous solution 25 mg/ml	MB	

Drug Name	Tier	Notes
ANTINEOPLASTIC - MULTIKINASE INHIBITORS**		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	4	PA; QL (30 EA per 30 days); SP
CAPRELSA ORAL TABLET 100 MG	4	PA; LA; QL (60 EA per 30 days); NDS
CAPRELSA ORAL TABLET 300 MG	4	PA; LA; QL (30 EA per 30 days); NDS
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	4	PA; LA; NDS
lapatinib ditosylate oral tablet 250 mg	4	PA; QL (180 EA per 30 days); NDS; SP
NERLYNX ORAL TABLET 40 MG	4	PA; LA; QL (180 EA per 30 days); NDS; SP
pazopanib hcl oral tablet 200 mg	4	PA; QL (120 EA per 30 days); SP
QINLOCK ORAL TABLET 50 MG	4	PA; LA; QL (90 EA per 30 days); NDS
RYDAPT ORAL CAPSULE 25 MG	4	PA; QL for AML=120/30QL for ASM, SM, AHN, and MCL= 240/30; QL (120 EA per 30 days)
sorafenib tosylate oral tablet 200 mg	4	PA; QL (120 EA per 30 days); SP
STIVARGA ORAL TABLET 40 MG	4	PA; QL (84 EA per 28 days); NDS; SP
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	4	PA; SP
XOSPATA ORAL TABLET 40 MG	4	PA; LA; QL (90 EA per 30 days); NDS
ANTINEOPLASTIC - MULTIPLE RECEPTOR ANTIBODIES**		
RYBREVANT INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS**		
AYVAKIT ORAL TABLET 100 MG, 200 MG, 300 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ANTINEOPLASTIC - PROTEASOME INHIBITORS**		
bortezomib injection solution reconstituted 3.5 mg	MB	
ANTINEOPLASTIC - RET INHIBITORS**		
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	4	PA; LA; QL (2 EA per 1 day); NDS
RETEVMO ORAL TABLET 40 MG	4	PA; LA; QL (3 EA per 1 day); NDS
ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS**		
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	4	PA; SP
ANTINEOPLASTIC - XPO1 INHIBITORS**		
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	4	PA; LA; QL (8 EA per 28 days); NDS
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; LA; QL (8 EA per 28 days); NDS

Drug Name	Tier	Notes
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	4	LA; QL (4 EA per 28 days); NDS
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; QL (4 packs per 28 days); NDS
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; LA; NDS
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG	4	PA; DX (Diagnosis Validation Required); QL (4 EA per 28 days); NDS; SP
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; QL (4 packs per 28 days); NDS
ANTINEOPLASTIC ANTIBIOTICS**		
valrubicin intravesical solution 40 mg/ml	MB	NDS
ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES**		
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; NDS
ANTINEOPLASTIC COMBINATIONS**		
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1800-30000 MG-UT/15ML	MB	PA
INQOVI ORAL TABLET 35-100 MG	4	PA; QL (5 EA per 28 days); NDS; SP
KEYTRUDA QLEX SUBCUTANEOUS SOLUTION 395-4800 MG -UNT/2.4ML, 790-9600 MG -UNT/4.8ML	MB	PA
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	4	PA; QL (40 EA per 28 days); NDS; SP
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 300-5000 MG -UT/2.5ML	MB	SP
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 600-10000 MG-UT/5ML	MB	PA
RYBREVANT FASPRO SUBCUTANEOUS SOLUTION 1600-20000 MG-UT/10ML, 2240-28000 MG-UT/14ML	MB	PA; SP
RYBREVANT FASPRO SUBCUTANEOUS SOLUTION 2400-30000 MG-UT/15ML, 3520-44000 MG-UT/22ML	MB	
TECENTRIQ HYBREZA SUBCUTANEOUS SOLUTION 1875-30000 MG-UT/15ML	MB	PA
ANTINEOPLASTIC ENZYMES**		
ONCASPAR INJECTION SOLUTION 750 UNIT/ML	MB	PA; NDS
ANTINEOPLASTICS MISC.**		
hydroxyurea oral capsule 500 mg	1	
MATULANE ORAL CAPSULE 50 MG	4	PA; SP
TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML	MB	
AROMATASE INHIBITORS**		

Drug Name	Tier	Notes
anastrozole oral tablet 1 mg	1	DX (Diagnosis Code at point of sale accepted)
exemestane oral tablet 25 mg	3	DX (Diagnosis at point of sale accepted)
letrozole oral tablet 2.5 mg	1	DX (Diagnosis code at point of sale accepted)
CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS**		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	4	PA; QL (21 EA per 28 days); NDS; SP
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	4	PA; QL (21 EA per 28 days); NDS; SP
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; LA; QL (21 EA per 28 days); NDS
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; LA; QL (42 EA per 28 days); NDS
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; LA; QL (63 EA per 28 days); NDS
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	4	PA; QL (60 EA per 30 days); NDS; SP
FOLIC ACID ANTAGONISTS RESCUE AGENTS**		
leucovorin calcium injection solution reconstituted 100 mg, 200 mg, 350 mg, 50 mg, 500 mg	MB	NDS
LEUCOVORIN CALCIUM ORAL TABLET 10 MG, 15 MG	2	
leucovorin calcium oral tablet 25 mg, 5 mg	1	
VYKOURA INJECTION SOLUTION 350 MG/35ML, 50 MG/5ML, 500 MG/50ML	MB	
IMIDAZOTETRAZINES**		
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	3	PA; NDS
ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS**		
TIBSOVO ORAL TABLET 250 MG	4	PA; LA; QL (60 EA per 30 days); NDS
JANUS ASSOCIATED KINASE (JAK) INHIBITORS**		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	4	PA; QL (60 EA per 30 days); SP
JAKAFI XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG, 33 MG, 44 MG, 55 MG	4	PA; STI (9/2026: Added per BA request); QL (30 EA per 30 Days); SP
LHRH ANALOGS**		
leuprolide acetate injection kit 1 mg/0.2ml	MB	PA not required if billed with Dx codes F64.1 - F64.9.; NDS

Drug Name	Tier	Notes
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	MB	PA
MITOTIC INHIBITORS**		
etoposide oral capsule 50 mg	3	NDS
NITROGEN MUSTARDS AND RELATED ANALOGUES**		
cyclophosphamide intravenous solution 1 gm/5ml, 500 mg/2.5ml	MB	
cyclophosphamide oral capsule 25 mg, 50 mg	3	
EVOMELA INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA
LEUKERAN ORAL TABLET 2 MG	4	PA; NDS; SP
NITROSOUREAS**		
carmustine intravenous solution reconstituted 100 mg	MB	
PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS**		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	4	PA; LA; QL (60 EA per 30 days); NDS
ITOVEBI ORAL TABLET 3 MG	4	PA; QL (2 EA per 1 day); NDS; SP
ITOVEBI ORAL TABLET 9 MG	4	PA; QL (1 EA per 1 day); NDS; SP
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; QL (60 EA per 30 days); NDS; SP
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	4	PA; QL (60 EA per 30 days); NDS
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	4	PA; QL (60 EA per 30 days); NDS; SP
ZYDELIG ORAL TABLET 100 MG, 150 MG	4	PA; LA; QL (60 EA per 30 days); NDS
POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS**		
LYNPARZA ORAL TABLET 100 MG, 150 MG	4	PA; QL (120 EA per 30 days); NDS; SP
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	4	PA; QL (120 EA per 30 days); SP
TALZENNA ORAL CAPSULE 0.1 MG, 0.35 MG	4	PA; QL (30 EA per 30 days); NDS; SP
TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG	4	PA; QL (30 EA per 30 days); SP
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	4	PA; QL (30 EA per 30 days); NDS; SP
PROGESTINS-ANTINEOPLASTIC**		
megestrol acetate oral suspension 40 mg/ml	1	
megestrol acetate oral suspension 400 mg/10ml	1	PA
megestrol acetate oral tablet 20 mg, 40 mg	1	

Drug Name	Tier	Notes
SELECTIVE ESTROGEN RECEPTOR DEGRADERS**		
ORSERDU ORAL TABLET 345 MG	4	PA; QL (30 EA per 30 days); SP
ORSERDU ORAL TABLET 86 MG	4	PA; QL (90 EA per 30 days); SP
VEPPANU ORAL TABLET 100 MG, 200 MG	4	PA; QL (30 EA per 30 Days); SP
SELECTIVE RETINOID X RECEPTOR AGONISTS**		
bexarotene oral capsule 75 mg	4	PA; SP
TOPOISOMERASE I INHIBITORS**		
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG	4	PA; NDS; SP
URINARY TRACT PROTECTIVE AGENTS**		
MESNEX ORAL TABLET 400 MG	4	
VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS**		
INLYTA ORAL TABLET 1 MG, 5 MG	4	PA; QL (120 EA per 30 days); SP
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	4	PA; QL (30 EA per 30 days); NDS; SP
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	4	PA; QL (90 EA per 30 days); NDS; SP
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	4	PA; QL (60 EA per 30 days); NDS; SP
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	4	PA; QL (90 EA per 30 days); NDS; SP
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	4	PA; QL (60 EA per 30 days); NDS; SP
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	4	PA; QL (90 EA per 30 days); NDS; SP
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	4	PA; QL (30 EA per 30 days); NDS; SP
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	4	PA; QL (60 EA per 30 days); NDS; SP
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS**		

Drug Name	Tier	Notes
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIPARKINSON DOPAMINERGICS**		
amantadine hcl oral capsule 100 mg	1	
amantadine hcl oral tablet 100 mg	1	
bromocriptine mesylate oral capsule 5 mg	1	
bromocriptine mesylate oral tablet 2.5 mg	1	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS**		
selegiline hcl oral capsule 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
selegiline hcl oral tablet 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
LEVODOPA COMBINATIONS**		
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	1	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	1	
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	1	
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	3	
NONERGOLINE DOPAMINE RECEPTOR AGONISTS**		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML	MB	LA; NDS
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
PERIPHERAL COMT INHIBITORS**		
entacapone oral tablet 200 mg	1	
ONGENTYS ORAL CAPSULE 50 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS**		

Drug Name	Tier	Notes
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lithium carbonate oral tablet 300 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
LITHIUM ORAL SOLUTION 8 MEQ/5ML	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIPSYCHOTICS - MISC.**		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	4	PA; QL (30 EA per 30 days); AL (Min 18 Years)

Drug Name	Tier	Notes
lurasidone hcl oral tablet 120 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 13 Years)
lurasidone hcl oral tablet 20 mg, 40 mg, 60 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 10 Years)
lurasidone hcl oral tablet 80 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 10 Years)
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 1 day)

Drug Name	Tier	Notes
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 1 day); SP
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
BENZISOXAZOLES**		
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.75 ML per 28 days); AL (Min 18 Years); NDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 ML per 28 days); AL (Min 18 Years); NDS

Drug Name	Tier	Notes
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.5 ML per 28 days); AL (Min 18 Years); NDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.25 ML per 28 days); AL (Min 18 Years); NDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.5 ML per 28 days); AL (Min 18 Years); NDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.875 ML per 84 days); AL (Min 18 Years); NDS

Drug Name	Tier	Notes
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.315 ML per 84 days); AL (Min 18 Years); NDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.75 ML per 84 days); AL (Min 18 Years); NDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.625 ML per 84 days); AL (Min 18 Years); NDS
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 12 Years)

Drug Name	Tier	Notes
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 vials per 28 days); AL (Min 18 Years); NDS
risperidone oral solution 1 mg/ml	1	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (480 ML per 30 days); AL (Min 5 Years)
risperidone oral tablet 0.25 mg	1	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 5 Years)
risperidone oral tablet 0.5 mg, 1 mg, 2 mg, 3 mg	1	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 5 Years)

Drug Name	Tier	Notes
risperidone oral tablet 4 mg	1	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 5 Years)
risperidone oral tablet dispersible 0.25 mg	3	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 5 Years)
risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg	3	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 5 Years)
risperidone oral tablet dispersible 4 mg	3	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 5 Years)
BUTYROPHENONES**		

Drug Name	Tier	Notes
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Min 18 Years)
haloperidol lactate injection solution 5 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
haloperidol lactate oral concentrate 2 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
DIBENZODIAZEPINES**		

Drug Name	Tier	Notes
clozapine oral tablet 100 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (270 EA per 30 days); AL (Min 6 Years)
clozapine oral tablet 200 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (135 EA per 30 days); AL (Min 6 Years)
clozapine oral tablet 25 mg, 50 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
DIBENZO-OXEPINO PYRROLES**		
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 10 Years)

Drug Name	Tier	Notes
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	4	PA; QL (30 EA per 30 days); AL (Min 18 Years)
DIBENZOTHIAZEPINES**		
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 400 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 400 mg, 50 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 6 Years)
quetiapine fumarate oral tablet 150 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
quetiapine fumarate oral tablet 300 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
DIBENZOXAZEPINES**		
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
MUSCARINIC AGENT - COMBINATIONS**		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 EA per 1 day); AL (Min 18 Years)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (56 EA per 365 days); AL (Min 18 Years)
PHENOTHIAZINES**		

Drug Name	Tier	Notes
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
COMPRO RECTAL SUPPOSITORY 25 MG	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
FLUPHENAZINE HCL ORAL CONCENTRATE 5 MG/ML	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
FLUPHENAZINE HCL ORAL ELIXIR 2.5 MG/5ML	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluphenazine hcl oral tablet 5 mg	1	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
prochlorperazine edisylate injection solution 10 mg/2ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
prochlorperazine rectal suppository 25 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
QUINOLINONE DERIVATIVES**		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3 EA per 84 days); AL (Min 18 Years)

Drug Name	Tier	Notes
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3 EA per 84 days); AL (Min 18 Years)
aripiprazole oral solution 1 mg/ml	3	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (750 ML per 30 days); AL (Min 6 Years)
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
aripiprazole oral tablet dispersible 10 mg, 15 mg	4	PA; PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.4 ML per 30 days); AL (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3.9 ML per 56 days); AL (Min 18 Years); NDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.6 ML per 28 days); AL (Min 18 Years); NDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.4 ML per 28 days); AL (Min 18 Years); NDS

Drug Name	Tier	Notes
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3.2 ML per 28 days); AL (Min 18 Years); NDS
THIENBENZODIAZEPINES**		
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
THIOXANTHENES**		
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTISEPTICS & DISINFECTANTS		

Drug Name	Tier	Notes
CHLORINE ANTISEPTICS**		
chlorhexidine gluconate solution 20 %	1	
ANTIVIRALS		
ANTIRETROVIRAL COMBINATIONS**		
abacavir sulfate-lamivudine oral tablet 600-300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Biktarvy Oral Tablet 30-120-15 MG, 50-200-25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML	MB	PA
Cimduo Oral Tablet 300-300 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
Delstrigo Oral Tablet 100-300-300 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Descovy Oral Tablet 120-15 MG	$0	PA for New Starts; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Descovy Oral Tablet 200-25 MG	$0	PA for New Starts; DX (Covered at a zero-dollar copay for the diagnosis of Pre-exposure prophylaxis (PrEP) per ACA); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
emtricitabine-tenofovir df oral tablet 167-250 mg, 200-300 mg	$0	DX (Covered at a zero-dollar copay for the diagnosis of Pre-exposure prophylaxis (PrEP) per ACA); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. *High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Evotaz Oral Tablet 300-150 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
Genvoya Oral Tablet 150-150-200-10 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Juluca Oral Tablet 50-25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
lamivudine-zidovudine oral tablet 150-300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)

Drug Name	Tier	Notes
Odefsey Oral Tablet 200-25-25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Prezcobix Oral Tablet 675-150 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Prezcobix Oral Tablet 800-150 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans. Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
Stribild Oral Tablet 150-150-200-300 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Symtuza Oral Tablet 800-150-200-10 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Triumeq Oral Tablet 600-50-300 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
triumeq pd oral tablet soluble 60-5-30 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
ANTIRETROVIRALS - CAPSID INHIBITORS**		
YEZTUGO ORAL TABLET 300 MG	MB	

Drug Name	Tier	Notes
YEZTUGO SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML	MB	
ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)**		
maraviroc oral tablet 150 mg, 300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
Selzentry Oral Solution 20 MG/ML	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR**		
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML	MB	
ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR**		
Rukobia Oral Tablet Extended Release 12 Hour 600 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ANTIRETROVIRALS - INTEGRASE INHIBITORS**		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML	MB	

Drug Name	Tier	Notes
Isentress HD Oral Tablet 600 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Isentress Oral Packet 100 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Isentress Oral Tablet 400 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Isentress Oral Tablet Chewable 100 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
Isentress Oral Tablet Chewable 25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
Tivicay Oral Tablet 50 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Tivicay PD Oral Tablet Soluble 5 MG	$0	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days); AL (Max 12 Years)
ANTIRETROVIRALS - PROTEASE INHIBITORS**		
Aptivus Oral Capsule 250 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)

Drug Name	Tier	Notes
atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
darunavir oral tablet 600 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
darunavir oral tablet 800 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
fosamprenavir calcium oral tablet 700 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
Prezista Oral Suspension 100 MG/ML	$0	QL (360 ML per 30 days)

Drug Name	Tier	Notes
Prezista Oral Tablet 150 MG, 75 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Reyataz Oral Packet 50 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (150 EA per 30 days); AL (Max 8 Years)
ritonavir oral tablet 100 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (360 EA per 30 days)
Viracept Oral Tablet 250 MG, 625 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES**		

Drug Name	Tier	Notes
efavirenz oral tablet 600 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
etravirine oral tablet 100 mg, 200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Intelence Oral Tablet 25 MG	$0	QL (60 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 400 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
nevirapine oral tablet 200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
Pifeltro Oral Tablet 100 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
rilpivirine hcl oral tablet 25 mg	$0	
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES**		
abacavir sulfate oral solution 20 mg/ml	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
abacavir sulfate oral tablet 300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES**		

Drug Name	Tier	Notes
emtricitabine oral capsule 200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Emtriva Oral Solution 10 MG/ML	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lamivudine oral solution 10 mg/ml	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
lamivudine oral tablet 150 mg, 300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES**		

Drug Name	Tier	Notes
zidovudine oral capsule 100 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
zidovudine oral syrup 50 mg/5ml	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
zidovudine oral tablet 300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES**		
tenofovir disoproxil fumarate oral tablet 300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); NDS

Drug Name	Tier	Notes
Viread Oral Powder 40 MG/GM	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (225 GM per 30 days); NDS
Viread Oral Tablet 150 MG, 200 MG, 250 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); NDS
ANTIRETROVIRALS ADJUVANTS**		
TYBOST ORAL TABLET 150 MG	2	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
ANTIVIRAL COMBINATIONS**		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	3	QL (40 EA per 365 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	3	QL (60 EA per 365 days)
CMV AGENTS**		
cidofovir intravenous solution 75 mg/ml	MB	
valganciclovir hcl oral solution reconstituted 50 mg/ml	4	PA; QL (540 ML per 30 days)
valganciclovir hcl oral tablet 450 mg	3	PA; QL (60 EA per 30 days)
HEPATITIS B AGENTS**		
entecavir oral tablet 0.5 mg, 1 mg	4	PA; QL (30 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
lamivudine oral tablet 100 mg	1	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	4	QL (30 EA per 30 days); NDS; SP
HEPATITIS C AGENT - COMBINATIONS**		
MAVYRET ORAL PACKET 50-20 MG	4	PA; QL (150 EA per 30 days); NDS; SP
MAVYRET ORAL TABLET 100-40 MG	4	PA; QL (3 EA per 1 day); NDS; SP
sofosbuvir-velpatasvir oral tablet 400-100 mg	4	PA; QL (84 EA per 365 days); NDS; SP
HEPATITIS C AGENTS**		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	4	PA; NDS; SP
ribavirin oral capsule 200 mg	3	PA; NDS
ribavirin oral tablet 200 mg	3	PA; NDS
HERPES AGENTS - PURINE ANALOGUES**		
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	1	
acyclovir oral tablet 400 mg, 800 mg	1	
acyclovir sodium intravenous solution 50 mg/ml	MB	
valacyclovir hcl oral tablet 1 gm, 500 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
HERPES AGENTS - THYMIDINE ANALOGUES**		
famciclovir oral tablet 125 mg, 250 mg, 500 mg	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
INFLUENZA AGENTS**		
rimantadine hcl oral tablet 100 mg	2	
MISC. ANTIVIRALS**		
LAGEVRIO ORAL CAPSULE 200 MG	3	QL (80 EA per 365 days)
VEKLURY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	
NEURAMINIDASE INHIBITORS**		
oseltamivir phosphate oral capsule 30 mg	3	QL (20 EA per 180 days)
oseltamivir phosphate oral capsule 45 mg, 75 mg	3	QL (10 EA per 180 days)
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	3	QL (180 ML per 180 days)
BETA BLOCKERS		
ALPHA-BETA BLOCKERS**		
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
labetalol hcl intravenous solution 5 mg/ml	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
BETA BLOCKERS CARDIO-SELECTIVE**		
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
esmolol hcl-sodium chloride intravenous solution 2000 mg/100ml	MB	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	3	
BETA BLOCKERS NON-SELECTIVE**		
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
pindolol oral tablet 10 mg, 5 mg	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
PROPRANOLOL HCL ORAL SOLUTION 20 MG/5ML, 40 MG/5ML	2	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	

Drug Name	Tier	Notes
TIMOLOL MALEATE ORAL TABLET 10 MG, 20 MG, 5 MG	2	
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKERS**		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	1	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	1	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
diltiazem hcl er oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl intravenous solution 50 mg/10ml	1	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	1	
KATERZIA ORAL SUSPENSION 1 MG/ML	3	AL (Max 12 Years)
nicardipine hcl in nacl intravenous solution 20-0.9 mg/200ml-%, 40-0.9 mg/200ml-%	MB	
nicardipine hcl oral capsule 20 mg, 30 mg	1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	1	
nimodipine oral capsule 30 mg	1	
TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg	2	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 240 mg	1	
verapamil hcl er oral capsule extended release 24 hour 180 mg	1	QL (60 EA per 30 days)

Drug Name	Tier	Notes
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
CARDIOTONICS		
CARDIAC GLYCOSIDES**		
digoxin injection solution 0.25 mg/ml	MB	
digoxin oral tablet 125 mcg, 250 mcg	1	
INOTROPES**		
dobutamine hcl intravenous solution 12.5 mg/ml, 250 mg/20ml	MB	
dopamine hcl intravenous solution 40 mg/ml	MB	
CARDIOVASCULAR AGENTS - MISC.		
CALCIUM CHANNEL BLOCKER & HMG COA REDUCTASE INHIBIT COMB**		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	3	QL (30 EA per 30 days)
NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB**		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG	3	PA; QL (60 EA per 30 days)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	1	QL (60 EA per 30 days)
PROSTAGLANDIN VASODILATORS**		
treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 50 mg/20ml	MB	PA
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS**		
ambrisentan oral tablet 10 mg, 5 mg	4	PA; QL (30 EA per 30 days); NDS; SP
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS**		
sildenafil citrate oral tablet 20 mg	3	QL (90 EA per 30 days)
tadalafil (pah) oral tablet 20 mg	1	
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION**		
cefadroxil oral capsule 500 mg	3	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	3	

Drug Name	Tier	Notes
cefadroxil oral tablet 1 gm	3	
cefazolin sodium injection solution reconstituted 500 mg	MB	
cephalexin oral capsule 250 mg, 500 mg	1	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
CEPHALOSPORINS - 2ND GENERATION**		
cefaclor oral capsule 250 mg, 500 mg	1	
cefoxitin sodium intravenous solution reconstituted 1 gm	MB	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefprozil oral tablet 250 mg, 500 mg	1	
cefuroxime axetil oral tablet 250 mg, 500 mg	1	
CEPHALOSPORINS - 3RD GENERATION**		
cefdinir oral capsule 300 mg	1	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	3	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	3	
ceftriaxone sodium injection solution reconstituted 1 gm	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ceftriaxone sodium intravenous solution reconstituted 1 gm, 2 gm	MB	
CEPHALOSPORINS - 4TH GENERATION**		
cefepime hcl intravenous solution reconstituted 2 gm	MB	
CEPHALOSPORINS - 5TH GENERATION**		

Drug Name	Tier	Notes
ceftaroline fosamil intravenous solution reconstituted 400 mg, 600 mg	MB	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	MB	
CONTRACEPTIVES		
BIPHASIC CONTRACEPTIVES - ORAL**		
AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG	3	PA; Up to a six-month supply. *NMAC 13.10.32.(8)
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
COMBINATION CONTRACEPTIVES - ORAL**		
Afirmelle Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
alyacen 1/35 oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
apri oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Aurovela Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Aurovela FE 1/20 Oral Tablet 1-20 MG-MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
Aviane Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
AYUNA ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
BALZIVA ORAL TABLET 0.4-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
blisovi 24 fe oral tablet 1-20 mg-mcg(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
blisovi fe 1/20 oral tablet 1-20 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
briellyn oral tablet 0.4-35 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
cryselle-28 oral tablet 0.3-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
Delyla Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg	3	Up to a six-month supply. *NMAC 13.10.32.(8)
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
elinest oral tablet 0.3-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
enskyce oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
estarylla oral tablet 0.25-35 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Falmina Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
Hailey FE 1.5/30 Oral Tablet 1.5-30 MG-MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Hailey FE 1/20 Oral Tablet 1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
isibloom oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
JASMIEL ORAL TABLET 3-0.02 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
juleber oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
junel fe 1/20 oral tablet 1-20 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
kaitlib fe oral tablet chewable 0.8-25 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Kalliga Oral Tablet 0.15-30 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
kelnor 1/35 oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
KURVELO ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LARIN 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
larin fe 1/20 oral tablet 1-20 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Lessina Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Loestrin Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
loestrin fe 1/20 oral tablet 1-20 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
loryna oral tablet 3-0.02 mg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
low-ogestrel oral tablet 0.3-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
LO-ZUMANDIMINE ORAL TABLET 3-0.02 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Lutera Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
marlissa oral tablet 0.15-30 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
microgestin fe 1/20 oral tablet 1-20 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Mili Oral Tablet 0.25-35 MG-MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
mono-linyah oral tablet 0.25-35 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
necon 1/35 (28) oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
nikki oral tablet 3-0.02 mg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
Orsythia Oral Tablet 0.1-20 MG-MCG	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
PHILITH ORAL TABLET 0.4-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
reclipsen oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
solia oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
sprintec 28 oral tablet 0.25-35 mg-mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Sronyx Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
SYEDA ORAL TABLET 3-0.03 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
vestura oral tablet 3-0.02 mg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Vienva Oral Tablet 0.1-20 MG-MCG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
VyLibra Oral Tablet 0.25-35 MG-MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
WERA ORAL TABLET 0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
wymzya fe oral tablet chewable 0.4-35 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
ZUMANDIMINE ORAL TABLET 3-0.03 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
COMBINATION CONTRACEPTIVES - TRANSDERMAL**		
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	$0	$0 Copay per PPACA guidelines; Up to a six-month supply. *NMAC 13.10.32.(8); QL (9 EA per 84 days)
xulane transdermal patch weekly 150-35 mcg/24hr	$0	$0 Copay per PPACA guidelines; Up to a six-month supply. *NMAC 13.10.32.(8); QL (9 EA per 84 days)
Zafemy Transdermal Patch Weekly 150-35 MCG/24HR	$0	$0 Copay per PPACA guidelines; Up to a six-month supply. *NMAC 13.10.32.(8); QL (9 EA per 84 days)
COMBINATION CONTRACEPTIVES - VAGINAL**		
EluRyng Vaginal Ring 0.12-0.015 MG/24HR	$0	Up to a six-month supply. *NMAC 13.10.32.(8); QL (3 EA per 84 days)
EnilloRing Vaginal Ring 0.12-0.015 MG/24HR	$0	Up to a six-month supply. *NMAC 13.10.32.(8); QL (3 EA per 84 days)
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	$0	Up to a six-month supply. *NMAC 13.10.32.(8); QL (3 EA per 84 days)
Haloette Vaginal Ring 0.12-0.015 MG/24HR	$0	Up to a six-month supply. *NMAC 13.10.32.(8); QL (3 EA per 84 days)
CONTINUOUS CONTRACEPTIVES - ORAL**		
amethyst oral tablet 90-20 mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
DOLISHALE ORAL TABLET 90-20 MCG	1	
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
COPPER CONTRACEPTIVES - IUD**		
Paragard Intrauterine Copper Intrauterine Intrauterine Device	$0	$0 Copay per PPACA guidelines.; QL (1 EA per 999 days)
EMERGENCY CONTRACEPTIVES**		
Aftera Oral Tablet 1.5 MG	$0	$0 Copay per PPACA guidelines.
Ella Oral Tablet 30 MG	$0	$0 Copay per PPACA guidelines.
levonorgestrel oral tablet 1.5 mg	$0	$0 Copay per PPACA guidelines.
My Way Oral Tablet 1.5 MG	$0	$0 Copay per PPACA guidelines.

Drug Name	Tier	Notes
Opcicon One-Step Oral Tablet 1.5 MG	$0	$0 Copay per PPACA guidelines.
Take Action Oral Tablet 1.5 MG	$0	$0 Copay per PPACA guidelines.
EXTENDED-CYCLE CONTRACEPTIVES - ORAL**		
ashlyna oral tablet 0.15-0.03 &0.01 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
camrese lo oral tablet 0.1-0.02 & 0.01 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
camrese oral tablet 0.15-0.03 &0.01 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
daysee oral tablet 0.15-0.03 &0.01 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Iclevia Oral Tablet 0.15-0.03 MG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
introvale oral tablet 0.15-0.03 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Jaimiess Oral Tablet 0.15-0.03 &0.01 MG	$0	$0 Copay per PPACA guidelines.; AG (Max 55 Years); Up to a six-month supply. *NMAC 13.10.32.(8)
jolessa oral tablet 0.15-0.03 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 &0.01 mg, 0.15-0.03 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
LoJaimiess Oral Tablet 0.1-0.02 & 0.01 MG	$0	$0 Copay per PPACA guidelines.; AG (Max 55 Years); Up to a six-month supply. *NMAC 13.10.32.(8)
setlakin oral tablet 0.15-0.03 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Simpesse Oral Tablet 0.15-0.03 &0.01 MG	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
PROGESTIN CONTRACEPTIVES - INJECTABLE**		
Depo-SubQ Provera 104 Subcutaneous Suspension Prefilled Syringe 104 MG/0.65ML	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	$0	$0 copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	$0	Up to a six-month supply. *NMAC 13.10.32.(8)
PROGESTIN CONTRACEPTIVES - IUD**		
Kyleena Intrauterine Intrauterine Device 19.5 MG	$0	QL (1 EA per 999 days)
PROGESTIN CONTRACEPTIVES - ORAL**		
Camila Oral Tablet 0.35 MG	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Deblitane Oral Tablet 0.35 MG	$0	$0 Copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Errin Oral Tablet 0.35 MG	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Heather Oral Tablet 0.35 MG	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Jencycla Oral Tablet 0.35 MG	$0	$0 Copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Lyleq Oral Tablet 0.35 MG	$0	$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
lyza oral tablet 0.35 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Nora-BE Oral Tablet 0.35 MG	$0	$0 Copay per PPACA guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
norethindrone oral tablet 0.35 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
norlyda oral tablet 0.35 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
norlyroc oral tablet 0.35 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Opill Oral Tablet 0.075 MG	$0	
sharobel oral tablet 0.35 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
TRIPHASIC CONTRACEPTIVES - ORAL**		
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
DASETTA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg	$0	$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
levonest oral tablet 50-30/75-40/ 125-30 mcg	$0	$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
PIRMELLA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TILIA FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
tri femynor oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LO-MARZIA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LO-MILI ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Tri-Mili Oral Tablet 0.18/0.215/0.25 MG-35 MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
trinessa (28) oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
trivora (28) oral tablet 50-30/75-40/ 125-30 mcg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Tri-VyLibra Oral Tablet 0.18/0.215/0.25 MG-35 MCG	$0	$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	$0	$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS**		
budesonide oral capsule delayed release particles 3 mg	3	QL (448 EA per 365 days)
DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML, 40 MG/ML, 80 MG/ML	MB	
dexamethasone intensol oral concentrate 1 mg/ml	2	
dexamethasone oral elixir 0.5 mg/5ml	1	
dexamethasone oral solution 0.5 mg/5ml	1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
dexamethasone sodium phosphate injection solution 20 mg/5ml	MB	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet therapy pack 4 mg	1	
prednisolone oral solution 15 mg/5ml	1	
prednisolone sodium phosphate oral solution 15 mg/5ml, 5 mg/5ml	1	
prednisone oral solution 5 mg/5ml	1	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	
MINERALOCORTICOIDS**		
fludrocortisone acetate oral tablet 0.1 mg	1	
STEROID COMBINATIONS**		

Drug Name	Tier	Notes
betamethasone sod phos & acet injection suspension 6 (3-3) mg/ml	MB	
CELESTONE SOLUSPAN INJECTION SUSPENSION 6 (3-3) MG/ML	MB	
COUGH/COLD/ALLERGY		
ANTITUSSIVE - NONNARCOTIC**		
benzonatate oral capsule 100 mg, 200 mg	1	
ANTITUSSIVE-EXPECTORANT**		
g tussin ac oral solution 100-10 mg/5ml	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
guaiatussin ac oral syrup 100-10 mg/5ml	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
guaifenesin-codeine oral solution 100-10 mg/5ml	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
MISC. RESPIRATORY INHALANTS**		
nasal mist inhalation aerosol solution 0.9 %	1	
sodium chloride inhalation nebulization solution 0.9 %, 7 %	1	
MUCOLYTICS**		
acetylcysteine inhalation solution 10 %, 20 %	1	
OPIOID ANTITUSSIVE-ANTIHISTAMINE**		
promethazine-codeine oral syrup 6.25-10 mg/5ml	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
DERMATOLOGICALS		
ACNE ANTIBIOTICS**		
clindamycin phos (once-daily) external gel 1 %	1	QL (60 GM per 30 days)
clindamycin phos (twice-daily) external gel 1 %	1	QL (60 GM per 30 days)
clindamycin phosphate external lotion 1 %	1	QL (60 ML per 30 days)
clindamycin phosphate external solution 1 %	1	
clindamycin phosphate external swab 1 %	1	
dapsone external gel 5 %, 7.5 %	3	
erythromycin external gel 2 %	1	
erythromycin external solution 2 %	1	
sulfacetamide sodium (acne) external lotion 10 %	3	

Drug Name	Tier	Notes
ACNE COMBINATIONS**		
benzoyl peroxide-erythromycin external gel 5-3 %	1	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-5 %	3	
sss 10-5 external cream 10-5 %	1	
sulfacetamide sodium-sulfur external cream 10-5 %	1	
sulfacetamide sodium-sulfur external lotion 10-5 %	1	
sulfacetamide sodium-sulfur external suspension 10-5 %	2	
sulfacetamide sodium-sulfur lotion 10-5 % external	1	
ACNE PRODUCTS**		
adapalene external cream 0.1 %	1	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. *; AL (Max 40 Years)
adapalene external gel 0.1 %	1	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. *; AL (Max 40 Years)
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	3	Length of therapy is limited to 24 weeks per 365 days. For additional treatment, prior authorization is required.
AZELEX EXTERNAL CREAM 20 %	2	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 40 MG	3	Length of therapy is limited to 24 weeks per 365 days. For additional treatment, Prior authorization is required.; QL (60 EA per 30 days)
CLARAVIS ORAL CAPSULE 30 MG	3	Length of therapy is limited to 24 weeks per 365 days. For additional treatment, Prior authorization is required.; QL (60 EA per 30 days); AL (Max 40 Years)
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	3	Length of therapy is limited to 24 weeks. Prior authorization is required for treatment beyond this.; QL (60 EA per 30 days); AL (Min 12 Years)
isotretinoin oral capsule 25 mg, 35 mg	3	QL (60 EA per 30 days); AL (Min 12 Years)

Drug Name	Tier	Notes
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	1	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. *; AL (Max 40 Years)
tretinoin external gel 0.01 %, 0.025 %	1	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. *; AL (Max 40 Years)
zenatane oral capsule 10 mg, 20 mg, 40 mg	3	Length of therapy is limited to 24 weeks per 365 days. For additional treatment, Prior authorization is required.; QL (60 EA per 30 days)
zenatane oral capsule 30 mg	3	Length of therapy is limited to 24 weeks per 365 days. For additional treatment, Prior authorization is required.; QL (60 EA per 30 days); AL (Max 40 Years)
ANTIBIOTICS - TOPICAL**		
gentamicin sulfate external cream 0.1 %	1	
GENTAMICIN SULFATE EXTERNAL OINTMENT 0.1 %	2	
mupirocin external ointment 2 %	1	
ANTIFUNGALS - TOPICAL COMBINATIONS**		
clotrimazole-betamethasone external cream 1-0.05 %	1	
clotrimazole-betamethasone external lotion 1-0.05 %	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	1	
ANTIFUNGALS - TOPICAL**		
ciclopirox external gel 0.77 %	1	
ciclopirox external shampoo 1 %	1	
ciclopirox external solution 8 %	1	QL (6.6 ML per 30 days)
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	

Drug Name	Tier	Notes
ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL**		
fluorouracil external cream 5 %	1	
fluorouracil external solution 2 %	2	
ANTIPSORIATICS - SYSTEMIC**		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	4	PA; QL (60 EA per 30 days); NDS; SP
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	4	PA; QL (0.5 ML per 84 days); SP
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	4	PA; QL (1 ML per 56 days); SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	4	PA; QL (1 ML per 84 days); NDS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; QL (1 ML per 84 days); NDS; SP
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	4	PA; QL (0.5 ML per 84 days); SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	4	PA; QL (0.5 ML per 84 days); SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	4	PA; QL (1 ML per 56 days); SP
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	4	PA; QL (1 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML	4	PA; QL (0.25 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.5ML	4	PA; QL (0.5 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	4	PA; QL (1 ML per 28 days); NDS; SP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML	4	PA; QL (0.5 ML per 84 days); SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	4	PA; QL (0.5 ML per 84 days); SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	4	PA; QL (1 ML per 56 days); SP
ANTIPSORIATICS**		
calcipotriene external cream 0.005 %	3	
calcipotriene external ointment 0.005 %	3	
calcipotriene external solution 0.005 %	3	
CALCITRENE EXTERNAL OINTMENT 0.005 %	2	
calcitriol external ointment 3 mcg/gm	3	ST
tazarotene external cream 0.05 %, 0.1 %	3	ST; QL (60 GM per 30 days)
tazarotene external gel 0.05 %, 0.1 %	3	ST; QL (100 GM per 30 days)
TAZORAC EXTERNAL CREAM 0.05 %	3	ST; QL (60 GM per 30 days)

Drug Name	Tier	Notes
ANTIVIRALS - TOPICAL**		
penciclovir external cream 1 %	2	QL (5 GM per 30 days)
ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES**		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	4	PA; QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	4	PA; QL (4 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML	4	PA; QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	4	PA; QL (4 ML per 28 days); NDS; SP
BURN PRODUCTS**		
silver sulfadiazine external cream 1 %	1	
CORTICOSTEROIDS - TOPICAL**		
alclometasone dipropionate external cream 0.05 %	1	
alclometasone dipropionate external ointment 0.05 %	1	
AMCINONIDE EXTERNAL OINTMENT 0.1 %	3	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	1	
betamethasone dipropionate aug external lotion 0.05 %	1	
betamethasone dipropionate aug external ointment 0.05 %	1	
betamethasone dipropionate external cream 0.05 %	1	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	1	
betamethasone valerate external cream 0.1 %	1	
betamethasone valerate external lotion 0.1 %	1	
betamethasone valerate external ointment 0.1 %	1	
clobetasol prop emollient base external cream 0.05 %	1	QL (60 GM per 30 days)
clobetasol propionate e external cream 0.05 %	1	
clobetasol propionate external cream 0.05 %	1	QL (60 GM per 30 days)
clobetasol propionate external gel 0.05 %	1	
clobetasol propionate external ointment 0.05 %	1	
clobetasol propionate external solution 0.05 %	1	
desoximetasone external cream 0.25 %	1	
desoximetasone external gel 0.05 %	1	

Drug Name	Tier	Notes
fluocinolone acetonide body external oil 0.01 %	1	
fluocinolone acetonide external cream 0.01 %, 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	1	
fluocinolone acetonide scalp external oil 0.01 %	1	
fluocinonide external cream 0.05 %	1	
fluocinonide external gel 0.05 %	1	
fluocinonide external ointment 0.05 %	1	
fluocinonide external solution 0.05 %	1	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external ointment 0.005 %	1	
halobetasol propionate external cream 0.05 %	1	
hydrocortisone butyrate external cream 0.1 %	1	
hydrocortisone butyrate external ointment 0.1 %	1	
hydrocortisone butyrate external solution 0.1 %	1	
hydrocortisone external cream 1 %, 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 0.5 %, 1 %, 2.5 %	1	
hydrocortisone valerate external cream 0.2 %	1	
MEDPURA HYDROCORTISONE EXTERNAL CREAM 1 %	1	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL**		
clotrimazole anti-fungal external cream 1 %	1	
clotrimazole external solution 1 %	1	
econazole nitrate external cream 1 %	1	
ketoconazole external cream 2 %	1	
ketoconazole external shampoo 2 %	1	

Drug Name	Tier	Notes
IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL**		
imiquimod external cream 5 %	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (12 gm per 28 days)
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS**		
podofilox external solution 0.5 %	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
LOCAL ANESTHETICS - TOPICAL**		
lidocaine external ointment 5 %	3	QL (500 GM per 30 days)
lidocaine external patch 5 %	3	QL (30 EA per 30 days)
lidocaine hcl external cream 3 %	1	
lidocaine hcl external solution 4 %	1	
MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL**		
pimecrolimus external cream 1 %	3	Continuous long-term use is not recommended. The length of treatment will be limited to 60 days. *; QL (120 GM per 365 days); AL (Min 2 Years)
tacrolimus external ointment 0.03 %, 0.1 %	3	Continuous long-term use of Protopic is not recommended by the FDA. The length of treatment will be limited to 60 days. *; AL (Min 2 Years)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL**		
EUCRISA EXTERNAL OINTMENT 2 %	4	PA; QL (60 EA per 30 days)

Drug Name	Tier	Notes
PHOTODYNAMIC THERAPY AGENTS - TOPICAL**		
AMELUZ EXTERNAL GEL 10 %	MB	
ROSACEA AGENTS**		
azelaic acid external gel 15 %	3	
FINACEA EXTERNAL FOAM 15 %	2	
metronidazole external cream 0.75 %	1	
metronidazole external gel 0.75 %	1	
metronidazole external lotion 0.75 %	1	
SCABICIDES & PEDICULICIDES**		
ivermectin external lotion 0.5 %	3	Approval length if criteria met: 1 month
permethrin external cream 5 %	1	
TOPICAL ANESTHETIC COMBINATIONS**		
lidocaine-prilocaine external cream 2.5-2.5 %	1	
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS**		
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG	MB	
dipyridamole intravenous solution 5 mg/ml	MB	
THYROGEN INTRAMUSCULAR SOLUTION RECONSTITUTED 0.9 MG	MB	QL (1 Course per 1 Lifetime); SP
DIAGNOSTIC TESTS**		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK GUIDE TEST IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK SMARTVIEW IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
KETOSTIX IN VITRO STRIP	2	

Drug Name	Tier	Notes
INFECTION TESTS**		
BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT	1	QL (4 EA per 30 days)
FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT	1	QL (4 EA per 30 days)
IHEALTH COVID-19 RAPID TEST IN VITRO KIT	1	QL (4 EA per 30 days)
PILOT COVID-19 AT-HOME TEST IN VITRO KIT	1	QL (4 EA per 30 days)
MULTIPLE URINE TESTS**		
CHEMSTRIP UGK IN VITRO STRIP	2	
RADIOGRAPHIC CONTRAST MEDIA - IRON OXIDE**		
FERABRIGHT INTRAVENOUS SOLUTION 300 MG/10ML, 510 MG/17ML	MB	
DIGESTIVE AIDS		
DIGESTIVE ENZYMES**		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	2	
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT	2	
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS**		
acetazolamide er oral capsule extended release 12 hour 500 mg	1	
acetazolamide oral tablet 125 mg, 250 mg	1	
acetazolamide sodium injection solution reconstituted 500 mg	MB	
methazolamide oral tablet 25 mg, 50 mg	1	
DIURETIC COMBINATIONS**		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
LOOP DIURETICS**		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
ethacrynic acid oral tablet 25 mg	4	PA
furosemide oral solution 10 mg/ml	1	
FUROSEMIDE ORAL SOLUTION 8 MG/ML	2	

Drug Name	Tier	Notes
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
POTASSIUM SPARING DIURETICS**		
amiloride hcl oral tablet 5 mg	1	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
triamterene oral capsule 100 mg, 50 mg	3	
THIAZIDES AND THIAZIDE-LIKE DIURETICS**		
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS**		
mifepristone oral tablet 200 mg	$0	
BISPHOSPHONATES**		
alendronate sodium oral tablet 10 mg, 35 mg, 70 mg	1	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT	3	
ibandronate sodium oral tablet 150 mg	3	ST; QL (1 EA per 28 days)
risedronate sodium oral tablet 150 mg	3	QL (1 EA per 30 days)
risedronate sodium oral tablet 30 mg, 5 mg	3	QL (30 EA per 30 days)
risedronate sodium oral tablet 35 mg	3	QL (4 EA per 28 days)
risedronate sodium oral tablet delayed release 35 mg	3	QL (4 EA per 28 days)
CALCIMIMETIC AGENTS**		
cinacalcet hcl oral tablet 30 mg	1	NDS
cinacalcet hcl oral tablet 60 mg, 90 mg	1	PA; NDS
CALCITONINS**		
calcitonin (salmon) injection solution 200 unit/ml	4	
calcitonin (salmon) nasal solution 200 unit/act	1	
DOPAMINE RECEPTOR AGONISTS**		
cabergoline oral tablet 0.5 mg	1	QL (56 EA per 28 days)
GNRH/LHRH ANTAGONISTS**		
ORILISSA ORAL TABLET 150 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ORILISSA ORAL TABLET 200 MG	4	PA; QL (60 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
GROWTH HORMONES**		
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	4	PA; NDS; SP
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS**		
calcitriol intravenous solution 1 mcg/ml	MB	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	
doxercalciferol intravenous solution 4 mcg/2ml	MB	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	3	
HYPOPHOSPHATASIA (HPP) AGENTS**		
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML	4	PA; LA
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)**		
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	4	PA; NDS; SP
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS**		
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG	MB	PA not required if billed with Dx codes F64.1 - F64.9.
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG	MB	PA not required if billed with Dx codes F64.1 - F64.9.
NEUROKININ 3 (NK3) RECEPTOR ANTAGONISTS**		
VEOZAH ORAL TABLET 45 MG	3	PA; QL (2 EA per 1 day); AL (Min 18 Years)
OVULATION STIMULANTS-GONADOTROPINS**		
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	MB	PA
OVULATION STIMULANTS-SYNTHETIC**		
clomiphene citrate oral tablet 50 mg	4	
PARATHYROID HORMONE AND DERIVATIVES**		
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	4	PA; NDS; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	4	PA; NDS; SP
PHENYLKETONURIA TREATMENT - AGENTS**		

Drug Name	Tier	Notes
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML	4	PA; LA; QL (7 ML per 28 days); NDS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML	4	PA; LA; QL (3 ML per 35 days); NDS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	PA; LA; QL (28 ML per 28 days); NDS
sapropterin dihydrochloride oral packet 100 mg, 500 mg	4	PA; LA; NDS
RANK LIGAND (RANKL) INHIBITORS**		
BOSAYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	
ENOBY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	
JUBBONTI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	SP
WYOST SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	SP
XTRENBO SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	
SCLEROSTIN INHIBITORS**		
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 105 MG/1.17ML	MB	PA; SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)**		
raloxifene hcl oral tablet 60 mg	1	DX (Covered at a zero-dollar copay for the prevention of breast cancer per ACA)
SOMATOSTATIC AGENTS**		
octreotide acetate intramuscular kit 20 mg, 30 mg	MB	
VASOPRESSIN**		
desmopressin ace spray refrig nasal solution 0.01 %	1	
desmopressin acetate injection solution 4 mcg/ml	4	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	1	
desmopressin acetate spray nasal solution 0.01 %	1	
X-LINKED HYPOPHOSPHATEMIA (XLH) TREATMENT - AGENTS**		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML, 20 MG/ML, 30 MG/ML	MB	PA; NDS
ESTROGENS		
ESTROGEN & PROGESTIN**		
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY	3	ST; QL (8 EA per 28 days)

Drug Name	Tier	Notes
estradiol-norethindrone acet oral tablet 1-0.5 mg	1	
JINTELI ORAL TABLET 1-5 MG-MCG	1	
MIMVEY ORAL TABLET 1-0.5 MG	1	
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg	1	
PREMPHASE ORAL TABLET 0.625-5 MG	2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	2	
ESTROGEN-PROGESTIN-GNRH ANTAGONIST**		
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG	4	PA; QL (60 EA per 30 days)
ESTROGENS**		
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	3	QL (8 EA per 28 days)
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML	MB	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML	MB	
DOTTI TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	1	QL (8 EA per 28 days)
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm	1	QL (1 EA per 1 day)
estradiol transdermal gel 1 mg/gm	1	QL (1 GM per 1 day)
estradiol transdermal gel 1.25 mg/1.25gm	1	QL (1.25 GM per 1 day)
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (8 EA per 28 days)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	1	QL (4 EA per 28 days)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%)	3	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY	3	
LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR	1	QL (8 EA per 28 days)
PREMARIN INJECTION SOLUTION RECONSTITUTED 25 MG	MB	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	2	
FLUOROQUINOLONES		

Drug Name	Tier	Notes
FLUOROQUINOLONES**		
CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%)	2	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ciprofloxacin in d5w intravenous solution 200 mg/100ml	MB	
levofloxacin oral solution 25 mg/ml	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
moxifloxacin hcl oral tablet 400 mg	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
GASTROINTESTINAL AGENTS - MISC.		
GALLSTONE SOLUBILIZING AGENTS**		
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet 250 mg, 500 mg	1	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS**		
lubiprostone oral capsule 24 mcg, 8 mcg	2	QL (60 EA per 30 days)
GASTROINTESTINAL STIMULANTS**		
metoclopramide hcl oral solution 5 mg/5ml	1	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS**		
alosetron hcl oral tablet 0.5 mg, 1 mg	4	
INFLAMMATORY BOWEL AGENTS**		
balsalazide disodium oral capsule 750 mg	1	
mesalamine er oral capsule extended release 24 hour 0.375 gm	3	QL (120 EA per 30 days)
mesalamine oral capsule delayed release 400 mg	3	
mesalamine oral tablet delayed release 1.2 gm	3	QL (120 EA per 30 days)
mesalamine rectal enema 4 gm	1	
mesalamine rectal suppository 1000 mg	4	QL (30 EA per 30 days)
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
INTERLEUKIN ANTAGONISTS**		
IMULDOSA INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	MB	PA; QL (30 ML per 365 days); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	4	PA; QL (1.2 ML per 56 days); SP

Drug Name	Tier	Notes
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	4	PA; QL (2.4 ML per 56 days); NDS; SP
STEQEYMA INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA
YESINTEK INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA
INTESTINAL ACIDIFIERS**		
lactulose encephalopathy oral solution 10 gm/15ml	1	
PHOSPHATE BINDER AGENTS**		
calcium acetate (phos binder) oral tablet 667 mg	1	
ferric citrate oral tablet 1 gm 210 mg(fe)	4	PA; QL (12 EA per 1 day)
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg	4	PA; QL (3 EA per 1 day)
lanthanum carbonate oral tablet chewable 750 mg	4	PA; QL (6 EA per 1 day)
sevelamer carbonate oral tablet 800 mg	4	
TRYPTOPHAN HYDROXYLASE INHIBITORS**		
XERMELO ORAL TABLET 250 MG	4	PA; LA; QL (90 EA per 30 days); NDS
TUMOR NECROSIS FACTOR ALPHA BLOCKERS**		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	4	PA; QL (1 kit per 28 days); NDS; SP
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	4	PA; QL (1 kit per 28 days); NDS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	4	PA; QL (3 kits per 28 days); NDS; SP
GENITOURINARY AGENTS - MISCELLANEOUS		
5-ALPHA REDUCTASE INHIBITORS**		
dutasteride oral capsule 0.5 mg	3	
finasteride oral tablet 5 mg	1	
ALPHA 1-ADRENOCEPTOR ANTAGONISTS**		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	QL (30 EA per 30 days)
tamsulosin hcl oral capsule 0.4 mg	1	
ANTI-INFECTIVE GENITOURINARY IRRIGANTS**		
neomycin-polymyxin b gu irrigation solution 40-200000	1	
CITRATES**		

Drug Name	Tier	Notes
potassium citrate er oral tablet extended release 10 meq (1080 mg), 5 meq (540 mg)	1	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG)	2	
INTERSTITIAL CYSTITIS AGENTS**		
ELMIRON ORAL CAPSULE 100 MG	3	PA; QL (90 EA per 30 days)
URINARY ANALGESICS**		
phenazopyridine hcl oral tablet 100 mg, 200 mg	1	
URINARY STONE AGENTS**		
tiopronin oral tablet 100 mg	3	PA; LA; QL (300 EA per 30 days); NDS
GOUT AGENTS		
GOUT AGENT COMBINATIONS**		
colchicine-probenecid oral tablet 0.5-500 mg	1	
GOUT AGENTS**		
allopurinol oral tablet 100 mg, 300 mg	1	
colchicine oral tablet 0.6 mg	1	
febuxostat oral tablet 40 mg, 80 mg	3	QL (30 EA per 30 days)
URICOSURICS**		
probenecid oral tablet 500 mg	1	
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS - MONOCLONAL ANTIBODIES**		
HEMLIBRA SUBCUTANEOUS SOLUTION 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML	4	PA; NDS
ANTIHEMOPHILIC PRODUCTS**		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	4	PA; NDS
adynovate intravenous solution reconstituted 1000 unit, 1500 unit, 2000 unit, 250 unit, 3000 unit, 500 unit, 750 unit	4	PA; NDS
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT	4	PA; NDS
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	4	PA; NDS
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	4	PA; NDS

Drug Name	Tier	Notes
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	4	PA; NDS
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	4	PA; NDS
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT	4	PA; NDS
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT	4	PA; NDS
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT	4	PA; NDS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT	4	PA; NDS
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT	4	PA; NDS
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT	4	PA; NDS
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 3000 UNIT, 500 UNIT	4	PA; NDS
KCENTRA INTRAVENOUS KIT 1000 UNIT, 500 UNIT	MB	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT	4	PA; NDS
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT	4	PA; NDS
KOGENATE FS INTRAVENOUS KIT 2000 UNIT, 3000 UNIT	4	PA; NDS
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	4	PA; NDS
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	4	PA; NDS
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG	4	PA; NDS
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	4	PA; NDS
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	4	PA; NDS
obizur intravenous solution reconstituted 500 unit	4	PA; NDS

Drug Name	Tier	Notes
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	4	PA; NDS
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT	4	PA; NDS
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED	MB	NDS
rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit	MB	NDS
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT	4	PA; NDS
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT	4	PA; NDS
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT	4	PA; NDS
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	4	PA; NDS
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	4	PA; NDS
BRADYKININ B2 RECEPTOR ANTAGONISTS**		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	4	PA; QL (18 ML per 28 days); NDS; SP
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML	4	PA; QL (18 ML per 28 days); NDS; SP
C1 ESTERASE INHIBITORS**		
BERINERT INTRAVENOUS KIT 500 UNIT	4	PA; NDS; SP
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	4	PA; NDS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	MB	PA; NDS; SP
COMPLEMENT C5 INHIBITORS**		
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA; NDS
ULTOMIRIS INTRAVENOUS SOLUTION 1100 MG/11ML, 300 MG/3ML	MB	PA; NDS
COMPLEMENT MASP-2 INHIBITORS**		
YARTEMLEA INTRAVENOUS SOLUTION 370 MG/2ML	MB	SP
DIRECT-ACTING P2Y12 INHIBITORS**		
KENGREAL INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA
ticagrelor oral tablet 60 mg	1	QL (60 EA per 30 days)
ticagrelor oral tablet 90 mg	1	Maximum of 730 tablets per lifetime.; QL (60 EA per 30 days)
PHOSPHODIESTERASE III INHIBITORS**		

Drug Name	Tier	Notes
cilostazol oral tablet 100 mg, 50 mg	1	
PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES**		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML	4	PA; QL (2 Vials per 28 days); NDS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; QL (2 ML per 28 days); NDS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	4	PA; QL (4 ML per 28 days); NDS; SP
PLATELET AGGREGATION INHIBITOR COMBINATIONS**		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	3	
PLATELET AGGREGATION INHIBITORS**		
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	1	
QUINAZOLINE AGENTS**		
anagrelide hcl oral capsule 0.5 mg, 1 mg	1	
THIENOPYRIDINE DERIVATIVES**		
clopidogrel bisulfate oral tablet 75 mg	1	
prasugrel hcl oral tablet 10 mg, 5 mg	1	
HEMATOPOIETIC AGENTS		
COBALAMINS**		
cyanocobalamin injection solution 1000 mcg/ml	1	
ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)**		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML	MB	PA; NDS
PROCRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply;; QL (12 ML per 28 days); NDS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 4000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML	MB	PA; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 3000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply;;; QL (12 ML per 28 days)

Drug Name	Tier	Notes
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply; QL (4 ML per 28 days)
FOLIC ACID/FOLATES**		
cvs folic acid oral tablet 800 mcg	$0	$0 copay per PPACA guidelines.; AL (Max 55 Years)
folic acid oral tablet 1 mg	1	
folic acid oral tablet 400 mcg	1	AL (Max 55 Years)
folic acid oral tablet 800 mcg	$0	$0 copay per PPACA guidelines.; AL (Max 55 Years)
gnp folic acid oral tablet 400 mcg	$0	$0 copay per PPACA guidelines.; AL (Max 55 Years)
kp folic acid oral tablet 800 mcg	$0	$0 copay per PPACA guidelines.; AL (Max 55 Years)
yl folic acid oral tablet 400 mcg	$0	$0 copay per PPACA guidelines.; AL (Max 55 Years)
GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)**		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML	MB	
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; NDS; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML	MB	PA; NDS; SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
IRON**		
ferumoxytol intravenous solution 510 mg/17ml	MB	
INJECTAFER INTRAVENOUS SOLUTION 100 MG/2ML	MB	
THROMBOPOIETIN (TPO) RECEPTOR AGONISTS**		
MULPLETA ORAL TABLET 3 MG	4	PA; QL (7 EA per 7 days); NDS; SP
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC**		
aminocaproic acid oral solution 0.25 gm/ml	4	PA; AL (Max 12 Years)
aminocaproic acid oral tablet 1000 mg, 500 mg	4	

Drug Name	Tier	Notes
CYKLOKAPRON INTRAVENOUS SOLUTION 1000 MG/10ML	MB	
tranexamic acid intravenous solution 1000 mg/10ml	MB	
tranexamic acid oral tablet 650 mg	1	QL (30 EA per 30 days)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS**		
phenobarbital oral elixir 20 mg/5ml, 30 mg/7.5ml, 60 mg/15ml	1	
PHENOBARBITAL ORAL TABLET 100 MG, 15 MG, 30 MG, 60 MG	2	
phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg	1	
BENZODIAZEPINE HYPNOTICS**		
flurazepam hcl oral capsule 15 mg, 30 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
midazolam hcl (pf) injection solution 10 mg/2ml, 2 mg/2ml, 5 mg/ml	1	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
midazolam hcl injection solution 10 mg/10ml, 10 mg/2ml, 2 mg/2ml, 25 mg/5ml, 5 mg/5ml, 5 mg/ml, 50 mg/10ml	1	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
midazolam hcl oral syrup 2 mg/ml	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
temazepam oral capsule 15 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
temazepam oral capsule 30 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
triazolam oral tablet 0.125 mg, 0.25 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS**		

Drug Name	Tier	Notes
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
zaleplon oral capsule 10 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	3	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
OREXIN RECEPTOR ANTAGONISTS**		

Drug Name	Tier	Notes
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	3	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
DAYVIGO ORAL TABLET 10 MG, 5 MG	4	PA; QL (30 EA per 30 days)
SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES**		
dexmedetomidine hcl in nacl intravenous solution 200 mcg/50ml, 400 mcg/100ml	MB	
SELECTIVE MELATONIN RECEPTOR AGONISTS**		
ramelteon oral tablet 8 mg	3	PA; QL (30 EA per 30 days)
LAXATIVES ***BOWEL EVACUANT COMBINATIONS*****		
GaviLyte-C Oral Solution Reconstituted 240 GM	$0	QL (8000 ML per 365 days); AL (Min 50 Years)
GaviLyte-G Oral Solution Reconstituted 236 GM	$0	QL (8000 ML per 30 days); AL (Min 50 Years)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	$0	$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AL (Min 50 Years)
peg-3350/electrolytes oral solution reconstituted 236 gm	$0	$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AL (Min 50 Years)
ELECTROLYTE-BASED OSMOTIC LAXATIVES**		
magnesium citrate oral solution 1.745 gm/30ml	1	
LAXATIVES - MISCELLANEOUS**		
lactulose oral solution 10 gm/15ml, 20 gm/30ml	1	
LOCAL ANESTHETICS-PARENTERAL ***LOCAL ANESTHETICS - AMIDES*****		
EXPAREL INJECTION SUSPENSION 1.3 %	MB	
MACROLIDES		
AZITHROMYCIN**		

Drug Name	Tier	Notes
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
CLARITHROMYCIN**		
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
clarithromycin oral tablet 250 mg, 500 mg	1	
ERYTHROMYCINS**		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML	4	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)

Drug Name	Tier	Notes
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML	4	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)
ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
erythromycin base oral tablet 250 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	4	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
FIDAXOMICIN**		
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	4	PA; QL (10 ML per 1 day)
MEDICAL DEVICES AND SUPPLIES		
CONDOMS - FEMALE**		
FC2 Female Condom	$0	$0 Copay per PPACA guidelines.; QL (144 EA per 365 days)
CONDOMS - MALE**		
condoms	$0	
Durex RealFeel Device	$0	
premium condoms lubricated	$0	
Trojan	$0	
DIAPHRAGMS**		
Caya Vaginal Diaphragm	$0	$0 copay per PPACA guidelines.
Omniflex Diaphragm Vaginal Diaphragm	$0	$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 60 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
Wide-Seal Diaphragm 65 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
Wide-Seal Diaphragm 70 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)

Drug Name	Tier	Notes
Wide-Seal Diaphragm 75 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
Wide-Seal Diaphragm 80 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
Wide-Seal Diaphragm 85 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
Wide-Seal Diaphragm 90 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
Wide-Seal Diaphragm 95 Vaginal Diaphragm 2 %	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)
GLUCOSE MONITORING TEST SUPPLIES**		
ACCU-CHEK FASTCLIX LANCETS	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
Accu-Chek Guide KIT w/Device	$0	QL (1 glucometer from Roche Free Meter Program per 24 Monthss)
Accu-Chek Guide Me Kit w/Device	$0	QL (1 glucometer from Roche Free Meter Program per 24 Monthss)
ACCU-CHEK SOFTCLIX LANCETS	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
DEXCOM G6 RECEIVER DEVICE	2	PA; QL (1 EA per 365 days)
DEXCOM G6 SENSOR	2	PA; QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER	2	PA; QL (1 EA per 90 days)
DEXCOM G7 15 DAY SENSOR	2	PA; QL (2 EA per 30 days)
DEXCOM G7 RECEIVER DEVICE	2	PA; QL (1 EA per 365 days)
DEXCOM G7 SENSOR	2	PA; QL (3 EA per 30 days)
FREESTYLE LIBRE 14 DAY READER DEVICE	2	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER DEVICE	2	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 2 SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 READER DEVICE	2	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 3 SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE	2	ST; QL (1 EA per 365 days)
GUARDIAN 4 GLUCOSE SENSOR	2	PA; QL (5 EA per 30 days)
GUARDIAN 4 TRANSMITTER	2	PA; QL (1 EA per 365 days)

Drug Name	Tier	Notes
GUARDIAN LINK 3 TRANSMITTER	2	PA; QL (1 EA per 365 days)
GUARDIAN SENSOR (3)	2	PA; QL (5 EA per 30 days)
guardian sensor 3	2	PA; QL (5 EA per 30 days)
MICROLET NEXT LANCETS	1	QL (3.4 EA per 1 day)
MINIMED INSTINCT GLUC SENSOR	2	PA; QL (2 EA per 30 days)
INSULIN ADMINISTRATION SUPPLIES**		
OMNIPOD 5 LIBRE INTRO KIT	3	PA; QL (1 EA per 365 days); NDS
OMNIPOD 5 LIBRE PODS	3	PA; QL (10 Pods per 30 days); NDS
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 KIT	3	PA; QL (1 EA per 365 days); NDS
OMNIPOD 5 LIBRE2 PLUS G6 PODS	3	PA; QL (10 Pods per 30 days); NDS
OMNIPOD DASH INTRO (GEN 4) KIT	3	PA; QL (1 EA per 365 days); NDS
OMNIPOD DASH PODS (GEN 4)	3	PA; QL (10 Pods per 30 days); NDS
NEEDLES & SYRINGES**		
BD PEN NEEDLE MINI U/F 31G X 5 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM	1	QL (100 EA per 30 days)
SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES**		
AEROCHAMBER PLUS FLO-VU	3	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
AEROCHAMBER PLUS FLOW VU	3	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
AEROCHAMBER Z-STAT PLUS	3	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
EASIVENT	3	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND	1	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-MD MASK	1	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-SM MASK	1	QL (2 EA per 180 days)
POCKET CHAMBER DEVICE	1	QL (2 EA per 180 days)
VORTEX VALVED HOLDING CHAMBER DEVICE	1	QL (2 EA per 180 days)
MIGRAINE PRODUCTS		
CGRP RECEPTOR ANTAGONISTS - MONOCOLONAL ANTIBODIES**		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	2	PA; QL (1 ML per 28 days); NDS
ERGOT COMBINATIONS**		

Drug Name	Tier	Notes
ergotamine-caffeine oral tablet 1-100 mg	3	QL (40 EA per 30 days)
MIGRAINE PRODUCTS**		
dihydroergotamine mesylate injection solution 1 mg/ml	3	ST; QL (8 ML per 30 days)
dihydroergotamine mesylate nasal solution 4 mg/ml	4	ST; QL (8 ML per 30 days)
SELECTIVE SEROTONIN AGONISTS 5-HT(1)**		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	3	ST; QL (18 EA per 30 days)
eletriptan hydrobromide oral tablet 20 mg, 40 mg	3	ST; QL (18 EA per 30 days)
frovatriptan succinate oral tablet 2.5 mg	3	ST; QL (18 EA per 30 days)
naratriptan hcl oral tablet 1 mg	3	QL (18 EA per 30 days)
naratriptan hcl oral tablet 2.5 mg	1	QL (18 EA per 30 days)
rizatriptan benzoate oral tablet 10 mg, 5 mg	1	QL (18 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	1	QL (18 EA per 30 days)
sumatriptan nasal solution 20 mg/act	1	QL (2 ML per 30 days)
sumatriptan nasal solution 5 mg/act	1	QL (6 EA per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	QL (18 EA per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	1	QL (2 ML per 30 days)
zolmitriptan oral tablet 2.5 mg, 5 mg	1	ST; QL (18 EA per 30 days)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	3	ST; QL (18 EA per 30 days)
MINERALS & ELECTROLYTES		
CALCIUM**		
calcium gluconate intravenous solution 10 %	MB	
FLUORIDE**		
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	$0	$0 copay per PPACA guidelines.; AL (Max 6 Years)
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
POTASSIUM**		
KLOR-CON 10 TABLET EXTENDED RELEASE 10 MEQ ORAL	1	Generic NDC: 00245-0836-11
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	1	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	1	
KLOR-CON ORAL PACKET 20 MEQ	1	

Drug Name	Tier	Notes
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	1	
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	1	
potassium chloride er oral capsule extended release 10 meq, 8 meq	1	
potassium chloride er oral tablet extended release 10 meq, 8 meq	1	
potassium chloride oral packet 20 meq	1	
ZINC**		
zinc sulfate intravenous solution 3 mg/ml	MB	
MISCELLANEOUS THERAPEUTIC CLASSES		
ANTILEPROTICS**		
THALOMID ORAL CAPSULE 100 MG, 50 MG	4	PA; NDS; SP
B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS**		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	4	PA; QL (4 ML per 28 days); NDS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	4	PA; QL (4 ML per 28 days); NDS; SP
CHELATING AGENTS**		
penicillamine oral tablet 250 mg	4	PA; QL (240 EA per 30 days)
CYCLOSPORINE ANALOGS**		
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	
cyclosporine modified oral solution 100 mg/ml	1	
cyclosporine oral capsule 100 mg, 25 mg	1	
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	
GENGRAF ORAL SOLUTION 100 MG/ML	2	
ENZYMES**		
HYLENEX INJECTION SOLUTION 150 UNIT/ML	MB	PA
IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES**		
lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg	4	PA; LA; NDS; SP
lenalidomide oral capsule 2.5 mg, 20 mg	4	PA; NDS; SP
INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS**		
mycophenolate mofetil oral capsule 250 mg	1	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	4	PA; AL (Max 12 Years)

Drug Name	Tier	Notes
mycophenolate mofetil oral tablet 500 mg	1	
MACROLIDE IMMUNOSUPPRESSANTS**		
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg	4	PA; NDS; SP
everolimus oral tablet 1 mg	4	PA
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	3	
tacrolimus er oral capsule extended release 24 hour 0.5 mg	3	PA; QL (30 EA per 30 days)
tacrolimus er oral capsule extended release 24 hour 1 mg	4	PA; QL (30 EA per 30 days)
tacrolimus er oral capsule extended release 24 hour 5 mg	4	PA; QL (90 EA per 30 days)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	
MONOCLONAL ANTIBODIES**		
SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG	MB	
POTASSIUM REMOVING AGENTS**		
LOKELMA ORAL PACKET 10 GM	4	PA; QL (30 EA per 30 days)
LOKELMA ORAL PACKET 5 GM	4	PA; QL (90 EA per 30 days)
sodium polystyrene sulfonate oral powder	1	
VELTASSA ORAL PACKET 1 GM, 16.8 GM, 25.2 GM, 8.4 GM	4	PA; QL (30 EA per 30 days)
PURINE ANALOGS**		
azathioprine oral tablet 50 mg	1	
SCLEROSING AGENTS**		
ETHAMOLIN INTRAVENOUS SOLUTION 5 %	MB	
MOUTH/THROAT/DENTAL AGENTS* *ANESTHETICS TOPICAL ORAL**		
lidocaine viscous hcl mouth/throat solution 2 %	1	
ANTI-INFECTIVES - THROAT**		
nystatin mouth/throat suspension 100000 unit/ml	1	
ANTISEPTICS - MOUTH/THROAT**		
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
PERIOGARD MOUTH/THROAT SOLUTION 0.12 %	1	
SALIVA STIMULANTS**		
pilocarpine hcl oral tablet 5 mg, 7.5 mg	1	QL (90 EA per 30 days)
STEROIDS - MOUTH/THROAT/DENTAL**		
ORALONE MOUTH/THROAT PASTE 0.1 %	1	QL (5 GM per 30 days)
triamcinolone acetonide mouth/throat paste 0.1 %	1	QL (5 GM per 30 days)

Drug Name	Tier	Notes
MULTIVITAMINS		
PEDIATRIC VITAMINS A & D W/ C**		
tri-vite pediatric oral solution 750-400-35 unit-mg/ml	$0	$0 Copay per PPACA Guidelines.; AL (Max 6 Years)
PRENATAL MV & MIN W/FE-FA**		
CO-NATAL FA ORAL TABLET	2	
INATAL GT ORAL TABLET	2	
multi prenatal oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
NIVA-PLUS ORAL TABLET 27-1 MG	2	
OBTREX ORAL TABLET	2	
pnv prenatal plus multivitamin oral tablet 27-1 mg	2	
PRENATABS RX ORAL TABLET 29-1 MG	2	
prenatal 19 oral tablet chewable , 29-1 mg	2	
prenatal one daily oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
prenatal oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
prenatal oral tablet 27-1 mg	2	
prenatal plus oral tablet 27-1 mg	2	
PRENATAL-U ORAL CAPSULE 106.5-1 MG	2	
right step prenatal oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
se-natal 19 oral tablet chewable 29-1 mg	2	
THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG	2	
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS**		
baclofen oral tablet 10 mg, 20 mg	1	
chlorzoxazone oral tablet 500 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	1	
LIORESAL INTRATHECAL SOLUTION 0.05 MG/ML	MB	
methocarbamol oral tablet 500 mg, 750 mg	1	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
DIRECT MUSCLE RELAXANTS**		
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	1	

Drug Name	Tier	Notes
VISCOSUPPLEMENTS**		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE 60 MG/3ML	MB	PA; NDS
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL ANTICHOLINERGICS**		
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
NASAL ANTIHISTAMINES**		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	1	
NASAL STEROIDS**		
budesonide nasal suspension 32 mcg/act	3	ST; Benefit Exclusion for group A000001 PRES Employees.
flunisolide nasal solution 25 mcg/act (0.025%)	2	BENEFIT EXCLUSION for group A00000001 Pres Emp
fluticasone propionate nasal suspension 50 mcg/act	1	BENEFIT EXCLUSION for group A0000001 Pres Emp
mometasone furoate nasal suspension 50 mcg/act	3	ST; BENEFIT EXCLUSION for group A000001 Pres Emp
NEUROMUSCULAR AGENTS		
ALS AGENTS - MISCELLANEOUS**		
RADICAVA INTRAVENOUS SOLUTION 30 MG/100ML	MB	PA
BENZATHIAZOLES**		
riluzole oral tablet 50 mg	4	
DEPOLARIZING MUSCLE RELAXANTS**		
ANECTINE INJECTION SOLUTION 20 MG/ML	MB	
QUELICIN INJECTION SOLUTION 20 MG/ML	MB	
succinylcholine chloride injection solution 20 mg/ml	MB	
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS**		
BOTOX INJECTION SOLUTION RECONSTITUTED 200 UNIT	MB	PA
MYOBLOC INTRAMUSCULAR SOLUTION 10000 UNIT/2ML, 2500 UNIT/0.5ML, 5000 UNIT/ML	MB	PA
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT	MB	PA
OPHTHALMIC AGENTS		
ALPHA ADRENERGIC AGONIST & CARBONIC ANHYDRASE INHIB COMB**		
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	3	QL (8 ML per 30 days)

Drug Name	Tier	Notes
BETA-BLOCKERS - OPHTHALMIC COMBINATIONS**		
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	3	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	1	
BETA-BLOCKERS - OPHTHALMIC**		
betaxolol hcl ophthalmic solution 0.5 %	1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 %	2	
carteolol hcl ophthalmic solution 1 %	1	
levobunolol hcl ophthalmic solution 0.5 %	1	
timolol maleate (once-daily) ophthalmic solution 0.5 %	3	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	1	
CYCLOPLEGIC MYDRIATICS**		
ATROPINE SULFATE OPHTHALMIC SOLUTION 1 %	2	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 2 %	2	
cyclopentolate hcl ophthalmic solution 1 %	1	
HOMATROPAIRE OPHTHALMIC SOLUTION 5 %	1	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	1	
tropicamide ophthalmic solution 0.5 %, 1 %	1	
MIOTICS - CHOLINESTERASE INHIBITORS**		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 %	2	
MIOTICS - DIRECT ACTING**		
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
OPHTHALMIC - MULTIPLE RECEPTOR ANGIOGENESIS INHIBITORS**		
VABYSMO INTRAVITREAL SOLUTION 6 MG/0.05ML	MB	PA; NDS
VABYSMO INTRAVITREAL SOLUTION PREFILLED SYRINGE 6 MG/0.05ML	MB	PA; NDS
OPHTHALMIC ANTIALLERGIC**		
ALOCRIL OPHTHALMIC SOLUTION 2 %	3	
azelastine hcl ophthalmic solution 0.05 %	1	
cromolyn sodium ophthalmic solution 4 %	1	
epinastine hcl ophthalmic solution 0.05 %	1	
OPHTHALMIC ANTIBIOTICS**		

Drug Name	Tier	Notes
CILOXAN OPHTHALMIC OINTMENT 0.3 %	2	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	
erythromycin ophthalmic ointment 5 mg/gm	$0	$0 Copay for members 1 year of age or younger per PPACA guidelines; AL (Max 1 Years)
gentamicin sulfate ophthalmic solution 0.3 %	1	
moxifloxacin hcl ophthalmic solution 0.5 %	3	
ofloxacin ophthalmic solution 0.3 %	1	
tobramycin ophthalmic solution 0.3 %	1	
TOBREX OPHTHALMIC OINTMENT 0.3 %	2	
OPHTHALMIC ANTI-INFECTIVE COMBINATIONS**		
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
OPHTHALMIC ANTIVIRALS**		
trifluridine ophthalmic solution 1 %	1	
OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS**		
brinzolamide ophthalmic suspension 1 %	3	
dorzolamide hcl ophthalmic solution 2 %	1	
OPHTHALMIC IMMUNOMODULATORS**		
cyclosporine (pf) ophthalmic emulsion 0.05 %	3	QL (60 EA per 30 days)
cyclosporine ophthalmic emulsion 0.05 %	3	QL (60 EA per 30 days)
OPHTHALMIC LOCAL ANESTHETICS**		
proparacaine hcl ophthalmic solution 0.5 %	1	
OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS**		
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
OPHTHALMIC PHOTOENHANCERS**		

Drug Name	Tier	Notes
EPIOXA HD/ EPIOXA OPHTHALMIC PREFILLED SYRINGE KIT 0.239 & 0.177 %	MB	Note to Providers: Photrexa and Epioxa are billed as part of the CXL procedure and are not reviewed by Pharmacy Services. These products are processed as medical claims only and are excluded from Pharmacy Claims Processing. When CPT 0401T (Corneal Cross-Linking) is reviewed, Photrexa or Epioxa should also be reviewed.
OPHTHALMIC RHO KINASE INHIBITORS**		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	2	ST
OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS**		
apraclonidine hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate ophthalmic solution 0.1 %	2	
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
OPHTHALMIC STEROID COMBINATIONS**		
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	3	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	1	
OPHTHALMIC STEROIDS**		
ALREX OPHTHALMIC SUSPENSION 0.2 %	3	ST
dexamethasone sodium phosphate ophthalmic solution 0.1 %	1	
fluorometholone ophthalmic suspension 0.1 %	1	
FML FORTE OPHTHALMIC SUSPENSION 0.25 %	2	
LOTEMAX SM OPHTHALMIC GEL 0.38 %	2	ST
loteprednol etabonate ophthalmic gel 0.5 %	3	ST
loteprednol etabonate ophthalmic suspension 0.5 %	3	ST
MAXIDEX OPHTHALMIC SUSPENSION 0.1 %	2	

Drug Name	Tier	Notes
PRED MILD OPHTHALMIC SUSPENSION 0.12 %	2	
prednisolone acetate ophthalmic suspension 1 %	1	
prednisolone sodium phosphate ophthalmic solution 1 %	1	
OPHTHALMIC SULFONAMIDES**		
sulfacetamide sodium ophthalmic solution 10 %	1	
OPHTHALMIC SURGICAL AIDS - COMBINATIONS**		
OMIDRIA INTRAOCULAR SOLUTION 1-0.3 %	MB	
PROSTAGLANDINS - OPHTHALMIC**		
bimatoprost ophthalmic solution 0.01 %	2	
latanoprost ophthalmic solution 0.005 %	1	
travoprost (bak free) ophthalmic solution 0.004 %	3	
VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS**		
EYLEA HD INTRAVITREAL SOLUTION 8 MG/0.07ML	MB	
PAVBLU INTRAVITREAL SOLUTION 2 MG/0.05ML	MB	
PAVBLU INTRAVITREAL SOLUTION PREFILLED SYRINGE 2 MG/0.05ML	MB	
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS**		
acetic acid otic solution 2 %	1	
OTIC ANTI-INFECTIVES**		
ofloxacin otic solution 0.3 %	1	
OTIC STEROID-ANTI-INFECTIVE COMBINATIONS**		
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	3	ST; QL (7.5 ML per 30 days); AL (Max 12 Years)
neomycin-polymyxin-hc otic solution 3.5-10000-1	1	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	1	
OTIC STEROIDS**		
fluocinolone acetonide otic oil 0.01 %	1	
hydrocortisone-acetic acid otic solution 1-2 %	1	
OXYTOCICS		
ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS**		

Drug Name	Tier	Notes
carboprost tromethamine intramuscular solution 250 mcg/ml	MB	
PREPIDIL VAGINAL GEL 0.5 MG/3GM	3	
OXYTOCICS**		
methylergonovine maleate injection solution 0.2 mg/ml	2	
methylergonovine maleate oral tablet 0.2 mg	2	
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
ANTITOXINS-ANTIVENINS**		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
ANAVIP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED	MB	
ANTIVIRAL MONOCLONAL ANTIBODIES**		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML	MB	
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML	MB	PA; NDS
IMMUNE SERUMS**		
CYTOGAM INTRAVENOUS SOLUTION 50 MG/ML	MB	PA
GAMMAGARD ERC INJECTION SOLUTION 10 GM/100ML, 5 GM/50ML	MB	PA; NDS
GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	MB	PA; NDS
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM	MB	PA; NDS
qivigy intravenous solution 10 gm/100ml, 5 gm/50ml	MB	
PENICILLINS		
AMINOPENICILLINS**		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
AMOXICILLIN ORAL TABLET CHEWABLE 125 MG, 250 MG	2	
ampicillin oral capsule 500 mg	2	
NATURAL PENICILLINS**		

Drug Name	Tier	Notes
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 600000 UNIT/ML	MB	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	1	
penicillin v potassium oral tablet 250 mg, 500 mg	1	
PENICILLIN COMBINATIONS**		
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	1	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	1	
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML	MB	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML	MB	
UNASYN INJECTION SOLUTION RECONSTITUTED 1.5 (1-0.5) GM	MB	
PENICILLINASE-RESISTANT PENICILLINS**		
dicloxacillin sodium oral capsule 250 mg, 500 mg	1	
PROGESTINS		
PROGESTINS**		
GALLIFREY ORAL TABLET 5 MG	1	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 625 mg/5ml	1	PA
norethindrone acetate oral tablet 5 mg	1	
progesterone oral capsule 100 mg, 200 mg	1	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ALCOHOL DETERRENTS**		
acamprosate calcium oral tablet delayed release 333 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)

Drug Name	Tier	Notes
disulfiram oral tablet 250 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
disulfiram oral tablet 500 mg	1	
ANTI-CATAPLECTIC AGENTS**		
sodium oxybate oral solution 500 mg/ml	4	PA; LA; QL (540 ML per 30 days); AL (Min 7 Years); NDS
BENZODIAZEPINES & TRICYCLIC AGENTS**		
CHLORDIAZEPOXIDE-AMITRIPTYLINE ORAL TABLET 10-25 MG, 5-12.5 MG	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
CHOLINOMIMETICS - ACHE INHIBITORS**		
donepezil hcl oral tablet 10 mg	1	QL (30 EA per 30 days)
donepezil hcl oral tablet 5 mg	1	QL (60 EA per 30 days)
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	PA; QL (30 EA per 30 days)
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	1	
GALANTAMINE HYDROBROMIDE ORAL SOLUTION 4 MG/ML	2	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	1	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	3	
MOVEMENT DISORDER DRUG THERAPY**		

Drug Name	Tier	Notes
AUSTEDO ORAL TABLET 12 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); NDS; SP
AUSTEDO ORAL TABLET 6 MG, 9 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); NDS; SP
tetrabenazine oral tablet 12.5 mg	4	PA; QL (90 EA per 30 days); NDS; SP
tetrabenazine oral tablet 25 mg	4	PA; QL (120 EA per 30 days); NDS; SP
MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS**		
teriflunomide oral tablet 14 mg, 7 mg	1	QL (30 EA per 30 days)
MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES**		
cladribine (10 tabs) oral tablet therapy pack 10 mg	4	PA; QL (20 EA per 326 days); SP
cladribine (4 tabs) oral tablet therapy pack 10 mg	4	PA; QL (8 EA per 326 days); SP
cladribine (5 tabs) oral tablet therapy pack 10 mg	4	PA; QL (10 EA per 326 days); SP
cladribine (6 tabs) oral tablet therapy pack 10 mg	4	PA; QL (12 EA per 326 days); SP
cladribine (7 tabs) oral tablet therapy pack 10 mg	4	PA; QL (14 EA per 326 days); SP
cladribine (8 tabs) oral tablet therapy pack 10 mg	4	PA; QL (16 EA per 326 days); SP
cladribine (9 tabs) oral tablet therapy pack 10 mg	4	PA; QL (18 EA per 326 days); SP
MULTIPLE SCLEROSIS AGENTS - INTERFERONS**		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML	4	QL (1 EA per 28 days); NDS; SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	4	QL (1 EA per 28 days); NDS; SP
MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES**		

Drug Name	Tier	Notes
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML	MB	PA
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML	MB	PA; NDS; SP
MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS**		
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	1	QL (60 EA per 30 days)
MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS**		
dalfampridine er oral tablet extended release 12 hour 10 mg	3	QL (60 EA per 30 days); NDS
MULTIPLE SCLEROSIS AGENTS**		
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	QL (30 ML per 30 days); NDS; SP
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	4	QL (12 ML per 28 days); NDS; SP
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS**		
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	3	ST; QL (30 EA per 30 days)
memantine hcl oral tablet 10 mg, 5 mg	1	QL (60 EA per 30 days)
PHENOTHIAZINES & TRICYCLIC AGENTS**		
PERPHENAZINE-AMITRIPTYLINE ORAL TABLET 2-10 MG, 2-25 MG, 4-10 MG, 4-25 MG, 4-50 MG	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
PSEUDOBULBAR AFFECT AGENT COMBINATIONS**		
NUEDEXTA ORAL CAPSULE 20-10 MG	4	PA; QL (60 EA per 30 days)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.**		

Drug Name	Tier	Notes
pimozide oral tablet 1 mg, 2 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
SMOKING DETERRENTS**		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	$0	$0 Copay per PPACA guidelines. Limited to two 90 day courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (360 EA per 365 days)
gnp nicotine transdermal patch 24 hour 21 mg/24hr	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (182 EA per 365 days)
goodsense nicotine mouth/throat gum 2 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (4300 EA per 365 days)

Drug Name	Tier	Notes
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (4300 EA per 365 days)
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3600 EA per 365 days)
nicotine transdermal kit 21-14-7 mg/24hr	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (182 EA per 365 days)

Drug Name	Tier	Notes
nicotine transdermal patch 24 hour 7 mg/24hr	$0	$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (182 EA per 365 days)
Nicotrol NS Nasal Solution 10 MG/ML	$0	ST; $0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (720 ML per 365 days)
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	$0	QL (106 EA per 365 days)
varenicline tartrate oral tablet 0.5 mg, 1 mg	$0	QL (360 EA per 365 days)
varenicline tartrate(continue) oral tablet 1 mg	$0	QL (360 EA per 365 days)
SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS**		
fingolimod hcl oral capsule 0.5 mg	3	
MAYZENT ORAL TABLET 0.25 MG	4	PA; QL (120 EA per 30 days); NDS; SP
MAYZENT ORAL TABLET 1 MG, 2 MG	4	PA; QL (30 EA per 30 days); NDS; SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG, 7 X 0.25 MG	4	PA; QL (1 pack per 365 days); NDS; SP
THIENBENZODIAZEPINES & OPIOID ANTAGONISTS**		

Drug Name	Tier	Notes
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
RESPIRATORY AGENTS - MISC.		
CFTR POTENTIATORS**		
KALYDECO ORAL PACKET 13.4 MG	4	PA; QL (2 packets per 1 day); AL (Max 6 Years); NDS; SP
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG	4	PA; QL (60 EA per 30 days); AL (Max 6 Years); NDS; SP
KALYDECO ORAL TABLET 150 MG	4	PA; QL (60 EA per 30 days); AL (Min 6 Years); NDS; SP
CYSTIC FIBROSIS AGENT - COMBINATIONS**		
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	4	PA; QL (120 EA per 30 days); NDS; SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG	4	PA; QL (60 EA per 30 days); NDS; SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG	4	PA; QL (60 EA per 30 days); AL (Min 6 Years and Max 12 Years); NDS; SP
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	4	PA; QL (90 EA per 30 days); NDS; SP
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	4	PA; QL (2 packets per 1 day); NDS; SP
HYDROLYTIC ENZYMES**		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	4	LA; NDS
PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS**		
nintedanib esylate oral capsule 100 mg, 150 mg	4	PA; QL (60 EA per 30 days); SP
SULFONAMIDES		
SULFONAMIDES**		
SULFADIAZINE ORAL TABLET 500 MG	1	
TETRACYCLINES ***TETRACYCLINES*****		
demeclocycline hcl oral tablet 150 mg, 300 mg	3	

Drug Name	Tier	Notes
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
TETRACYCLINE HCL ORAL CAPSULE 250 MG	2	
TETRACYCLINE HCL ORAL CAPSULE 500 MG	2	QL (120 EA per 30 days)
THYROID AGENTS		
ANTITHYROID AGENTS**		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	1	
THYROID HORMONES**		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG	2	
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
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	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	1	
TOXOIDS		
TOXOID COMBINATIONS**		
Adacel Intramuscular Suspension 5-2-15.5 LF-MCG/0.5	$0	$0 Copay for Preventative Services.

Drug Name	Tier	Notes
Boostrix Intramuscular Suspension Prefilled Syringe 5-2.5-18.5 LF-MCG/0.5	$0	$0 Copay for Preventative Services.
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS**		
BENTYL INTRAMUSCULAR SOLUTION 10 MG/ML	MB	
dicyclomine hcl intramuscular solution 10 mg/ml	MB	
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	1	
dicyclomine hcl oral tablet 20 mg	1	
BELLADONNA ALKALOIDS**		
atropine sulfate injection solution 8 mg/20ml	MB	
atropine sulfate injection solution prefilled syringe 1 mg/10ml	MB	
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	1	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	1	
hyoscyamine sulfate oral solution 0.125 mg/ml	1	
hyoscyamine sulfate oral tablet 0.125 mg	1	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	1	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG	1	
H-2 ANTAGONISTS**		
cimetidine hcl oral solution 300 mg/5ml	1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
famotidine oral tablet 20 mg, 40 mg	1	
nizatidine oral capsule 150 mg, 300 mg	2	
MISC. ANTI-ULCER**		
sucralfate oral suspension 1 gm/10ml	3	QL (1200 ML per 30 days); AL (Max 12 Years)
sucralfate oral tablet 1 gm	1	
PROTON PUMP INHIBITORS**		
esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg	1	Benefit Exclusion for group A000001 PRES Employees.; QL (30 EA per 30 days)

Drug Name	Tier	Notes
lansoprazole oral capsule delayed release 15 mg, 30 mg	3	Benefit Exclusion for group A0000001 PRES Employees.; QL (60 EA per 30 days)
omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg	1	Benefit Exclusion for group A000001 PRES Employees.; QL (60 EA per 30 days)
omeprazole oral capsule delayed release 10 mg, 40 mg	1	Benefit Exclusion for group A0000001 PRES Employees.; QL (60 EA per 30 days)
omeprazole oral capsule delayed release 20 mg	1	Benefit Exclusion for group A000001 PRES Employees.; QL (60 EA per 30 days)
pantoprazole sodium intravenous solution reconstituted 40 mg	MB	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	Benefit Exclusion for the following groups A0000001 Pres Employees; QL (60 EA per 30 days)
PROTONIX INTRAVENOUS SOLUTION RECONSTITUTED 40 MG	MB	
rabeprazole sodium oral tablet delayed release 20 mg	1	Benefit Exclusion for group A0000001 PRES Employees.; QL (60 EA per 30 days)
QUATERNARY ANTICHOLINERGICS**		
glycopyrrolate +rfid injection solution 0.2 mg/ml	1	
glycopyrrolate injection solution 0.2 mg/ml, 0.4 mg/2ml, 1 mg/5ml, 4 mg/20ml	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
ULCER DRUGS - PROSTAGLANDINS**		
misoprostol oral tablet 100 mcg, 200 mcg	1	
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)**		
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral tablet 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	1	QL (30 EA per 30 days)
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	3	QL (30 EA per 30 days)
tolterodine tartrate oral tablet 1 mg, 2 mg	1	
trospium chloride er oral capsule extended release 24 hour 60 mg	3	ST; QL (30 EA per 30 days)
trospium chloride oral tablet 20 mg	3	
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS**		

Drug Name	Tier	Notes
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	3	ST; QL (1 EA per 1 day)
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS**		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS**		
flavoxate hcl oral tablet 100 mg	1	
VACCINES		
BACTERIAL VACCINES**		
Capvaxive Intramuscular Solution Prefilled Syringe 0.5 ML	$0	QL (0.5 ML per 1 Lifetime)
MenQuadfi Intramuscular Solution 0.5 ML	$0	
Menveo Intramuscular Solution	$0	$0 Copay for Preventative Services.
Menveo Intramuscular Solution Reconstituted	$0	$0 Copay for Preventative Services.
Penbraya Intramuscular Suspension Reconstituted	$0	
Pneumovax 23 Injection Solution Prefilled Syringe 25 MCG/0.5ML	$0	$0 Copay for Preventative Services
Prevnar 20 Intramuscular Suspension Prefilled Syringe 0.5 ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 1 Lifetime)
Trumenba Intramuscular Suspension Prefilled Syringe 0.5 ML	$0	
Vaxneuvance Intramuscular Suspension Prefilled Syringe 0.5 ML	$0	$0 Copay Preventative Services
VIRAL VACCINE COMBINATIONS**		
M-M-R II Injection Solution Reconstituted	$0	
Twinrix Intramuscular Suspension Prefilled Syringe 720-20 ELU-MCG/ML	$0	
VIRAL VACCINES**		
Abrysvo Intramuscular Solution Reconstituted 120 MCG/0.5ML	$0	AL (Min 60 Years)
Afluria Intramuscular Suspension	$0	QL (0.5 ML per 180 days)
Afluria Preservative Free Intramuscular Suspension Prefilled Syringe 0.5 ML	$0	QL (0.5 ML per 180 days)
Arexvy Intramuscular Suspension Reconstituted 120 MCG/0.5ML	$0	AL (Min 60 Years)
Comirnaty Intramuscular Suspension Prefilled Syringe 30 MCG/0.3ML	$0	AL (Min 12 Years)
Engerix-B Injection Suspension 20 MCG/ML	$0	$0 Copay for Preventative Services.
Flublok Intramuscular Solution Prefilled Syringe 0.5 ML	$0	PA; QL (0.5 ML per 180 Days); AL (Min 9 Years)
Flucelvax Intramuscular Suspension	$0	QL (0.5 ML per 180 days)

Drug Name	Tier	Notes
Flucelvax Intramuscular Suspension Prefilled Syringe 0.5 ML	$0	QL (0.5 ML per 180 days)
FluMist Nasal Liquid	$0	QL (0.5 mL per 180 days); AL (Min 2 Years and Max 49 Years)
Fluzone Intramuscular Suspension	$0	QL (0.5 ML per 180 days)
Gardasil 9 Intramuscular Suspension 0.5 ML	$0	$0 Copay PPACA Guidelines.; AL (Min 9 Years and Max 45 Years)
Gardasil 9 Intramuscular Suspension Prefilled Syringe 0.5 ML	$0	$0 Copay PPACA Guidelines.; AL (Min 9 Years and Max 45 Years)
Havrix Intramuscular Suspension Prefilled Syringe 720 EL U/0.5ML	$0	$0 Copay for Preventative Services
Heplisav-B Intramuscular Solution Prefilled Syringe 20 MCG/0.5ML	$0	
mNexspike Intramuscular Suspension Prefilled Syringe 10 MCG/0.2ML	$0	AL (Min 12 Years)
MResvia Intramuscular Suspension Prefilled Syringe 50 MCG/0.5ML	$0	
Recombivax HB Injection Suspension 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	$0	$0 Copay for Preventative Services.
Shingrix Intramuscular Suspension Prefilled Syringe 50 MCG/0.5ML	$0	QL (2 vials per 1 Lifetime); AL (Min 50 Years)
Shingrix Intramuscular Suspension Reconstituted 50 MCG/0.5ML	$0	QL (2 vials per 1 Lifetime); AL (Min 50 Years)
Spikevax Intramuscular Suspension Prefilled Syringe 50 MCG/0.5ML	$0	
Vaqta Intramuscular Suspension 25 UNIT/0.5ML	$0	$0 Copay for Preventative Services
Vaqta Intramuscular Suspension 50 UNIT/ML	$0	$0 Copay for Preventative Services.
Varivax Injection Suspension Reconstituted 1350 PFU/0.5ML	$0	$0 Copay for Preventative Services.
VAGINAL AND RELATED PRODUCTS		
IMIDAZOLE-RELATED ANTIFUNGALS**		
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
SPERMICIDES**		
Encare Vaginal Suppository 100 MG	$0	$0 Copay per PPACA guidelines.; QL (144 EA per 365 days)
Options Gynol II Contraceptive Vaginal Gel 3 %	$0	$0 copay per PPACA guidelines.; QL (1026 GM per 365 days)
Today Sponge Vaginal 1000 MG	$0	
VCF Vaginal Contraceptive Vaginal Film 28 %	$0	$0 Copay per PPACA guidelines.; QL (144 EA per 365 days)
VCF Vaginal Contraceptive Vaginal Gel 4 %	$0	$0 copay per PPACA guidelines.
VAGINAL ANTI-INFECTIVES**		

Drug Name	Tier	Notes
clindamycin phosphate vaginal cream 2 %	1	
metronidazole vaginal gel 0.75 %	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
VAGINAL ESTROGENS**		
estradiol vaginal tablet 10 mcg	1	
ESTRING VAGINAL RING 7.5 MCG/24HR	3	QL (1 EA per 90 days)
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR	3	QL (1 EA per 90 days)
PREMARIN VAGINAL CREAM 0.625 MG/GM	2	
YUVAFEM VAGINAL TABLET 10 MCG	1	
VAGINAL PROGESTINS**		
CRINONE VAGINAL GEL 8 %	3	PA
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS**		
EPINEPHRINE INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML, 0.3 MG/0.3ML	1	
VASOPRESSORS**		
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	1	
VITAMINS		
VITAMIN D**		
ergocalciferol oral capsule 1.25 mg (50000 ut)	1	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	1	
VITAMIN K**		
phytonadione oral tablet 5 mg	4	

Medical Benefit

Drug Name	Tier	Notes
ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG	MB	PA
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML	MB	NDS; SP
ADCETRIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA; NDS
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG	MB	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	MB	PA; NDS
azacitidine injection suspension reconstituted 100 mg	MB	NDS
BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	PA; NDS
BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG, 400 MG	MB	PA; NDS
benztropine mesylate injection solution 1 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	MB	
BLINCYTO INTRAVENOUS SOLUTION RECONSTITUTED 35 MCG	MB	PA
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT	MB	PA
CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA; NDS
daptomycin intravenous solution reconstituted 500 mg	MB	
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT	MB	PA; NDS
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG	MB	PA; NDS; SP
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML	MB	PA; QL (6 ML per 180 days); NDS
FemCap Vaginal Device 22 MM, 26 MM, 30 MM	$0	$0 copay per PPACA guidelines.; QL (1 EA per 365 days)

Drug Name	Tier	Notes
FERRLECIT INTRAVENOUS SOLUTION 12.5 MG/ML	MB	
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/200ML, 5 GM/100ML	MB	PA
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 20 GM/400ML	MB	PA; NDS
fluphenazine decanoate injection solution 25 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluphenazine hcl injection solution 2.5 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fosaprepitant dimeglumine intravenous solution reconstituted 150 mg	MB	QL (4 EA per 30 days)
fosphenytoin sodium injection solution 100 mg pe/2ml, 500 mg pe/10ml	MB	
GAMIFANT INTRAVENOUS SOLUTION 10 MG/2ML, 50 MG/10ML	MB	PA; NDS
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	MB	PA; NDS
GAZYVA INTRAVENOUS SOLUTION 1000 MG/40ML	MB	PA
heparin sod (porcine) in d5w intravenous solution 100 unit/ml	MB	
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	MB	
INFED INJECTION SOLUTION 50 MG/ML	MB	
INJECTAFER INTRAVENOUS SOLUTION 750 MG/15ML	MB	
JELMYTO KIT 2 X 40 MG	MB	PA; QL (17 Doses per 1 Lifetime); NDS

Drug Name	Tier	Notes
JELMYTO SOLUTION RECONSTITUTED 80 (2 X 40) MG	MB	PA; QL (17 Doses per 1 Lifetime); NDS
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG	MB	PA; NDS
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML	MB	PA; NDS
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA; NDS
KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 10 MG, 30 MG, 60 MG	MB	PA
LIBTAYO INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; NDS
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
micafungin sodium intravenous solution reconstituted 50 mg	MB	
Mirena (52 MG) Intrauterine Intrauterine Device 20 MCG/DAY	$0	$0 Copay per PPACA guidelines; QL (1 EA per 999 Years)
Mirena (52 MG) Intrauterine Intrauterine Device 21 MCG/DAY	$0	$0 Copay per PPACA guidelines; QL (1 EA per 8 Years)
na ferric gluc cplx in sucrose intravenous solution 12.5 mg/ml	MB	
Nexplanon Subcutaneous Implant 68 MG	$0	$0 Copay per PPACA guidelines; QL (1 EA per 999 Years)
ONPATTRO INTRAVENOUS SOLUTION 10 MG/5ML	MB	PA; NDS
OPDIVO INTRAVENOUS SOLUTION 100 MG/10ML, 40 MG/4ML	MB	PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	MB	PA; NDS
palonosetron hcl intravenous solution 0.25 mg/5ml	MB	QL (5 ML per 5 days)
PERJETA INTRAVENOUS SOLUTION 420 MG/14ML	MB	PA; NDS
procainamide hcl injection solution 100 mg/ml, 500 mg/ml	MB	
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	MB	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG	MB	
Skyla Intrauterine Intrauterine Device 13.5 MG	$0	$0 Copay per PPACA guidelines.; QL (1 EA per 999 days)
TESTOPEL IMPLANT PELLET 75 MG	MB	PA; QL (6 EA per 90 days)

Drug Name	Tier	Notes
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED 420 MG	MB	
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED 180 MG	MB	PA; NDS
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML	MB	PA; SP
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	MB	PA
VENOFER INTRAVENOUS SOLUTION 20 MG/ML	MB	
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	MB	PA; NDS; SP
YERVOY INTRAVENOUS SOLUTION 200 MG/40ML, 50 MG/10ML	MB	PA; NDS
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA
ZALTRAP INTRAVENOUS SOLUTION 200 MG/8ML	MB	PA; NDS
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	MB	PA
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG	MB	
zoledronic acid intravenous concentrate 4 mg/5ml	MB	NDS
zoledronic acid intravenous solution 4 mg/100ml, 5 mg/100ml	MB	NDS