PRESBYTERIAN
Turquoise Care

# Presbyterian Turquoise Care Formulary/Preferred Drug Listing

The Presbyterian Turquoise Care Preferred Drug List is subject to change.

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).

## Definition of Status

| Icon | Status | Definition |
|---|---|---|
|  | Formulary | Medication Covered on Formulary. |
|  | Medical Benefit | Medical Drug Office Administered Specialty Pharmaceutical. |
|  | $0 | $0 copay per Patient Protection and Affordable Care Act (PPACA) guidelines. |
|  | Medical Exception | A drug that is not on the Plan's Formulary. An exception may be requested by a prescriber, a member, or their appointed representative. The prescriber must provide information to support the Medical Exception request by fax, phone, or regular mail. |
|  | Benefit Exclusion | Benefit Exclusion Not a Covered benefit. |
|  | Non-Formulary | Medication Not Covered on Formulary. |

## Definition of Restrictions

| Icon | Restriction | Definition |
|---|---|---|
|  | 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 dosages. |
|  | Generic Indicator | A generic drug is approved by the U.S. Food and Drug Administration (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. |
|  | Limited Access | Limited Access. |
|  | Non-Extended Day Supply | This drug is limited to a one-month supply. |
|  | Over-the-Counter | Drugs that can be sold without a prescription. |



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| Icon | Restriction | Definition |
|---|---|---|
|  | Prior Authorization | Prior Authorization is a clinical evaluation process to determine if the requested Health Care Service is medically necessary, a Covered Benefit, and if it is being delivered in the most appropriate healthcare setting. |
|  | Quantity Limit | A limit to the amount of drug Presbyterian Turquoise Care will pay for in a period of time. Presbyterian uses medical guidelines and FDA-approved recommendations from drug makers to set these quantity limits. |
|  | Schedule II Max Day | Schedule II max day. |
|  | 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. |
|  | Step Therapy | 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 FDA-approved and treat the same condition as the corresponding Step-Therapy drugs. |
|  | 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. |
|  | Diagnosis Code | Diagnosis Code. |
|  | User Note 1-9 | User Note 1-9. |


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| 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* | Covered | 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* | Covered | 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* | Covered | QL (30 EA per 30 days); AL (Min 6 Years) |
| *amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg* | Covered | 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* | Covered | QL (90 EA per 30 days); AL (Min 3 Years) |
| *amphetamine-dextroamphetamine oral tablet 30 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| ***AMPHETAMINES***** | | |
| *dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| *dextroamphetamine sulfate oral tablet 10 mg, 5 mg* | Covered | 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* | Covered | PA; QL (30 EA per 30 days); AL (Min 6 Years) |
| ***ANALEPTICS***** | | |
| *caffeine citrate intravenous solution 60 mg/3ml* | Covered | |
| *caffeine citrate oral solution 20 mg/ml* | Covered | |
| ***DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)***** | | |
| **SUNOSI ORAL TABLET 150 MG, 75 MG** | Covered | PA; QL (30 EA per 30 Days); AL (Min 18 Years) |
| ***HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS***** | | |
| **WAKIX ORAL TABLET 17.8 MG** | Covered | PA; LA; QL (60 EA per 30 days); AL (Min 18 Years) |
| **WAKIX ORAL TABLET 4.45 MG** | Covered | PA; LA; QL (14 EA per 7 days); AL (Min 18 Years) |
| ***STIMULANTS - MISC.***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg* | Covered | 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* | Covered | ST; QL (30 EA per 30 days); AL (Min 6 Years) |
| *dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg* | Covered | ST; QL (60 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg* | Covered | QL (30 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg* | Covered | QL (30 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er (osm) oral tablet extended release 36 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er oral tablet extended release 10 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er oral tablet extended release 20 mg* | Covered | QL (90 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg* | Covered | QL (30 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl er oral tablet extended release 24 hour 36 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl oral solution 10 mg/5ml* | Covered | QL (450 ML per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl oral solution 5 mg/5ml* | Covered | QL (180 ML per 30 days); AL (Min 6 Years) |
| *methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg* | Covered | QL (90 EA per 30 days); AL (Min 3 Years) |
| *modafinil oral tablet 100 mg, 200 mg* | Covered | QL (30 EA per 30 days) |
| ***AMINOGLYCOSIDES*** | | |
| ***AMINOGLYCOSIDES***** | | |
| *neomycin sulfate oral tablet 500 mg* | Covered | |
| *tobramycin inhalation nebulization solution 300 mg/5ml* | Covered | SP |
| ***ANALGESICS - ANTI-INFLAMMATORY*** | | |
| ***ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS***** | | |
| **RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG** | Covered | PA; QL (90 EA per 365 days); SP |
| **XELJANZ ORAL SOLUTION 1 MG/ML** | Covered | PA; QL (300 ML per 30 days); AL (Min 2 Years and Max 12 Years); SP |
| **XELJANZ ORAL TABLET 10 MG, 5 MG** | Covered | PA; QL (60 EA per 30 days); SP |

| Drug Name | Tier | Notes |
|---|---|---|
| **XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG** | Covered | PA; QL (112 EA per 6 Months); SP |
| ***ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES***** | | |
| **AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML** | Covered | PA; Coverage applies to approved products only. Covered NDCs: 55513-0482-01 and 555130482-02; QL (1.6 ML per 28 days); SP |
| **AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML** | Covered | PA; Coverage applies to approved products only. Covered NDCs: 72511-0400-01 and 72511-0400-02.; QL (3.2 EA per 28 days); SP |
| **AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML** | Covered | PA; Coverage applies to approved products only. Covered NDCs: 55513-0481-01 and 55513-0481-02; QL (1.6 ML per 28 days); SP |
| **AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML** | Covered | PA; Coverage applies to approved products only. Covered NDCs: 55513-0479-01 and 55513-0479-02; QL (1.6 ML per 28 days); SP |
| **AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML** | Covered | PA; QL (0.4 ML per 28 days); SP |
| **AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML** | Covered | PA; QL (0.8 EA per 28 days); SP |
| ***CYCLOOXYGENASE 2 (COX-2) INHIBITORS***** | | |
| *celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg* | Covered | QL (60 EA per 30 days) |
| ***GOLD COMPOUNDS***** | | |
| **RIDAURA ORAL CAPSULE 3 MG** | Covered | |
| ***INTERLEUKIN-6 RECEPTOR INHIBITORS***** | | |
| **ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML** | Covered | PA; QL (3.6 ML per 28 days); SP |
| Actemra Intravenous Solution 200 MG/10ML, 400 MG/20ML, 80 MG/4ML | MB | |
| **ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML** | Covered | PA; QL (3.6 ML per 28 days); SP |
| **KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML** | Covered | PA; QL (2.28 ML per 28 days); SP |

| Drug Name | Tier | Notes |
|---|---|---|
| **KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML** | Covered | PA; QL (2.28 ML per 28 days); SP |
| ***NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)***** | | |
| *diclofenac sodium er oral tablet extended release 24 hour 100 mg* | Covered | |
| *diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg* | Covered | |
| *etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg* | Covered | |
| *etodolac oral capsule 200 mg, 300 mg* | Covered | |
| *etodolac oral tablet 400 mg, 500 mg* | Covered | |
| *flurbiprofen oral tablet 100 mg, 50 mg* | Covered | |
| *ibuprofen junior strength oral tablet chewable 100 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| Ibuprofen Lysine Intravenous Solution 10 MG/ML | MB | |
| *ibuprofen oral suspension 100 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ibuprofen oral tablet 200 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | Covered | |
| **INDOCIN RECTAL SUPPOSITORY 50 MG** | Covered | |
| *indomethacin er oral capsule extended release 75 mg* | Covered | |
| *indomethacin oral capsule 25 mg, 50 mg* | Covered | |
| *indomethacin oral suspension 25 mg/5ml* | Covered | |
| *ketoprofen er oral capsule extended release 24 hour 200 mg* | Covered | |
| **MEDI-FIRST IBUPROFEN ORAL TABLET 200 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *meloxicam oral tablet 15 mg, 7.5 mg* | Covered | |
| **MOTRIN IB ORAL TABLET 200 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *nabumetone oral tablet 500 mg, 750 mg* | Covered | |
| *naproxen oral suspension 125 mg/5ml* | Covered | |
| *naproxen oral tablet 250 mg, 375 mg, 500 mg* | Covered | |


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|---|---|---|
| *naproxen sodium oral tablet 275 mg, 550 mg* | Covered | |
| *oxaprozin oral tablet 600 mg* | Covered | |
| *piroxicam oral capsule 10 mg, 20 mg* | Covered | |
| *sulindac oral tablet 150 mg, 200 mg* | Covered | |
| ***PHOSPHODIESTERASE 4 (PDE4) INHIBITORS***** | | |
| **OTEZLA ORAL TABLET 30 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| **OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG** | Covered | PA; QL (55 EA per 28 days); SP |
| ***PYRIMIDINE SYNTHESIS INHIBITORS***** | | |
| *leflunomide oral tablet 10 mg, 20 mg* | Covered | |
| ***SELECTIVE COSTIMULATION MODULATORS***** | | |
| **ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML** | Covered | PA; QL (4 ML per 28 days); SP |
| **ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML** | Covered | PA; QL (4 ML per 28 days); SP |
| **ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML** | Covered | PA; QL (1.6 ML per 28 days); SP |
| **ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML** | Covered | PA; QL (2.8 ML per 28 days); SP |
| ***SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS***** | | |
| **ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML** | Covered | PA; QL (4 ML per 28 days); SP |
| **ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML** | Covered | PA; QL (2 ML per 28 days); SP |
| **ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML** | Covered | PA; QL (2 ML per 28 days); SP |
| **ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML** | Covered | PA; QL (4 ML per 28 days); SP |
| **ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML** | Covered | PA; QL (4 ML per 28 days); SP |
| ***ANALGESICS - NONNARCOTIC*** | | |
| ***ANALGESICS OTHER***** | | |
| *acetaminophen childrens oral suspension 160 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *acetaminophen junior strength oral tablet dispersible 160 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *acetaminophen oral liquid 160 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *acetaminophen oral solution 160 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *acetaminophen oral tablet 325 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (12 EA per 1 day) |
| *acetaminophen oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (8 EA per 1 day) |
| *acetaminophen oral tablet chewable 160 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *acetaminophen oral tablet chewable 80 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *acetaminophen rapid tabs child oral tablet dispersible 80 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *arthritis pain relief oral tablet extended release 650 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (6 EA per 1 day) |
| ***ANALGESICS-SEDATIVES***** | | |
| *butalbital-apap-caffeine oral tablet 50-325-40 mg* | Covered | QL (180 EA per 30 days) |
| ***SALICYLATES***** | | |
| *aspirin low dose oral tablet chewable 81 mg* | Covered | |
| *aspirin low dose oral tablet delayed release 81 mg* | Covered | |
| *aspirin low strength oral tablet chewable 81 mg* | Covered | |
| *aspirin oral tablet 325 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *aspirin oral tablet chewable 81 mg* | Covered | |
| *aspirin oral tablet delayed release 325 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *aspirin oral tablet delayed release 81 mg* | Covered | |
| *childrens aspirin oral tablet chewable 81 mg* | Covered | |
| *diflunisal oral tablet 500 mg* | Covered | |
| **MEDI-FIRST ASPIRIN ORAL TABLET 325 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| **MEDIQUE ASPIRIN ORAL TABLET 325 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *salsalate oral tablet 500 mg, 750 mg* | Covered | |
| ***ANALGESICS - OPIOID*** | | |
| ***CODEINE COMBINATIONS***** | | |
| *acetaminophen-codeine oral solution 120-12 mg/5ml* | Covered | PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years) |
| *acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg* | Covered | 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) |
| *acetaminophen-codeine oral tablet 300-60 mg* | Covered | PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (13 EA per 1 day); AL (Min 12 Years) |
| *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg* | Covered | 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) |
| *butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg* | Covered | PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (6 EA per 1 day); AL (Min 12 Years) |
| ***HYDROCODONE COMBINATIONS***** | | |
| *hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml* | Covered | |
| *hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg* | Covered | QL (12 EA per 1 day) |
| *hydrocodone-ibuprofen oral tablet 7.5-200 mg* | Covered | QL (5 EA per 1 day) |
| ***OPIOID AGONISTS***** | | |
| *codeine sulfate oral tablet 30 mg, 60 mg* | Covered | 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* | Covered | ST; QL (10 EA per 30 days) |
| *hydromorphone hcl oral liquid 1 mg/ml* | Covered | QL (50 ML per 1 day) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg* | Covered | QL (6 EA per 1 day) |
| *meperidine hcl oral solution 50 mg/5ml* | Covered | QL (1200 ML per 30 days) |
| *meperidine hcl oral tablet 50 mg* | Covered | QL (180 EA per 30 days) |
| *methadone hcl oral solution 10 mg/5ml, 5 mg/5ml* | Covered | PA; QL (900 ML per 30 days) |
| *methadone hcl oral tablet 10 mg, 5 mg* | Covered | PA; QL (180 EA per 30 days) |
| *morphine sulfate (concentrate) oral solution 20 mg/ml* | Covered | 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* | Covered | 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* | Covered | 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* | Covered | QL (180 EA per 30 days) |
| *morphine sulfate er oral tablet extended release 15 mg, 200 mg, 30 mg, 60 mg* | Covered | QL (90 EA per 30 days) |
| *morphine sulfate oral solution 10 mg/5ml* | Covered | QL (900 ML per 30 days) |
| *morphine sulfate oral tablet 15 mg, 30 mg* | Covered | QL (180 EA per 30 days) |
| *oxycodone hcl oral concentrate 100 mg/5ml* | Covered | QL (180 ML per 30 days) |
| *oxycodone hcl oral solution 5 mg/5ml* | Covered | QL (2700 ML per 30 days) |
| *oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg* | Covered | 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* | Covered | ST; QL (60 EA per 30 days) |
| *tramadol hcl oral tablet 50 mg* | Covered | 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) |
| ***OPIOID COMBINATIONS***** | | |
| **ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG** | Covered | QL (12 EA per 1 day) |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg* | Covered | QL (12 EA per 1 day) |
| *oxycodone-acetaminophen oral tablet 5-325 mg* | Covered | QL (8 EA per 1 day) |
| ***OPIOID PARTIAL AGONISTS***** | | |
| **BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML, 8 MG/0.16ML** | Covered | QL (0.64 ML per 28 days) |
| **BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 24 MG/0.48ML, 32 MG/0.64ML** | Covered | QL (1.92 ML per 28 days) |

| Drug Name | Tier | Notes |
|---|---|---|
| **BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML** | Covered | QL (0.36 ML per 28 days) |
| **BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 64 MG/0.18ML** | Covered | QL (0.18 ML per 28 days) |
| **BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 96 MG/0.27ML** | Covered | QL (0.27 ML per 28 days) |
| *buprenorphine hcl sublingual tablet sublingual 2 mg* | Covered | QL (3 EA per 1 day); AL (Min 16 Years) |
| *buprenorphine hcl sublingual tablet sublingual 8 mg* | Covered | PA; QL (4 EA per 1 day); AL (Min 16 Years) |
| *buprenorphine hcl-naloxone hcl sublingual film 12-3 mg* | Covered | 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* | Covered | QL (90 EA per 30 days); AL (Min 16 Years) |
| *buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg* | Covered | QL (90 EA per 30 days); AL (Min 16 Years) |
| *buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg* | Covered | QL (120 EA per 30 days); AL (Min 16 Years) |
| **SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML** | Covered | QL (0.5 ML per 30 days) |
| **SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/1.5ML** | Covered | QL (1.5 ML per 30 days) |
| **ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 5.7-1.4 MG** | Covered | QL (3 EA per 1 day) |
| **ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 11.4-2.9 MG** | Covered | QL (1 EA per 1 day) |
| **ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 2.9-0.71 MG, 8.6-2.1 MG** | Covered | QL (2 EA per 1 day) |
| ***ANDROGENS-ANABOLIC*** | | |
| ***ANDROGENS***** | | |
| **ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR** | Covered | PA; QL (60 EA per 30 days) |
| **ANDRODERM TRANSDERMAL PATCH 24 HOUR 4 MG/24HR** | Covered | PA; QL (30 EA per 30 days) |
| *danazol oral capsule 100 mg, 200 mg, 50 mg* | Covered | |
| *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml* | Covered | PA |
| *testosterone enanthate intramuscular solution 200 mg/ml* | Covered | PA |
| *testosterone transdermal gel 10 mg/act (2%)* | Covered | PA; QL (120 GM per 30 days) |
| *testosterone transdermal gel 12.5 mg/act (1%), 50 mg/5gm (1%)* | Covered | PA; QL (300 GM per 30 days) |
| *testosterone transdermal gel 25 mg/2.5gm (1%)* | Covered | PA; QL (75 GM per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***ANORECTAL AND RELATED PRODUCTS*** | | |
| ***INTRARECTAL STEROIDS***** | | |
| *hydrocortisone rectal enema 100 mg/60ml* | Covered | |
| ***RECTAL ANESTHETIC/STEROIDS***** | | |
| *lidocaine-hydrocort (perianal) external cream 3-0.5 %* | Covered | |
| **PROCTOFOAM HC EXTERNAL FOAM 1-1 %** | Covered | |
| ***RECTAL STEROIDS***** | | |
| *hydrocortisone (perianal) external cream 2.5 %* | Covered | |
| **PROCTOCARE-HC EXTERNAL CREAM 2.5 %** | Covered | |
| **PROCTO-MED HC EXTERNAL CREAM 2.5 %** | Covered | |
| **PROCTOSOL HC EXTERNAL CREAM 2.5 %** | Covered | |
| **PROCTOZONE-HC EXTERNAL CREAM 2.5 %** | Covered | |
| ***ANTHELMINTICS*** | | |
| ***ANTHELMINTICS***** | | |
| *albendazole oral tablet 200 mg* | Covered | PA |
| *reeses pinworm medicine oral suspension 144 (50 base) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (60 ML per 30 days) |
| ***ANTIANGINAL AGENTS*** | | |
| ***ANTIANGINALS-OTHER***** | | |
| *ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg* | Covered | ST |
| ***NITRATES***** | | |
| *isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg* | Covered | |
| *isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg* | Covered | |
| *isosorbide mononitrate oral tablet 10 mg, 20 mg* | Covered | |
| **NITRO-BID TRANSDERMAL OINTMENT 2 %** | Covered | |
| **NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR** | Covered | |
| *nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg* | Covered | |
| *nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr* | Covered | |
| ***ANTIANXIETY AGENTS*** | | |
| ***ANTIANXIETY AGENTS - MISC.***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *buspirone hcl oral tablet 10 mg, 15 mg, 5 mg, 7.5 mg* | Covered | QL (90 EA per 30 days) |
| *buspirone hcl oral tablet 30 mg* | Covered | QL (60 EA per 30 days) |
| *hydroxyzine hcl oral syrup 10 mg/5ml* | Covered | |
| *hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg* | Covered | |
| *hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg* | Covered | |
| *meprobamate oral tablet 200 mg, 400 mg* | Covered | |
| ***BENZODIAZEPINES***** | | |
| *alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg* | Covered | QL (30 EA per 30 days) |
| *alprazolam er oral tablet extended release 24 hour 3 mg* | Covered | QL (60 EA per 30 days) |
| **ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML** | Covered | |
| *alprazolam oral tablet 0.25 mg* | Covered | Max two Benzodiazepines.; QL (90 EA per 30 days) |
| *alprazolam oral tablet 0.5 mg, 1 mg* | Covered | QL (90 EA per 30 days) |
| *alprazolam oral tablet 2 mg* | Covered | QL (135 EA per 30 days) |
| *alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg* | Covered | QL (30 EA per 30 days) |
| *alprazolam xr oral tablet extended release 24 hour 3 mg* | Covered | QL (60 EA per 30 days) |
| *chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg* | Covered | QL (120 EA per 30 days) |
| *clorazepate dipotassium oral tablet 15 mg* | Covered | QL (180 EA per 30 days) |
| *clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg* | Covered | QL (90 EA per 30 days) |
| *diazepam oral tablet 10 mg, 2 mg, 5 mg* | Covered | QL (120 EA per 30 days) |
| *lorazepam oral concentrate 2 mg/ml* | Covered | |
| *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg* | Covered | QL (90 EA per 30 days) |
| ***ANTIARRHYTHMICS*** | | |
| ***ANTIARRHYTHMICS TYPE I-A***** | | |
| *disopyramide phosphate oral capsule 100 mg, 150 mg* | Covered | |
| **NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG** | Covered | |
| *quinidine gluconate er oral tablet extended release 324 mg* | Covered | |
| *quinidine sulfate oral tablet 200 mg, 300 mg* | Covered | |
| ***ANTIARRHYTHMICS TYPE I-B***** | | |
| *mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg* | Covered | |
| ***ANTIARRHYTHMICS TYPE I-C***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *flecainide acetate oral tablet 100 mg, 150 mg, 50 mg* | Covered | |
| *propafenone hcl oral tablet 150 mg, 225 mg, 300 mg* | Covered | |
| ***ANTIARRHYTHMICS TYPE III***** | | |
| *amiodarone hcl oral tablet 200 mg, 400 mg* | Covered | |
| **MULTAQ ORAL TABLET 400 MG** | Covered | PA; QL (60 EA per 30 days) |
| **PACERONE ORAL TABLET 100 MG** | Covered | |
| ***ANTIASTHMATIC AND BRONCHODILATOR AGENTS*** | | |
| ***5-LIPOXYGENASE INHIBITORS***** | | |
| *zileuton er oral tablet extended release 12 hour 600 mg* | Covered | PA; QL (120 EA per 30 days); SP |
| ***ADRENERGIC COMBINATIONS***** | | |
| **BREYNA INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT** | Covered | QL (10.2 GM per 30 days) |
| *budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act* | Covered | QL (10.2 GM per 30 days) |
| **COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT** | Covered | QL (4 GM per 30 days) |
| **DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT** | Covered | ST; QL (13 GM per 30 days); AL (Max 12 Years) |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | Covered | PA; Step Edit Criteria applies to Dulera and Symbicort. Coverage of Dulera and Symbicort requires a prescription claim history of an orally inhaled corticosteroid or orally inhaled anticholinergic within the past 120 days OR FEV1 of less than 50%.; 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* | Covered | AL (Min 12 Years) |
| *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml* | Covered | |
| **STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT** | Covered | ST |
| **WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT** | Covered | PA; QL (60 EA per 30 days) |
| ***ANTI-INFLAMMATORY AGENTS***** | | |
| *cromolyn sodium inhalation nebulization solution 20 mg/2ml* | Covered | |
| ***BETA ADRENERGICS***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act* | Covered | Formulary NDCs/Manufactures: 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* | Covered | |
| *albuterol sulfate oral syrup 2 mg/5ml* | Covered | |
| *albuterol sulfate oral tablet 2 mg, 4 mg* | Covered | |
| **SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT** | Covered | |
| *terbutaline sulfate oral tablet 2.5 mg, 5 mg* | Covered | |
| ***BRONCHODILATORS - ANTICHOLINERGICS***** | | |
| **ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT** | Covered | |
| *ipratropium bromide inhalation solution 0.02 %* | Covered | |
| **SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT** | Covered | |
| ***LEUKOTRIENE RECEPTOR ANTAGONISTS***** | | |
| *montelukast sodium oral tablet 10 mg* | Covered | QL (30 EA per 30 days) |
| *montelukast sodium oral tablet chewable 4 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| *zafirlukast oral tablet 10 mg, 20 mg* | Covered | |
| ***MIXED ADRENERGICS***** | | |
| **ASTHMANEFRIN REFILL INHALATION NEBULIZATION SOLUTION 2.25 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS***** | | |
| *roflumilast oral tablet 500 mcg* | Covered | PA; QL (30 EA per 30 days) |
| ***STEROID INHALANTS***** | | |
| **ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT** | Covered | QL (12.2 GM per 30 days) |
| **ALVESCO INHALATION AEROSOL SOLUTION 80 MCG/ACT** | Covered | QL (6.1 GM per 30 days) |
| *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml* | Covered | QL (120 ML per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act* | Covered | |
| *fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act* | Covered | |
| **QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT** | Covered | QL (10.6 GM per 30 days) |
| **QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT** | Covered | QL (21.2 GM per 30 days) |
| ***XANTHINES***** | | |
| **ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML** | Covered | |
| *theophylline er oral tablet extended release 12 hour 300 mg, 450 mg* | Covered | |
| *theophylline er oral tablet extended release 24 hour 400 mg, 600 mg* | Covered | |
| ***ANTICOAGULANTS*** | | |
| ***COUMARIN ANTICOAGULANTS***** | | |
| **JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG** | Covered | |
| *warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg* | Covered | |
| ***DIRECT FACTOR XA INHIBITORS***** | | |
| **XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML** | Covered | QL (600 ML per 30 days) |
| **XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG** | Covered | QL (30 EA per 30 days) |
| **XARELTO ORAL TABLET 2.5 MG** | Covered | PA; QL (60 EA per 30 days) |
| **XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG** | Covered | QL (51 EA per 90 days) |
| ***HEPARINS AND HEPARINOID-LIKE AGENTS***** | | |
| **BD HEPARIN POSIFLUSH INTRAVENOUS SOLUTION 10 UNIT/ML, 100 UNIT/ML** | Covered | |
| *heparin na (pork) lock flsh pf intravenous solution 10 unit/ml, 100 unit/ml* | Covered | |
| *heparin sod (pork) lock flush intravenous solution 10 unit/ml, 100 unit/ml* | Covered | |
| *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml* | Covered | |
| *heparin sodium (porcine) pf injection solution 1000 unit/ml* | Covered | |
| ***LOW MOLECULAR WEIGHT HEPARINS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *enoxaparin sodium injection solution 300 mg/3ml* | Covered | PA; Maximum 30 syringes per 90 days. Prior authorization required for amounts exceeding plan quantity limits. |
| *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* | Covered | PA; Maximum 30 syringes per 90 days. Prior authorization required for amounts exceeding plan quantity limits. |
| **FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML** | Covered | 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* | Covered | PA |
| ***ANTICONVULSANTS*** | | |
| ***ANTICONVULSANTS - BENZODIAZEPINES***** | | |
| *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg* | Covered | QL (90 EA per 30 days) |
| *clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg* | Covered | QL (90 EA per 30 days) |
| *diazepam rectal gel 10 mg, 2.5 mg, 20 mg* | Covered | ST; QL (5 EA per 30 days); AL (Max 17 Years) |
| **NAYZILAM NASAL SOLUTION 5 MG/0.1ML** | Covered | PA; QL (10 delivery systems per 30 days) |
| **VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML** | Covered | PA; QL (10 EA per 30 days) |
| **VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML** | Covered | PA; QL (5 packs per 30 Days) |
| **VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML** | Covered | PA; QL (5 packs per 30 Days) |
| **VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML** | Covered | PA; QL (10 EA per 30 days) |
| ***ANTICONVULSANTS - MISC.***** | | |
| *carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg* | Covered | |
| *carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg* | Covered | |
| *carbamazepine oral suspension 100 mg/5ml* | Covered | |
| *carbamazepine oral tablet 200 mg* | Covered | |
| *carbamazepine oral tablet chewable 100 mg* | Covered | |
| *gabapentin oral capsule 100 mg, 300 mg, 400 mg* | Covered | |
| *gabapentin oral solution 250 mg/5ml* | Covered | |
| *gabapentin oral tablet 600 mg, 800 mg* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *lacosamide oral solution 10 mg/ml* | Covered | |
| *lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg* | Covered | QL (60 EA per 30 days) |
| *lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg* | Covered | PA; QL (30 EA per 30 days) |
| *lamotrigine er oral tablet extended release 24 hour 200 mg, 250 mg, 300 mg* | Covered | PA; QL (60 EA per 30 days) |
| *lamotrigine oral tablet 100 mg, 150 mg, 200 mg* | Covered | QL (60 EA per 30 days) |
| *lamotrigine oral tablet 25 mg* | Covered | QL (120 EA per 30 days) |
| *lamotrigine oral tablet chewable 25 mg* | Covered | |
| *levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg* | Covered | ST; QL (120 EA per 30 days) |
| *levetiracetam oral solution 100 mg/ml* | Covered | |
| *levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg* | Covered | |
| *oxcarbazepine oral suspension 300 mg/5ml* | Covered | |
| *oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg* | Covered | |
| *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg* | Covered | QL (90 EA per 30 days) |
| *pregabalin oral capsule 225 mg, 300 mg* | Covered | QL (60 EA per 30 days) |
| *primidone oral tablet 250 mg, 50 mg* | Covered | |
| *topiramate oral capsule sprinkle 15 mg, 25 mg* | Covered | |
| *topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg* | Covered | |
| *zonisamide oral capsule 100 mg, 25 mg, 50 mg* | Covered | |
| ***HYDANTOINS***** | | |
| **DILANTIN ORAL CAPSULE 30 MG** | Covered | |
| *phenytoin oral suspension 125 mg/5ml* | Covered | |
| *phenytoin oral tablet chewable 50 mg* | Covered | |
| *phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg* | Covered | |
| ***SUCCINIMIDES***** | | |
| *ethosuximide oral capsule 250 mg* | Covered | |
| *ethosuximide oral solution 250 mg/5ml* | Covered | |
| ***VALPROIC ACID***** | | |
| *divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg* | Covered | |
| *divalproex sodium oral capsule delayed release sprinkle 125 mg* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg* | Covered | |
| *valproic acid oral capsule 250 mg* | Covered | |
| ***ANTIDEPRESSANTS*** | | |
| ***ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)***** | | |
| *mirtazapine oral tablet 15 mg, 30 mg, 45 mg* | Covered | QL (30 EA per 30 days) |
| *mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg* | Covered | PA; QL (30 EA per 30 days) |
| ***ANTIDEPRESSANTS - MISC.***** | | |
| *bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg* | Covered | QL (60 EA per 30 days) |
| *bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg* | Covered | QL (90 EA per 30 days) |
| *bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg* | Covered | QL (30 EA per 30 days) |
| *bupropion hcl oral tablet 100 mg* | Covered | QL (135 EA per 30 days) |
| *bupropion hcl oral tablet 75 mg* | Covered | QL (120 EA per 30 days) |
| ***MONOAMINE OXIDASE INHIBITORS (MAOIS)***** | | |
| **EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR** | Covered | PA; QL (30 EA per 30 days) |
| **MARPLAN ORAL TABLET 10 MG** | Covered | PA; QL (180 EA per 30 days); AL (Min 18 Years) |
| *phenelzine sulfate oral tablet 15 mg* | Covered | |
| *tranylcypromine sulfate oral tablet 10 mg* | Covered | |
| ***SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)***** | | |
| *citalopram hydrobromide oral solution 10 mg/5ml* | Covered | QL (600 ML per 30 days) |
| *citalopram hydrobromide oral tablet 10 mg, 20 mg* | Covered | QL (60 EA per 30 days) |
| *citalopram hydrobromide oral tablet 40 mg* | Covered | QL (30 EA per 30 days) |
| *escitalopram oxalate oral solution 5 mg/5ml* | Covered | QL (600 ML per 30 days) |
| *escitalopram oxalate oral tablet 10 mg* | Covered | QL (45 EA per 30 days) |
| *escitalopram oxalate oral tablet 20 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| *fluoxetine hcl oral capsule 10 mg, 40 mg* | Covered | QL (60 EA per 30 days) |
| *fluoxetine hcl oral capsule 20 mg* | Covered | QL (120 EA per 30 days) |
| *fluoxetine hcl oral solution 20 mg/5ml* | Covered | QL (600 ML per 30 days) |
| *fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg* | Covered | ST; QL (30 EA per 30 days) |
| *fluvoxamine maleate oral tablet 100 mg* | Covered | QL (90 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *fluvoxamine maleate oral tablet 25 mg* | Covered | QL (30 EA per 30 days) |
| *fluvoxamine maleate oral tablet 50 mg* | Covered | QL (45 EA per 30 days) |
| *paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg* | Covered | ST |
| *paroxetine hcl oral suspension 10 mg/5ml* | Covered | PA; QL (900 ML per 30 days) |
| *paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg* | Covered | QL (30 EA per 30 days) |
| *paroxetine hcl oral tablet 40 mg* | Covered | QL (45 EA per 30 days) |
| *sertraline hcl oral concentrate 20 mg/ml* | Covered | QL (300 ML per 30 days) |
| *sertraline hcl oral tablet 100 mg, 25 mg* | Covered | QL (60 EA per 30 days) |
| *sertraline hcl oral tablet 50 mg* | Covered | QL (45 EA per 30 days) |
| ***SEROTONIN MODULATORS***** | | |
| *nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg* | Covered | PA; QL (60 EA per 30 days); AL (Min 18 Years) |
| *trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg* | Covered | |
| **TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG** | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| *vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg* | Covered | 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* | Covered | QL (30 EA per 30 days); AL (Min 18 Years) |
| *duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg* | Covered | QL (60 EA per 30 days) |
| **FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG** | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| **FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG** | Covered | PA; QL (1 Pack per 6 Months); AL (Min 18 Years) |
| *venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg* | Covered | QL (60 EA per 30 days) |
| *venlafaxine hcl er oral capsule extended release 24 hour 75 mg* | Covered | QL (90 EA per 30 days) |
| *venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg* | Covered | QL (90 EA per 30 days) |
| ***TRICYCLIC AGENTS***** | | |
| *amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | Covered | |
| *amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg* | Covered | |
| *clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg* | Covered | |
| *desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| *doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | Covered | |
| *doxepin hcl oral concentrate 10 mg/ml* | Covered | |
| *imipramine hcl oral tablet 10 mg, 25 mg, 50 mg* | Covered | |
| *nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg* | Covered | |
| *protriptyline hcl oral tablet 10 mg* | Covered | PA; QL (60 EA per 30 days); AL (Min 18 Years) |
| *protriptyline hcl oral tablet 5 mg* | Covered | PA; QL (90 EA per 30 days); AL (Min 18 Years) |
| *trimipramine maleate oral capsule 100 mg, 50 mg* | Covered | PA; QL (60 EA per 30 days); AL (Min 18 Years) |
| *trimipramine maleate oral capsule 25 mg* | Covered | PA; QL (90 EA per 30 days); AL (Min 18 Years) |
| ***ANTIDIABETICS*** | | |
| ***ALPHA-GLUCOSIDASE INHIBITORS***** | | |
| *acarbose oral tablet 100 mg, 25 mg, 50 mg* | Covered | |
| ***ANTIDIABETIC - AMYLIN ANALOGS***** | | |
| **SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML** | Covered | PA |
| **SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML** | Covered | PA |
| ***BIGUANIDES***** | | |
| *metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg* | Covered | |
| *metformin hcl oral tablet 1000 mg, 500 mg, 850 mg* | Covered | |
| ***DIABETIC OTHER***** | | |
| **BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE** | Covered | |
| **BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE** | Covered | |
| **GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML** | Covered | |
| **GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML** | Covered | |
| **GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML** | Covered | |
| **GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML** | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS***** | | |
| *alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg* | Covered | 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* | Covered | ST; QL (60 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* | Covered | ST; QL (30 EA per 30 days) |
| ***HUMAN INSULIN***** | | |
| **ADMELOG SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS** | Covered | QL (45 ML per 30 days) |
| **ADMELOG SOLUTION 100 UNIT/ML INJECTION** | Covered | QL (50 ML per 30 days) |
| **HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML** | Covered | PA; QL (1 ML per 1 day) |
| **HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML** | Covered | PA; QL (18 ML per 30 days) |
| *insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml* | Covered | QL (45 ML per 30 days) |
| *insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml* | Covered | QL (45 ML per 30 days) |
| *insulin aspart injection solution 100 unit/ml* | Covered | QL (50 ML per 30 days) |
| *insulin aspart penfill solution cartridge 100 unit/ml subcutaneous* | Covered | QL (45 ML per 30 days) |
| *insulin aspart prot & aspart suspension (70-30) 100 unit/ml subcutaneous* | Covered | QL (50 ML per 30 days) |
| *insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml* | Covered | ST; QL (45 ML per 30 days) |
| *insulin degludec subcutaneous solution 100 unit/ml* | Covered | ST; QL (50 ML per 30 days) |
| *insulin glargine-yfgn subcutaneous solution 100 unit/ml* | Covered | QL (50 ML per 30 days) |
| *insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml* | Covered | QL (45 ML per 30 days) |
| **NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML** | Covered | QL (50 ML per 30 days) |
| **NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML** | Covered | QL (50 ML per 30 days) |
| **NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML** | Covered | QL (45 ML per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| **NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML** | Covered | QL (45 ML per 30 days) |
| **NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML** | Covered | QL (50 ML per 30 days) |
| **NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML** | Covered | QL (50 ML per 30 days) |
| **NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML** | Covered | QL (45 ML per 30 days) |
| **NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML** | Covered | QL (45 ML per 30 days) |
| **NOVOLIN R INJECTION SOLUTION 100 UNIT/ML** | Covered | QL (50 ML per 30 days) |
| **NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML** | Covered | QL (50 ML per 30 days) |
| **REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML** | Covered | QL (45 ML per 30 days) |
| ***INCRETIN MIMETIC AGENTS (GIP & GLP-1 RECEPTOR AGONISTS)***** | | |
| **MOUNJARO SUBCUTANEOUS SOLUTION PEN-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** | Covered | PA; QL (2 ML per 28 days) |
| ***INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)***** | | |
| **TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML** | Covered | PA; QL (2 ML per 28 days) |
| ***MEGLITINIDE ANALOGUES***** | | |
| *nateglinide oral tablet 120 mg, 60 mg* | Covered | |
| *repaglinide oral tablet 0.5 mg, 1 mg* | Covered | ST; QL (120 EA per 30 days) |
| *repaglinide oral tablet 2 mg* | Covered | ST; QL (240 EA per 30 days) |
| ***SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS***** | | |
| **FARXIGA ORAL TABLET 10 MG, 5 MG** | Covered | PA; QL (30 EA per 30 days) |
| **STEGLATRO ORAL TABLET 15 MG** | Covered | ST; QL (30 EA per 30 days) |
| **STEGLATRO ORAL TABLET 5 MG** | Covered | ST; QL (30 EA per 30 Days) |
| ***SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB***** | | |
| **SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG** | Covered | ST; QL (60 EA per 30 days) |
| ***SULFONYLUREA-BIGUANIDE COMBINATIONS***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg* | Covered | |
| *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg* | Covered | QL (60 EA per 30 days) |
| *glyburide-metformin oral tablet 5-500 mg* | Covered | QL (120 EA per 30 days) |
| ***SULFONYLUREAS***** | | |
| *glimepiride oral tablet 1 mg, 2 mg, 4 mg* | Covered | |
| *glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg* | Covered | |
| *glipizide oral tablet 10 mg, 5 mg* | Covered | |
| *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg* | Covered | |
| ***SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS***** | | |
| *pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg* | Covered | ST |
| ***THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS***** | | |
| *pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg* | Covered | ST |
| ***THIAZOLIDINEDIONES***** | | |
| *pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg* | Covered | QL (30 EA per 30 days) |
| ***ANTIDIARRHEAL/PROBIOTIC AGENTS*** | | |
| ***ANTIPERISTALTIC AGENTS***** | | |
| *diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml* | Covered | |
| *diphenoxylate-atropine oral tablet 2.5-0.025 mg* | Covered | |
| ***ANTIDOTES AND SPECIFIC ANTAGONISTS*** | | |
| ***OPIOID ANTAGONISTS***** | | |
| *naloxone hcl injection solution 0.4 mg/ml* | Covered | Naloxone injectable used with nasal atomizer is covered.; QL (2 ML per 30 days) |
| *naloxone hcl injection solution prefilled syringe 2 mg/2ml* | Covered | |
| *naloxone hcl nasal liquid 4 mg/0.1ml* | Covered | |
| *naltrexone hcl oral tablet 50 mg* | Covered | |
| **NARCAN NASAL LIQUID 4 MG/0.1ML** | Covered | |
| **VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG** | Covered | QL (1 EA per 30 days) |
| ***ANTIEMETICS*** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***5-HT3 RECEPTOR ANTAGONISTS***** | | |
| **ANZEMET ORAL TABLET 50 MG** | Covered | PA; QL (4 EA per 28 days) |
| *granisetron hcl intravenous solution 4 mg/4ml* | Covered | |
| *granisetron hcl oral tablet 1 mg* | Covered | ST; QL (20 EA per 30 days) |
| *ondansetron hcl oral solution 4 mg/5ml* | Covered | AL (Max 4 Years) |
| *ondansetron hcl oral tablet 4 mg, 8 mg* | Covered | QL (90 EA per 30 days) |
| *ondansetron oral tablet dispersible 4 mg, 8 mg* | Covered | QL (90 EA per 30 days) |
| Palonosetron HCl Intravenous Solution 0.25 MG/2ML | MB | QL (2 ML per 5 days) |
| ***ANTIEMETICS - ANTICHOLINERGIC***** | | |
| *trimethobenzamide hcl oral capsule 300 mg* | Covered | |
| ***SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS***** | | |
| *aprepitant oral capsule 125 mg, 40 mg* | Covered | PA; QL (1 EA per 30 days) |
| *aprepitant oral capsule 80 & 125 mg, 80 mg* | Covered | PA; QL (3 EA per 30 days) |
| **EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML** | Covered | PA; QL (6 EA per 28 days) |
| ***ANTIFUNGALS*** | | |
| ***ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)***** | | |
| Eraxis Intravenous Solution Reconstituted 100 MG, 50 MG | MB | |
| ***ANTIFUNGALS***** | | |
| *griseofulvin microsize oral suspension 125 mg/5ml* | Covered | |
| *griseofulvin ultramicrosize oral tablet 125 mg, 250 mg* | Covered | |
| *nystatin oral tablet 500000 unit* | Covered | |
| *terbinafine hcl oral tablet 250 mg* | Covered | QL (90 EA per 365 days) |
| ***IMIDAZOLES***** | | |
| *ketoconazole oral tablet 200 mg* | Covered | |
| ***TRIAZOLES***** | | |
| *fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml* | Covered | |
| *fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg* | Covered | |
| *itraconazole oral capsule 100 mg* | Covered | ST; QL (168 EA per 365 days) |
| *voriconazole oral suspension reconstituted 40 mg/ml* | Covered | PA; QL (6 ML per 1 day) |
| *voriconazole oral tablet 200 mg, 50 mg* | Covered | PA; QL (60 EA per 30 days) |
| ***ANTIHISTAMINES*** | | |
| ***ANTIHISTAMINES - ETHANOLAMINES***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *aler-cap oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *allergy oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **BANOPHEN ORAL CAPSULE 25 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *complete allergy medicine oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs allergy oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *diphenhist oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *diphenhydramine hcl oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *eq allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ft allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp allergy oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *goodsense allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **MEDI-PHEDRYL ORAL CAPSULE 25 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| *meijer antihistamine allergy oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *pharbedryl oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *qc allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra allergy medication oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra allergy relief oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sb allergy oral capsule 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **WAL-DRYL ALLERGY ORAL CAPSULE 25 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***ANTIHISTAMINES - NON-SEDATING***** | | |
| *all day allergy childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *all-day allergy childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **ALLEGRA ALLERGY CHILDRENS ORAL TABLET DISPERSIBLE 30 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *allergy relief (cetirizine) oral capsule 10 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *allergy relief childrens 24-hr oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *allergy relief childrens oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cetirizine hcl allergy child oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cetirizine hcl childrens alrgy oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| *cetirizine hcl childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cetirizine hcl oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *cetirizine hcl oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cetirizine hcl oral tablet 10 mg, 5 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *cetirizine hcl oral tablet chewable 10 mg, 5 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *childrens 24 hour allergy oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *childrens loratadine oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *cvs allergy relief childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *eq allerg relief child (cetir) oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *eq allergy relief (cetirizine) oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *eql all day allergy childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *fexofenadine hcl oral tablet 180 mg, 60 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ft allergy relief childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp all day allergy childrens oral solution 1 mg/ml, 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *goodsense all day allergy oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *hm all day allergy childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **KLS ALLER-TEC CHILDRENS ORAL SOLUTION 5 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *loratadine oral tablet 10 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *qc allergy relief childrens oral syrup 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *qc childrens allergy oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra allergy relief childrens oral solution 1 mg/ml, 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra allergy relief childrens oral syrup 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sb cetirizine hcl childrens oral solution 1 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sm all day allergy childrens oral solution 5 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **WAL-ZYR ALL DAY ALLERGY CHILD ORAL SOLUTION 5 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **WAL-ZYR ALLERGY CHILDRENS ORAL SOLUTION 1 MG/ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **WAL-ZYR CHILDRENS ORAL SOLUTION 1 MG/ML, 5 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **WAL-ZYR ORAL SOLUTION 5 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***ANTIHISTAMINES - PHENOTHIAZINES***** | | |
| *promethazine hcl oral solution 6.25 mg/5ml* | Covered | |
| *promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg* | Covered | |
| *promethazine hcl rectal suppository 12.5 mg, 25 mg* | Covered | |
| ***ANTIHISTAMINES - PIPERIDINES***** | | |
| *cyproheptadine hcl oral syrup 2 mg/5ml* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *cyproheptadine hcl oral tablet 4 mg* | Covered | |
| ***ANTIHYPERLIPIDEMICS*** | | |
| ***BILE ACID SEQUESTRANTS***** | | |
| *cholestyramine light oral packet 4 gm* | Covered | |
| *cholestyramine light oral powder 4 gm/dose* | Covered | |
| *cholestyramine oral packet 4 gm* | Covered | |
| *cholestyramine oral powder 4 gm/dose* | Covered | |
| *colesevelam hcl oral packet 3.75 gm* | Covered | QL (30 EA per 30 days) |
| *colesevelam hcl oral tablet 625 mg* | Covered | |
| **PREVALITE ORAL POWDER 4 GM/DOSE** | Covered | |
| ***FIBRIC ACID DERIVATIVES***** | | |
| *fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg* | Covered | |
| *fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg* | Covered | |
| *gemfibrozil oral tablet 600 mg* | Covered | |
| ***HMG COA REDUCTASE INHIBITORS***** | | |
| *atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg* | Covered | QL (30 EA per 30 days) |
| *lovastatin oral tablet 10 mg, 20 mg, 40 mg* | Covered | |
| *pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg* | Covered | |
| *rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| *simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg* | Covered | |
| ***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* | Covered | ST |
| ***INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS***** | | |
| *ezetimibe oral tablet 10 mg* | Covered | |
| ***NICOTINIC ACID DERIVATIVES***** | | |
| *niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg* | Covered | |
| **NIACOR ORAL TABLET 500 MG** | Covered | |
| ***PCSK9 INHIBITORS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| **REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML** | Covered | PA; QL (3.5 ML per 28 days); SP |
| **REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML** | Covered | PA; HeFH or ASCVD: 2 injections monthly. HoFH: 3 injections monthly.; QL (2 ML per 28 days); SP |
| **REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML** | Covered | PA; HeFH or ASCVD: 2 injections monthly. HoFH: 3 injections monthly.; QL (2 ML per 30 days); SP |
| ***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* | Covered | |
| ***ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE***** | | |
| *benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg* | Covered | |
| *captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg* | Covered | |
| *enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg* | Covered | |
| *fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg* | Covered | |
| *lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg* | Covered | |
| *quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg* | Covered | |
| ***ACE INHIBITORS***** | | |
| *benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | Covered | |
| *captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg* | Covered | |
| *enalapril maleate oral solution 1 mg/ml* | Covered | PA |
| *enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg* | Covered | |
| *fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg* | Covered | |
| *lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg* | Covered | |
| *moexipril hcl oral tablet 15 mg, 7.5 mg* | Covered | |
| **QBRELIS ORAL SOLUTION 1 MG/ML** | Covered | PA |
| *quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg* | Covered | |
| *ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE***** | | |
| *candesartan cilexetil-hctz oral tablet 16-12.5 mg* | Covered | ST; QL (60 EA per 30 days) |
| *candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg* | Covered | ST; QL (30 EA per 30 days) |
| *irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg* | Covered | QL (60 EA per 30 days) |
| *irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg* | Covered | QL (30 EA per 30 days) |
| *losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg* | Covered | |
| *valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg* | Covered | ST |
| ***ANGIOTENSIN II RECEPTOR ANTAGONISTS***** | | |
| *candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg* | Covered | ST; QL (60 EA per 30 days) |
| *candesartan cilexetil oral tablet 32 mg* | Covered | ST; QL (30 EA per 30 days) |
| *irbesartan oral tablet 150 mg, 300 mg, 75 mg* | Covered | QL (30 EA per 30 days) |
| *losartan potassium oral tablet 100 mg, 25 mg, 50 mg* | Covered | |
| *olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| *valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg* | Covered | QL (60 EA per 30 Days) |
| ***ANTIADRENERGICS - CENTRALLY ACTING***** | | |
| *clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg* | Covered | |
| *guanfacine hcl oral tablet 1 mg, 2 mg* | Covered | |
| *methyldopa oral tablet 250 mg, 500 mg* | Covered | |
| ***ANTIADRENERGICS - PERIPHERALLY ACTING***** | | |
| *doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg* | Covered | |
| *prazosin hcl oral capsule 1 mg, 2 mg, 5 mg* | Covered | |
| *terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | Covered | |
| ***BETA BLOCKER & DIURETIC COMBINATIONS***** | | |
| *atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg* | Covered | |
| *bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg* | Covered | |
| *metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg* | Covered | |
| ***VASODILATORS***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg* | Covered | |
| *minoxidil oral tablet 10 mg, 2.5 mg* | Covered | |
| ***ANTI-INFECTIVE AGENTS - MISC.*** | | |
| ***ANTI-INFECTIVE AGENTS - MISC.***** | | |
| *metronidazole oral tablet 250 mg, 500 mg* | Covered | |
| *pentamidine isethionate inhalation solution reconstituted 300 mg* | Covered | QL (1 EA per 28 days) |
| *trimethoprim oral tablet 100 mg* | Covered | |
| **XIFAXAN ORAL TABLET 200 MG** | Covered | PA; QL (9 EA per 30 days) |
| **XIFAXAN ORAL TABLET 550 MG** | Covered | PA; QL (60 EA per 30 days) |
| ***ANTI-INFECTIVE MISC. - COMBINATIONS***** | | |
| *sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml* | Covered | |
| *sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg* | Covered | |
| ***ANTIPROTOZOAL AGENTS***** | | |
| *atovaquone oral suspension 750 mg/5ml* | Covered | |
| ***CYCLIC LIPOPEPTIDES***** | | |
| DAPTOmycin Intravenous Solution Reconstituted 500 MG | MB | |
| ***GLYCOPEPTIDES***** | | |
| *vancomycin hcl intravenous solution reconstituted 500 mg* | Covered | |
| *vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml* | Covered | QL (300 ML per 14 days) |
| ***LEPROSTATICS***** | | |
| *dapsone oral tablet 100 mg, 25 mg* | Covered | |
| ***LINCOSAMIDES***** | | |
| *clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg* | Covered | |
| *clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml* | Covered | |
| ***MONOBACTAMS***** | | |
| **CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG** | Covered | PA; QL (84 ML per 56 days); SP |
| ***OXAZOLIDINONES***** | | |
| Linezolid in Sodium Chloride Intravenous Solution 600-0.9 MG/300ML-% | MB | PA |

| Drug Name | Tier | Notes |
|---|---|---|
| Linezolid Intravenous Solution 600 MG/300ML | MB | PA |
| *linezolid oral suspension reconstituted 100 mg/5ml* | Covered | PA |
| *linezolid oral tablet 600 mg* | Covered | PA |
| Zyvox Intravenous Solution 200 MG/100ML | MB | PA |
| ***URINARY ANTI-INFECTIVES***** | | |
| *methenamine hippurate oral tablet 1 gm* | Covered | |
| *methenamine mandelate oral tablet 0.5 gm, 1 gm* | Covered | |
| *nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg* | Covered | |
| *nitrofurantoin monohyd macro oral capsule 100 mg* | Covered | |
| *nitrofurantoin oral suspension 25 mg/5ml* | Covered | QL (560 ML per 7 days); AL (Max 12 Years) |
| ***ANTIMALARIALS*** | | |
| ***ANTIMALARIALS***** | | |
| *chloroquine phosphate oral tablet 250 mg, 500 mg* | Covered | |
| *hydroxychloroquine sulfate oral tablet 200 mg* | Covered | |
| *primaquine phosphate oral tablet 26.3 (15 base) mg* | Covered | |
| ***ANTIMYASTHENIC/CHOLINERGIC AGENTS*** | | |
| ***ANTIMYASTHENIC/CHOLINERGIC AGENTS***** | | |
| **FIRDAPSE ORAL TABLET 10 MG** | Covered | PA; LA; QL (240 EA per 30 days); SP |
| *pyridostigmine bromide oral solution 60 mg/5ml* | Covered | |
| *pyridostigmine bromide oral tablet 60 mg* | Covered | |
| ***ANTIMYCOBACTERIAL AGENTS*** | | |
| ***ANTIMYCOBACTERIAL AGENTS***** | | |
| *cycloserine oral capsule 250 mg* | Covered | |
| *ethambutol hcl oral tablet 100 mg, 400 mg* | Covered | |
| *isoniazid oral syrup 50 mg/5ml* | Covered | |
| *isoniazid oral tablet 100 mg, 300 mg* | Covered | |
| **PRIFTIN ORAL TABLET 150 MG** | Covered | |
| *pyrazinamide oral tablet 500 mg* | Covered | |
| *rifabutin oral capsule 150 mg* | Covered | |
| *rifampin oral capsule 150 mg, 300 mg* | Covered | |
| ***ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***ALKYLATING AGENTS***** | | |
| **MYLERAN ORAL TABLET 2 MG** | Covered | PA; SP |
| Zepzelca Intravenous Solution Reconstituted 4 MG | MB | PA |
| ***ANDROGEN BIOSYNTHESIS INHIBITORS***** | | |
| *abiraterone acetate oral tablet 250 mg* | Covered | QL (120 EA per 30 days) |
| ***ANTIADRENALS***** | | |
| **LYSODREN ORAL TABLET 500 MG** | Covered | |
| ***ANTIANDROGENS***** | | |
| *bicalutamide oral tablet 50 mg* | Covered | ST |
| **ERLEADA ORAL TABLET 240 MG** | Covered | PA; QL (1 EA per 1 day); SP |
| **ERLEADA ORAL TABLET 60 MG** | Covered | PA; QL (120 EA per 30 days) |
| **NUBEQA ORAL TABLET 300 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **XTANDI ORAL CAPSULE 40 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **XTANDI ORAL TABLET 40 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **XTANDI ORAL TABLET 80 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| ***ANTIESTROGENS***** | | |
| **FARESTON ORAL TABLET 60 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| *tamoxifen citrate oral tablet 10 mg, 20 mg* | Covered | |
| ***ANTIMETABOLITES***** | | |
| *capecitabine oral tablet 150 mg, 500 mg* | Covered | |
| *mercaptopurine oral tablet 50 mg* | Covered | |
| *methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml* | Covered | |
| *methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml* | Covered | |
| *methotrexate sodium injection solution reconstituted 1 gm* | Covered | |
| *methotrexate sodium oral tablet 2.5 mg* | Covered | |
| **TABLOID ORAL TABLET 40 MG** | Covered | PA; SP |
| **TREXALL ORAL TABLET 5 MG** | Covered | |
| Vidaza Injection Suspension Reconstituted 100 MG | MB | |
| **XATMEP ORAL SOLUTION 2.5 MG/ML** | Covered | PA |
| ***ANTINEOPLASTIC - ALK INHIBITORS***** | | |
| **ALECENSA ORAL CAPSULE 150 MG** | Covered | PA; LA; QL (240 EA per 30 days) |
| **ALUNBRIG ORAL TABLET 180 MG, 90 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **ALUNBRIG ORAL TABLET 30 MG** | Covered | PA; QL (60 EA per 30 days); SP |


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| Drug Name | Tier | Notes |
|---|---|---|
| **ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG** | Covered | PA; LA; QL (30 EA per 30 days) |
| **LORBRENA ORAL TABLET 100 MG** | Covered | PA; QL (30 EA per 30 Days); SP |
| **LORBRENA ORAL TABLET 25 MG** | Covered | PA; QL (90 EA per 30 days); SP |
| **XALKORI ORAL CAPSULE 200 MG, 250 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| ***ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES***** | | |
| Monjuvi Intravenous Solution Reconstituted 200 MG | MB | PA |
| ***ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES***** | | |
| Ruxience Intravenous Solution 100 MG/10ML, 500 MG/50ML | MB | PA |
| ***ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX***** | | |
| Mylotarg Intravenous Solution Reconstituted 4.5 MG | MB | PA |
| ***ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES***** | | |
| Darzalex Intravenous Solution 100 MG/5ML, 400 MG/20ML | MB | PA |
| ***ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX***** | | |
| Polivy Intravenous Solution Reconstituted 140 MG, 30 MG | MB | PA |
| ***ANTINEOPLASTIC - ANTI-HER2 AGENTS***** | | |
| Ogivri Intravenous Solution Reconstituted 150 MG, 420 MG | MB | |
| Trazimera Intravenous Solution Reconstituted 420 MG | MB | |
| **TUKYSA ORAL TABLET 150 MG, 50 MG** | Covered | PA; LA; QL (120 EA per 30 days) |
| ***ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES***** | | |
| Libtayo Intravenous Solution 350 MG/7ML | MB | PA |
| Opdivo Intravenous Solution 120 MG/12ML | MB | PA |
| ***ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES***** | | |
| Bavencio Intravenous Solution 200 MG/10ML | MB | PA |
| ***ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES***** | | |
| Empliciti Intravenous Solution Reconstituted 300 MG, 400 MG | MB | PA |

| Drug Name | Tier | Notes |
|---|---|---|
| ***ANTINEOPLASTIC - BCL-2 INHIBITORS***** | | |
| **VENCLEXTA ORAL TABLET 10 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| **VENCLEXTA ORAL TABLET 100 MG** | Covered | PA; LA; QL (120 EA per 30 days) |
| **VENCLEXTA ORAL TABLET 50 MG** | Covered | PA; LA; QL (30 EA per 30 days) |
| **VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG** | Covered | PA; LA; QL (1 PACK per 28 days) |
| ***ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS***** | | |
| **BOSULIF ORAL CAPSULE 100 MG** | Covered | PA; QL (3 EA per 1 day); SP |
| **BOSULIF ORAL TABLET 100 MG** | Covered | PA; QL (90 EA per 30 days); SP |
| **BOSULIF ORAL TABLET 400 MG, 500 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG** | Covered | PA; LA; QL (30 EA per 30 days) |
| *imatinib mesylate oral tablet 100 mg, 400 mg* | Covered | PA; QL (60 EA per 30 days); SP |
| **SPRYCEL ORAL TABLET 100 MG, 20 MG, 50 MG, 70 MG, 80 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **SPRYCEL ORAL TABLET 140 MG** | Covered | PA; QL (30 EA per 30 days) |
| **TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| ***ANTINEOPLASTIC - BRAF KINASE INHIBITORS***** | | |
| **BRAFTOVI ORAL CAPSULE 75 MG** | Covered | PA; QL (180 EA per 30 days); SP |
| **TAFINLAR ORAL CAPSULE 50 MG, 75 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **ZELBORAF ORAL TABLET 240 MG** | Covered | PA; QL (240 EA per 30 days); SP |
| ***ANTINEOPLASTIC - BTK INHIBITORS***** | | |
| **BRUKINSA ORAL CAPSULE 80 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **CALQUENCE ORAL TABLET 100 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| **IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG** | Covered | PA; LA; QL (28 EA per 28 days) |
| **JAYPIRCA ORAL TABLET 100 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| **JAYPIRCA ORAL TABLET 50 MG** | Covered | 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* | Covered | PA; QL (60 EA per 30 days); SP |
| *gefitinib oral tablet 250 mg* | Covered | PA; LA; QL (30 EA per 30 days) |
| **GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG** | Covered | PA; LA |
| **TAGRISSO ORAL TABLET 40 MG, 80 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG** | Covered | PA; QL (30 EA per 30 Days); SP |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***ANTINEOPLASTIC - FGFR KINASE INHIBITORS***** | | |
| **BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG** | Covered | PA; SP |
| **PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG** | Covered | PA; LA; QL (14 EA per 21 days) |
| ***ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS***** | | |
| **DAURISMO ORAL TABLET 100 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **DAURISMO ORAL TABLET 25 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| **ERIVEDGE ORAL CAPSULE 150 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **ODOMZO ORAL CAPSULE 200 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| ***ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS***** | | |
| **ZOLINZA ORAL CAPSULE 100 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| ***ANTINEOPLASTIC - IMMUNOMODULATORS***** | | |
| **POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG** | Covered | PA; QL (21 EA per 28 days); SP |
| ***ANTINEOPLASTIC - KRAS INHIBITORS***** | | |
| **LUMAKRAS ORAL TABLET 120 MG** | Covered | PA; QL (240 EA per 30 days); SP |
| **LUMAKRAS ORAL TABLET 320 MG** | Covered | PA; QL (3 EA per 1 day); SP |
| ***ANTINEOPLASTIC - MEK INHIBITORS***** | | |
| **MEKINIST ORAL TABLET 0.5 MG** | Covered | PA; QL (90 EA per 30 days); SP |
| **MEKINIST ORAL TABLET 2 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **MEKTOVI ORAL TABLET 15 MG** | Covered | PA; LA; QL (180 EA per 30 days) |
| ***ANTINEOPLASTIC - MET INHIBITORS***** | | |
| **TABRECTA ORAL TABLET 150 MG, 200 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| ***ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS***** | | |
| **TAZVERIK ORAL TABLET 200 MG** | Covered | PA; LA; QL (240 EA per 30 Days) |
| ***ANTINEOPLASTIC - MTOR KINASE INHIBITORS***** | | |
| *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg* | Covered | PA; SP |
| *everolimus oral tablet soluble 2 mg, 3 mg, 5 mg* | Covered | PA; SP |
| ***ANTINEOPLASTIC - MULTIKINASE INHIBITORS***** | | |
| **CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **CAPRELSA ORAL TABLET 100 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| **CAPRELSA ORAL TABLET 300 MG** | Covered | PA; LA; QL (30 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| **COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG** | Covered | PA; LA |
| *lapatinib ditosylate oral tablet 250 mg* | Covered | PA; QL (180 EA per 30 days); SP |
| **NERLYNX ORAL TABLET 40 MG** | Covered | PA; LA; QL (180 EA per 30 days) |
| *pazopanib hcl oral tablet 200 mg* | Covered | PA; QL (120 EA per 30 days); SP |
| **QINLOCK ORAL TABLET 50 MG** | Covered | PA; LA; QL (90 EA per 30 days) |
| **RYDAPT ORAL CAPSULE 25 MG** | Covered | PA; Quantity limit for acute myeloid leukemia (AML) is 120 capsules per 30; Quantity limit for aggressive systemic mastocytosis (ASM),systemic mastocytosis w/assosicated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL) is 240 capsules per 30; QL (120 EA per 30 days) |
| *sorafenib tosylate oral tablet 200 mg* | Covered | PA; QL (120 EA per 30 days); SP |
| **STIVARGA ORAL TABLET 40 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| *sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg* | Covered | PA; SP |
| **XOSPATA ORAL TABLET 40 MG** | Covered | PA; LA; QL (90 EA per 30 Days) |
| ***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** | Covered | PA; QL (30 Tablets per 30 Days); SP |
| **AYVAKIT ORAL TABLET 25 MG, 50 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| ***ANTINEOPLASTIC - PROTEASOME INHIBITORS***** | | |
| Bortezomib Injection Solution Reconstituted 3.5 MG | MB | |
| ***ANTINEOPLASTIC - RET INHIBITORS***** | | |
| **RETEVMO ORAL CAPSULE 40 MG** | Covered | PA; QL (180 EA per 30 days); SP |
| **RETEVMO ORAL CAPSULE 80 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| ***ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS***** | | |
| **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG** | Covered | PA; SP |
| ***ANTINEOPLASTIC - XPO1 INHIBITORS***** | | |
| **XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG** | Covered | PA; LA; QL (8 EA per 28 days) |
| **XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG** | Covered | PA; LA; QL (4 EA per 28 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| **XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG** | Covered | PA; LA; QL (8 EA per 28 days) |
| **XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG** | Covered | PA; LA; QL (4 EA per 28 days) |
| **XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG** | Covered | PA; LA; QL (4 Packs per 28 days) |
| **XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG** | Covered | PA; LA; QL (8 EA per 28 days) |
| **XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG** | Covered | PA; LA; QL (4 Packs per 28 days) |
| ***ANTINEOPLASTIC COMBINATIONS***** | | |
| Darzalex Faspro Subcutaneous Solution 1800-30000 MG-UT/15ML | MB | PA |
| **INQOVI ORAL TABLET 35-100 MG** | Covered | PA; QL (5 EA per 28 days); SP |
| **KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG** | Covered | PA; LA; QL (49 EA per 28 days) |
| **KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG** | Covered | PA; LA; QL (70 EA per 28 days) |
| **KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG** | Covered | PA; LA; QL (91 EA per 28 days) |
| **LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG** | Covered | PA; LA; QL (40 EA per 28 days) |
| Vyxeos Intravenous Suspension Reconstituted 44-100 MG | MB | PA |
| ***ANTINEOPLASTIC ENZYMES***** | | |
| Oncaspar Injection Solution 750 UNIT/ML | MB | PA |
| ***ANTINEOPLASTICS MISC.***** | | |
| **ALFERON N INJECTION SOLUTION 5000000 UNIT/ML** | Covered | |
| *hydroxyurea oral capsule 500 mg* | Covered | |
| **MATULANE ORAL CAPSULE 50 MG** | Covered | PA; SP |
| ***AROMATASE INHIBITORS***** | | |
| *anastrozole oral tablet 1 mg* | Covered | |
| *exemestane oral tablet 25 mg* | Covered | |
| *letrozole oral tablet 2.5 mg* | Covered | |
| ***CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS***** | | |
| **IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG** | Covered | PA; QL (21 EA per 28 days); SP |
| **KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG** | Covered | PA; LA; QL (21 EA per 28 Days) |
| **KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG** | Covered | PA; LA; QL (42 EA per 28 Days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| **KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG** | Covered | PA; LA; QL (63 EA per 28 Days) |
| **VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| ***ESTROGENS-ANTINEOPLASTIC***** | | |
| **EMCYT ORAL CAPSULE 140 MG** | Covered | PA; SP |
| ***FOLIC ACID ANTAGONISTS RESCUE AGENTS***** | | |
| *leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg* | Covered | |
| ***IMIDAZOTETRAZINES***** | | |
| *temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg* | Covered | PA; SP |
| ***ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS***** | | |
| **TIBSOVO ORAL TABLET 250 MG** | Covered | PA; LA; QL (60 EA per 30 Days) |
| ***JANUS ASSOCIATED KINASE (JAK) INHIBITORS***** | | |
| **JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| ***LHRH ANALOGS***** | | |
| Leuprolide Acetate Injection Kit 1 MG/0.2ML | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| Lupron Depot (1-Month) Intramuscular Kit 3.75 MG, 7.5 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| Lupron Depot (3-Month) Intramuscular Kit 11.25 MG, 22.5 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| Lupron Depot (4-Month) Intramuscular Kit 30 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| Lupron Depot (6-Month) Intramuscular Kit 45 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| Trelstar Mixject Intramuscular Suspension Reconstituted 11.25 MG, 22.5 MG, 3.75 MG | MB | PA |
| ***MITOTIC INHIBITORS***** | | |
| *etoposide oral capsule 50 mg* | Covered | |
| ***NITROGEN MUSTARDS AND RELATED ANALOGUES***** | | |
| *cyclophosphamide oral capsule 25 mg, 50 mg* | Covered | |
| Evomela Intravenous Solution Reconstituted 50 MG | MB | PA |
| **LEUKERAN ORAL TABLET 2 MG** | Covered | PA; SP |


Such services are funded in part with the State of New Mexico.

| Drug Name | Tier | Notes |
|---|---|---|
| *melphalan oral tablet 2 mg* | Covered | |
| ***NITROSOUREAS***** | | |
| Carmustine Intravenous Solution Reconstituted 300 MG, 50 MG | MB | |
| ***PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS***** | | |
| **COPIKTRA ORAL CAPSULE 15 MG, 25 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| **PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG** | Covered | PA; QL (60 EA per 30 Days); SP |
| **PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG** | Covered | PA; QL (60 EA per 30 Days) |
| **PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG** | Covered | PA; QL (60 EA per 30 Days); SP |
| **ZYDELIG ORAL TABLET 100 MG, 150 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| ***POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS***** | | |
| **LYNPARZA ORAL TABLET 100 MG, 150 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **TALZENNA ORAL CAPSULE 1 MG** | Covered | PA; QL (30 EA per 30 Days); SP |
| **ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| ***PROGESTINS-ANTINEOPLASTIC***** | | |
| *megestrol acetate oral suspension 40 mg/ml* | Covered | |
| *megestrol acetate oral tablet 20 mg, 40 mg* | Covered | |
| ***SELECTIVE ESTROGEN RECEPTOR DEGRADERS***** | | |
| **ORSERDU ORAL TABLET 345 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **ORSERDU ORAL TABLET 86 MG** | Covered | PA; QL (90 EA per 30 days); SP |
| ***SELECTIVE RETINOID X RECEPTOR AGONISTS***** | | |
| *bexarotene oral capsule 75 mg* | Covered | PA; SP |
| ***TOPOISOMERASE I INHIBITORS***** | | |
| **HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG** | Covered | PA; SP |
| ***VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS***** | | |
| **INLYTA ORAL TABLET 1 MG, 5 MG** | Covered | PA; QL (4 EA per 1 day); SP |


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| Drug Name | Tier | Notes |
|---|---|---|
| **LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG** | Covered | PA; LA; QL (30 EA per 30 days) |
| **LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG** | Covered | PA; LA; QL (90 EA per 30 days) |
| **LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| **LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG** | Covered | PA; LA; QL (90 EA per 30 days) |
| **LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| **LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG** | Covered | PA; LA; QL (90 EA per 30 days) |
| **LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG** | Covered | PA; LA; QL (30 EA per 30 days) |
| **LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG** | Covered | PA; LA; QL (60 EA per 30 days) |
| ***ANTIPARKINSON AND RELATED THERAPY AGENTS*** | | |
| ***ANTIPARKINSON ANTICHOLINERGICS***** | | |
| *benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg* | Covered | |
| *trihexyphenidyl hcl oral tablet 2 mg, 5 mg* | Covered | |
| ***ANTIPARKINSON DOPAMINERGICS***** | | |
| *amantadine hcl oral capsule 100 mg* | Covered | |
| *amantadine hcl oral tablet 100 mg* | Covered | |
| *bromocriptine mesylate oral capsule 5 mg* | Covered | |
| *bromocriptine mesylate oral tablet 2.5 mg* | Covered | |
| ***ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS***** | | |
| *selegiline hcl oral capsule 5 mg* | Covered | |
| *selegiline hcl oral tablet 5 mg* | Covered | |
| ***LEVODOPA COMBINATIONS***** | | |
| *carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg* | Covered | |
| *carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg* | Covered | |
| *carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg* | Covered | |
| ***NONERGOLINE DOPAMINE RECEPTOR AGONISTS***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg* | Covered | |
| *ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg* | Covered | |
| ***PERIPHERAL COMT INHIBITORS***** | | |
| *entacapone oral tablet 200 mg* | Covered | |
| **ONGENTYS ORAL CAPSULE 50 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| ***ANTIPSYCHOTICS/ANTIMANIC AGENTS*** | | |
| ***ANTIMANIC AGENTS***** | | |
| *lithium carbonate er oral tablet extended release 300 mg, 450 mg* | Covered | |
| *lithium carbonate oral capsule 150 mg, 300 mg, 600 mg* | Covered | |
| *lithium carbonate oral tablet 300 mg* | Covered | |
| *lithium oral solution 8 meq/5ml* | Covered | |
| ***ANTIPSYCHOTICS - MISC.***** | | |
| **CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG** | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| *lurasidone hcl oral tablet 120 mg* | Covered | QL (30 EA per 30 days); AL (Min 13 Years) |
| *lurasidone hcl oral tablet 20 mg, 40 mg, 60 mg* | Covered | QL (30 EA per 30 days); AL (Min 10 Years) |
| *lurasidone hcl oral tablet 80 mg* | Covered | QL (60 EA per 30 days); AL (Min 10 Years) |
| **VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG** | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| **VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG** | Covered | PA; QL (1 BOX per 365 days); AL (Min 18 Years) |
| *ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| ***BENZISOXAZOLES***** | | |
| **FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG** | Covered | PA; QL (60 EA per 30 Days); AL (Min 18 Years) |
| **FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG** | Covered | PA; QL (1 Pack per 365 days); AL (Min 18 Years) |
| **INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML** | Covered | QL (0.75 ML per 28 Days); AL (Min 18 Years); SP |
| **INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML** | Covered | QL (1 ML per 28 Days); AL (Min 18 Years); SP |
| **INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML** | Covered | QL (1.5 ML per 28 Days); AL (Min 18 Years); SP |


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| Drug Name | Tier | Notes |
|---|---|---|
| **INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML** | Covered | QL (0.25 ML per 28 Days); AL (Min 18 Years); SP |
| **INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML** | Covered | QL (0.5 ML per 28 Days); AL (Min 18 Years); SP |
| **INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML** | Covered | QL (0.88 ML per 84 days); AL (Min 18 Years); SP |
| **INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML** | Covered | QL (1.32 ML per 84 days); AL (Min 18 Years); SP |
| **INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML** | Covered | QL (1.75 ML per 84 Days); AL (Min 18 Years); SP |
| **INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML** | Covered | QL (2.63 ML per 84 days); AL (Min 18 Years); SP |
| *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg* | Covered | PA; QL (30 EA per 30 Days); AL (Min 18 Years) |
| *paliperidone er oral tablet extended release 24 hour 6 mg* | Covered | PA; QL (60 EA per 30 Days); AL (Min 18 Years) |
| **PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG** | Covered | PA; QL (1 EA per 28 days); AL (Min 18 Years) |
| *risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg* | Covered | QL (2 vials per 28 days); AL (Min 18 Years); SP |
| *risperidone oral solution 1 mg/ml* | Covered | PA required for patients younger than 5 years of age; QL (480 ML per 30 days); AL (Min 5 Years) |
| *risperidone oral tablet 0.25 mg* | Covered | PA required for patients younger than 5 years of age; QL (90 EA per 30 days); AL (Min 5 Years) |
| *risperidone oral tablet 0.5 mg, 1 mg, 2 mg, 3 mg* | Covered | PA required for patients younger than 5 years of age; QL (60 EA per 30 days); AL (Min 5 Years) |
| *risperidone oral tablet 4 mg* | Covered | PA required for patients younger than 5 years of age; QL (120 EA per 30 days); AL (Min 5 Years) |
| *risperidone oral tablet dispersible 0.25 mg* | Covered | PA; PA required for patients younger than 5 years of age; QL (90 EA per 30 days); AL (Min 5 Years) |
| *risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg* | Covered | PA; PA required for patients younger than 5 years of age; QL (60 EA per 30 days); AL (Min 5 Years) |
| *risperidone oral tablet dispersible 4 mg* | Covered | PA; PA required for patients younger than 5 years of age; QL (120 EA per 30 days); AL (Min 5 Years) |
| ***BUTYROPHENONES***** | | |
| *haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml* | Covered | AL (Min 18 Years) |

| Drug Name | Tier | Notes |
|---|---|---|
| *haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg* | Covered | |
| ***DIBENZODIAZEPINES***** | | |
| *clozapine oral tablet 100 mg* | Covered | QL (270 EA per 30 days); AL (Min 6 Years) |
| *clozapine oral tablet 200 mg* | Covered | QL (135 EA per 30 days); AL (Min 6 Years) |
| *clozapine oral tablet 25 mg, 50 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| *clozapine oral tablet dispersible 100 mg* | Covered | PA; QL (270 EA per 30 days); AL (Min 6 Years) |
| *clozapine oral tablet dispersible 12.5 mg* | Covered | PA; QL (60 EA per 30 days); AL (Min 6 Years) |
| *clozapine oral tablet dispersible 25 mg* | Covered | PA; QL (180 EA per 30 days); AL (Min 6 Years) |
| ***DIBENZO-OXEPINO PYRROLES***** | | |
| *asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg* | Covered | PA; QL (60 EA per 30 days); AL (Min 10 Years) |
| **SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR** | Covered | 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* | Covered | QL (30 EA per 30 days) |
| *quetiapine fumarate er oral tablet extended release 24 hour 400 mg* | Covered | QL (60 EA per 30 days) |
| *quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 400 mg, 50 mg* | Covered | QL (90 EA per 30 days); AL (Min 6 Years) |
| *quetiapine fumarate oral tablet 300 mg* | Covered | QL (60 EA per 30 days); AL (Min 6 Years) |
| ***DIBENZOXAZEPINES***** | | |
| *loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg* | Covered | |
| ***PHENOTHIAZINES***** | | |
| *chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg* | Covered | |
| **COMPRO RECTAL SUPPOSITORY 25 MG** | Covered | |
| *fluphenazine decanoate injection solution 25 mg/ml* | Covered | |
| *fluphenazine hcl oral concentrate 5 mg/ml* | Covered | |
| *fluphenazine hcl oral elixir 2.5 mg/5ml* | Covered | |
| *fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg* | Covered | |
| *perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| *prochlorperazine maleate oral tablet 10 mg, 5 mg* | Covered | |
| *prochlorperazine rectal suppository 25 mg* | Covered | |
| *thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg* | Covered | |
| *trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg* | Covered | |
| ***QUINOLINONE DERIVATIVES***** | | |
| **ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG** | Covered | PA; QL (1 EA per 28 days); AL (Min 18 Years); SP |
| **ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG** | Covered | PA; QL (1 EA per 28 days); AL (Min 18 Years); SP |
| *aripiprazole oral solution 1 mg/ml* | Covered | 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* | Covered | QL (30 EA per 30 days); AL (Min 6 Years) |
| *aripiprazole oral tablet dispersible 10 mg, 15 mg* | Covered | PA; QL (30 EA per 30 days); AL (Min 6 Years) |
| **ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML** | Covered | QL (2.4 ML per 30 days); AL (Min 18 Years); SP |
| **ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML** | Covered | QL (3.9 ML per 56 days); AL (Min 18 Years); SP |
| **ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML** | Covered | QL (1.6 ML per 28 days); AL (Min 18 Years); SP |
| **ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML** | Covered | QL (2.4 ML per 28 days); AL (Min 18 Years); SP |
| **ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML** | Covered | QL (3.2 ML per 28 days); AL (Min 18 Years); SP |
| **REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG** | Covered | PA; QL (30 EA per 30 days); AL (Min 13 Years) |
| ***THIENBENZODIAZEPINES***** | | |
| *olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg* | Covered | PA required for patients younger than 6 years of age.; QL (30 EA per 30 days); AL (Min 6 Years) |
| *olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg* | Covered | QL (30 EA per 30 days); AL (Min 6 Years) |
| **ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG** | Covered | PA; QL (2 EA per 28 days); AL (Min 18 Years); SP |
| **ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG** | Covered | PA; QL (1 EA per 28 days); AL (Min 18 Years); SP |
| ***THIOXANTHENES***** | | |
| *thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg* | Covered | |
| ***ANTISEPTICS & DISINFECTANTS*** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***CHLORINE ANTISEPTICS***** | | |
| *antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **BETASEPT SURGICAL SCRUB EXTERNAL SOLUTION 4 %** | Covered | |
| **BIOPATCH EXTERNAL** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **BIOPATCH PROTECTIVE DISK/CHG EXTERNAL (DRESSING)** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *chlorhexidine gluconate external solution 2 %, 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs hand wash advanced antibac external solution 2 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **DYNA-HEX 2 EXTERNAL SOLUTION 2 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **DYNA-HEX 4 EXTERNAL SOLUTION 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ft antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp antibacterial hand soap external solution 2 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *qc antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sm antiseptic skin cleanser external solution 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***ANTIVIRALS*** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***ANTIRETROVIRAL COMBINATIONS***** | | |
| *abacavir sulfate-lamivudine oral tablet 600-300 mg* | Covered | QL (30 EA per 30 days) |
| **BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG** | Covered | 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** | Covered | QL (30 EA per 30 Days) |
| **COMPLERA ORAL TABLET 200-25-300 MG** | Covered | QL (30 EA per 30 days) |
| **DELSTRIGO ORAL TABLET 100-300-300 MG** | Covered | QL (30 EA per 30 days) |
| **DESCOVY ORAL TABLET 120-15 MG, 200-25 MG** | Covered | PA for New Starts; QL (30 EA per 30 days) |
| **DOVATO ORAL TABLET 50-300 MG** | Covered | QL (30 EA per 30 days) |
| *efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg* | Covered | QL (30 EA per 30 days) |
| *emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg* | Covered | QL (30 EA per 30 days) |
| **EVOTAZ ORAL TABLET 300-150 MG** | Covered | QL (30 EA per 30 days) |
| **GENVOYA ORAL TABLET 150-150-200-10 MG** | Covered | QL (30 EA per 30 days) |
| **JULUCA ORAL TABLET 50-25 MG** | Covered | QL (30 EA per 30 days) |
| *lamivudine-zidovudine oral tablet 150-300 mg* | Covered | QL (60 EA per 30 days) |
| *lopinavir-ritonavir oral solution 400-100 mg/5ml* | Covered | QL (300 ML per 30 days) |
| *lopinavir-ritonavir oral tablet 100-25 mg* | Covered | QL (60 EA per 30 days) |
| *lopinavir-ritonavir oral tablet 200-50 mg* | Covered | QL (120 EA per 30 days) |
| *lopinavir-ritonavir tablet 100-25 mg oral* | Covered | QL (60 EA per 30 days) |
| *lopinavir-ritonavir tablet 200-50 mg oral* | Covered | QL (120 EA per 30 days) |
| **ODEFSEY ORAL TABLET 200-25-25 MG** | Covered | QL (30 EA per 30 days) |
| **PREZCOBIX ORAL TABLET 800-150 MG** | Covered | QL (30 EA per 30 days) |
| **STRIBILD ORAL TABLET 150-150-200-300 MG** | Covered | QL (30 EA per 30 days) |
| **SYMTUZA ORAL TABLET 800-150-200-10 MG** | Covered | QL (30 EA per 30 Days) |
| **TRIUMEQ ORAL TABLET 600-50-300 MG** | Covered | QL (30 EA per 30 days) |
| **TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG** | Covered | QL (180 EA per 30 days) |
| ***ANTIRETROVIRALS - CAPSID INHIBITORS***** | | |
| **SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG** | Covered | PA |
| Sunlenca Subcutaneous Solution 463.5 MG/1.5ML | MB | PA |
| ***ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)***** | | |
| *maraviroc oral tablet 150 mg, 300 mg* | Covered | QL (120 EA per 30 days) |

| Drug Name | Tier | Notes |
|---|---|---|
| **SELZENTRY ORAL SOLUTION 20 MG/ML** | Covered | QL (900 ML per 30 days) |
| ***ANTIRETROVIRALS - FUSION INHIBITORS***** | | |
| **FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG** | Covered | QL (60 EA per 30 days) |
| ***ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR***** | | |
| **RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG** | Covered | QL (60 EA per 30 days) |
| ***ANTIRETROVIRALS - INTEGRASE INHIBITORS***** | | |
| Apretude Intramuscular Suspension Extended Release 600 MG/3ML | MB | |
| **ISENTRESS HD ORAL TABLET 600 MG** | Covered | QL (60 EA per 30 days) |
| **ISENTRESS ORAL PACKET 100 MG** | Covered | QL (60 EA per 30 days) |
| **ISENTRESS ORAL TABLET 400 MG** | Covered | QL (60 EA per 30 days) |
| **ISENTRESS ORAL TABLET CHEWABLE 100 MG** | Covered | QL (60 EA per 30 days) |
| **ISENTRESS ORAL TABLET CHEWABLE 25 MG** | Covered | QL (120 EA per 30 days) |
| **TIVICAY ORAL TABLET 50 MG** | Covered | QL (30 EA per 30 days) |
| **TIVICAY PD ORAL TABLET SOLUBLE 5 MG** | Covered | PA; QL (180 EA per 30 Days); AL (Max 12 Years) |
| ***ANTIRETROVIRALS - PROTEASE INHIBITORS***** | | |
| **APTIVUS ORAL CAPSULE 250 MG** | Covered | QL (120 EA per 30 days) |
| *atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg* | Covered | QL (60 EA per 30 days) |
| *darunavir oral tablet 600 mg* | Covered | QL (60 EA per 30 days) |
| *darunavir oral tablet 800 mg* | Covered | QL (30 EA per 30 days) |
| *fosamprenavir calcium oral tablet 700 mg* | Covered | QL (120 EA per 30 days) |
| **PREZISTA ORAL SUSPENSION 100 MG/ML** | Covered | QL (360 ML per 30 days) |
| **PREZISTA ORAL TABLET 150 MG, 75 MG** | Covered | QL (60 EA per 30 days) |
| **REYATAZ ORAL PACKET 50 MG** | Covered | QL (150 EA per 30 days); AL (Max 8 Years) |
| *ritonavir oral tablet 100 mg* | Covered | QL (360 EA per 30 days) |
| **VIRACEPT ORAL TABLET 250 MG, 625 MG** | Covered | QL (120 EA per 30 days) |
| ***ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES***** | | |
| **EDURANT ORAL TABLET 25 MG** | Covered | |
| *efavirenz oral capsule 200 mg, 50 mg* | Covered | QL (30 EA per 30 days) |
| *efavirenz oral tablet 600 mg* | Covered | QL (30 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *etravirine oral tablet 100 mg, 200 mg* | Covered | QL (60 EA per 30 days) |
| *nevirapine er oral tablet extended release 24 hour 400 mg* | Covered | QL (30 EA per 30 days) |
| *nevirapine oral tablet 200 mg* | Covered | QL (30 EA per 30 days) |
| **PIFELTRO ORAL TABLET 100 MG** | Covered | QL (30 EA per 30 days) |
| ***ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES***** | | |
| *abacavir sulfate oral solution 20 mg/ml* | Covered | QL (900 ML per 30 days) |
| *abacavir sulfate oral tablet 300 mg* | Covered | QL (60 EA per 30 days) |
| ***ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES***** | | |
| *emtricitabine oral capsule 200 mg* | Covered | QL (30 EA per 30 days) |
| **EMTRIVA ORAL SOLUTION 10 MG/ML** | Covered | QL (720 ML per 30 days) |
| *lamivudine oral solution 10 mg/ml* | Covered | |
| *lamivudine oral tablet 150 mg* | Covered | QL (60 EA per 30 days) |
| *lamivudine oral tablet 300 mg* | Covered | QL (30 EA per 30 days) |
| ***ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES***** | | |
| *zidovudine oral capsule 100 mg* | Covered | QL (60 EA per 30 days) |
| *zidovudine oral syrup 50 mg/5ml* | Covered | |
| *zidovudine oral tablet 300 mg* | Covered | QL (60 EA per 30 days) |
| ***ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES***** | | |
| *tenofovir disoproxil fumarate oral tablet 300 mg* | Covered | QL (30 EA per 30 days) |
| **VIREAD ORAL POWDER 40 MG/GM** | Covered | QL (225 GM per 30 days) |
| **VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG** | Covered | QL (30 EA per 30 days) |
| ***ANTIRETROVIRALS ADJUVANTS***** | | |
| **TYBOST ORAL TABLET 150 MG** | Covered | QL (30 EA per 30 days) |
| ***ANTIVIRAL COMBINATIONS***** | | |
| **PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG** | Covered | QL (40 EA per 365 days) |
| **PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG** | Covered | QL (60 EA per 365 days) |
| ***CMV AGENTS***** | | |
| *valganciclovir hcl oral solution reconstituted 50 mg/ml* | Covered | PA; QL (900 ML per 30 days) |
| *valganciclovir hcl oral tablet 450 mg* | Covered | PA; QL (60 EA per 30 days) |
| ***HEPATITIS B AGENTS***** | | |
| *entecavir oral tablet 0.5 mg, 1 mg* | Covered | PA; QL (30 EA per 30 days); SP |


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| Drug Name | Tier | Notes |
|---|---|---|
| *lamivudine oral tablet 100 mg* | Covered | |
| **VEMLIDY ORAL TABLET 25 MG** | Covered | QL (30 EA per 30 days); SP |
| ***HEPATITIS C AGENT - COMBINATIONS***** | | |
| **MAVYRET ORAL PACKET 50-20 MG** | Covered | QL (150 EA per 30 days); SP |
| **MAVYRET ORAL TABLET 100-40 MG** | Covered | QL (3 EA per 1 day); SP |
| *sofosbuvir-velpatasvir oral tablet 400-100 mg* | Covered | QL (1 EA per 1 day); SP |
| ***HEPATITIS C AGENTS***** | | |
| **PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML** | Covered | PA; SP |
| *ribavirin oral tablet 200 mg* | Covered | PA; SP |
| ***HERPES AGENTS - PURINE ANALOGUES***** | | |
| *acyclovir oral capsule 200 mg* | Covered | |
| *acyclovir oral suspension 200 mg/5ml* | Covered | |
| *acyclovir oral tablet 400 mg, 800 mg* | Covered | |
| *valacyclovir hcl oral tablet 1 gm, 500 mg* | Covered | |
| ***HERPES AGENTS - THYMIDINE ANALOGUES***** | | |
| *famciclovir oral tablet 125 mg, 250 mg, 500 mg* | Covered | ST |
| ***INFLUENZA AGENTS***** | | |
| *rimantadine hcl oral tablet 100 mg* | Covered | |
| ***MISC. ANTIVIRALS***** | | |
| **LAGEVRIO ORAL CAPSULE 200 MG** | Covered | QL (80 EA per 365 days) |
| Veklury Intravenous Solution Reconstituted 100 MG | MB | |
| ***NEURAMINIDASE INHIBITORS***** | | |
| *oseltamivir phosphate oral capsule 30 mg* | Covered | QL (20 EA per 180 days) |
| *oseltamivir phosphate oral capsule 45 mg, 75 mg* | Covered | QL (10 EA per 180 days) |
| *oseltamivir phosphate oral suspension reconstituted 6 mg/ml* | Covered | QL (180 ML per 180 days) |
| **RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT** | Covered | QL (20 EA per 180 days) |
| ***BETA BLOCKERS*** | | |
| ***ALPHA-BETA BLOCKERS***** | | |
| *carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg* | Covered | |
| *labetalol hcl oral tablet 100 mg, 200 mg, 300 mg* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***BETA BLOCKERS CARDIO-SELECTIVE***** | | |
| *acebutolol hcl oral capsule 200 mg, 400 mg* | Covered | |
| *atenolol oral tablet 100 mg, 25 mg, 50 mg* | Covered | |
| *betaxolol hcl oral tablet 10 mg, 20 mg* | Covered | |
| *bisoprolol fumarate oral tablet 10 mg, 5 mg* | Covered | |
| *metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg* | Covered | |
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | Covered | |
| ***BETA BLOCKERS NON-SELECTIVE***** | | |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | Covered | |
| *pindolol oral tablet 10 mg, 5 mg* | Covered | |
| *propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg* | Covered | |
| *propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml* | Covered | |
| *propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg* | Covered | |
| *sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg* | Covered | |
| *sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg* | Covered | |
| *timolol maleate oral tablet 10 mg, 20 mg, 5 mg* | Covered | |
| ***CALCIUM CHANNEL BLOCKERS*** | | |
| ***CALCIUM CHANNEL BLOCKERS***** | | |
| *amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg* | Covered | |
| **CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG** | Covered | |
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg* | Covered | |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | Covered | |
| *diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg* | Covered | |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg* | Covered | |
| *diltiazem hcl intravenous solution 50 mg/10ml* | Covered | |
| *diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg* | Covered | |
| *felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| **KATERZIA ORAL SUSPENSION 1 MG/ML** | Covered | AL (Max 12 Years) |
| niCARdipine HCl in NaCl Intravenous Solution 20-0.9 MG/200ML-%, 40-0.9 MG/200ML-% | MB | |
| *nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | Covered | |
| *nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg* | Covered | |
| *nifedipine oral capsule 10 mg, 20 mg* | Covered | |
| *nimodipine oral capsule 30 mg* | Covered | |
| *nisoldipine er oral tablet extended release 24 hour 20 mg, 30 mg, 40 mg* | Covered | |
| **TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG** | Covered | |
| **TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG** | Covered | |
| *verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 200 mg, 240 mg, 300 mg* | Covered | |
| *verapamil hcl er oral capsule extended release 24 hour 180 mg* | Covered | QL (60 EA per 30 days) |
| *verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg* | Covered | |
| *verapamil hcl oral tablet 120 mg, 40 mg, 80 mg* | Covered | |
| ***CARDIOTONICS*** | | |
| ***CARDIAC GLYCOSIDES***** | | |
| *digoxin oral solution 0.05 mg/ml* | Covered | |
| *digoxin oral tablet 125 mcg, 250 mcg* | Covered | |
| ***CARDIOVASCULAR AGENTS - MISC.*** | | |
| ***NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB***** | | |
| **ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG** | Covered | PA; QL (60 EA per 30 days) |
| ***PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS***** | | |
| *ambrisentan oral tablet 10 mg, 5 mg* | Covered | PA; QL (30 EA per 30 days); SP |
| ***PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS***** | | |
| *sildenafil citrate oral tablet 20 mg* | Covered | PA; QL (90 EA per 30 days) |
| ***CEPHALOSPORINS*** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***CEPHALOSPORIN COMBINATIONS***** | | |
| Avycaz Intravenous Solution Reconstituted 2.5 (2-0.5) GM | MB | |
| ***CEPHALOSPORINS - 1ST GENERATION***** | | |
| *cephalexin oral capsule 250 mg, 500 mg* | Covered | |
| *cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | Covered | |
| ***CEPHALOSPORINS - 2ND GENERATION***** | | |
| *cefaclor oral capsule 250 mg, 500 mg* | Covered | |
| *cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | Covered | |
| *cefprozil oral tablet 250 mg, 500 mg* | Covered | |
| *cefuroxime axetil oral tablet 250 mg, 500 mg* | Covered | |
| ***CEPHALOSPORINS - 3RD GENERATION***** | | |
| *cefdinir oral capsule 300 mg* | Covered | |
| *cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | Covered | |
| *cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml* | Covered | |
| *cefpodoxime proxetil oral tablet 100 mg, 200 mg* | Covered | |
| ***CONTRACEPTIVES*** | | |
| ***BIPHASIC CONTRACEPTIVES - ORAL***** | | |
| **AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)** | Covered | |
| *desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)* | Covered | |
| **KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)** | Covered | |
| **PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)** | Covered | |
| **SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)** | Covered | |
| *viorele oral tablet 0.15-0.02/0.01 mg (21/5)* | Covered | |
| **VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)** | Covered | |
| ***COMBINATION CONTRACEPTIVES - ORAL***** | | |
| **AFIRMELLE ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| **ALTAVERA ORAL TABLET 0.15-30 MG-MCG** | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *alyacen 1/35 oral tablet 1-35 mg-mcg* | Covered | |
| **APRI ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)** | Covered | |
| **AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **AVIANE ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| **AYUNA ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **BALZIVA ORAL TABLET 0.4-35 MG-MCG** | Covered | |
| **BLISOVI 24 FE ORAL TABLET 1-20 MG-MCG(24)** | Covered | |
| **BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| *briellyn oral tablet 0.4-35 mg-mcg* | Covered | |
| **CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG** | Covered | |
| **DASETTA 1/35 ORAL TABLET 1-35 MG-MCG** | Covered | |
| **DELYLA ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| *desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg* | Covered | |
| *drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg* | Covered | |
| **ELINEST ORAL TABLET 0.3-30 MG-MCG** | Covered | |
| **ENSKYCE ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **ESTARYLLA ORAL TABLET 0.25-35 MG-MCG** | Covered | AL (Max 55 Years) |
| *ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg* | Covered | |
| **FALMINA ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| **HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)** | Covered | |
| **HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **JASMIEL ORAL TABLET 3-0.02 MG** | Covered | |
| **JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **JUNEL 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| **JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)** | Covered | |
| **KALLIGA ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **KELNOR 1/35 ORAL TABLET 1-35 MG-MCG** | Covered | |
| **KELNOR 1/50 ORAL TABLET 1-50 MG-MCG** | Covered | |
| **KURVELO ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **LARIN 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **LARIN 24 FE ORAL TABLET 1-20 MG-MCG(24)** | Covered | |
| **LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **LESSINA ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| *levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg* | Covered | |
| **LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG** | Covered | |
| **LOESTRIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **LORYNA ORAL TABLET 3-0.02 MG** | Covered | |
| **LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG** | Covered | |
| **LO-ZUMANDIMINE ORAL TABLET 3-0.02 MG** | Covered | |
| **LUTERA ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| *marlissa oral tablet 0.15-30 mg-mcg* | Covered | |
| **MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG** | Covered | |
| **MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG** | Covered | |
| **MONO-LINYAH ORAL TABLET 0.25-35 MG-MCG** | Covered | AL (Max 55 Years) |
| **NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG** | Covered | |
| **NIKKI ORAL TABLET 3-0.02 MG** | Covered | |
| *norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| *norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg* | Covered | |
| *norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg* | Covered | |
| *norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg* | Covered | AL (Max 55 Years) |
| **NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG** | Covered | |
| **NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG** | Covered | |
| **NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG** | Covered | |
| **NYMYO ORAL TABLET 0.25-35 MG-MCG** | Covered | AL (Max 55 Years) |
| **OCELLA ORAL TABLET 3-0.03 MG** | Covered | |
| **ORSYTHIA ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| **PHILITH ORAL TABLET 0.4-35 MG-MCG** | Covered | |
| **PORTIA-28 ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **RECLIPSEN ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **SOLIA ORAL TABLET 0.15-30 MG-MCG** | Covered | |
| **SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG** | Covered | AL (Max 55 Years) |
| **SRONYX ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| **SYEDA ORAL TABLET 3-0.03 MG** | Covered | |
| **TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)** | Covered | |
| **VIENVA ORAL TABLET 0.1-20 MG-MCG** | Covered | |
| **VYFEMLA ORAL TABLET 0.4-35 MG-MCG** | Covered | |
| **WERA ORAL TABLET 0.5-35 MG-MCG** | Covered | |
| **WYMZYA FE ORAL TABLET CHEWABLE 0.4-35 MG-MCG** | Covered | |
| **ZUMANDIMINE ORAL TABLET 3-0.03 MG** | Covered | |
| ***COMBINATION CONTRACEPTIVES - TRANSDERMAL***** | | |
| **XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR** | Covered | QL (3 EA per 28 days); AL (Max 55 Years) |
| **ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR** | Covered | AL (Max 55 Years) |
| ***COMBINATION CONTRACEPTIVES - VAGINAL***** | | |
| **ELURYNG VAGINAL RING 0.12-0.015 MG/24HR** | Covered | QL (1 EA per 28 days); AL (Max 55 Years) |
| *etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr* | Covered | QL (1 EA per 28 days); AL (Max 55 Years) |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***CONTINUOUS CONTRACEPTIVES - ORAL***** | | |
| **AMETHYST ORAL TABLET 90-20 MCG** | Covered | |
| *levonorgestrel-ethinyl estrad oral tablet 90-20 mcg* | Covered | |
| ***COPPER CONTRACEPTIVES - IUD***** | | |
| **PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE** | Covered | AL (Max 55 Years) |
| ***EMERGENCY CONTRACEPTIVES***** | | |
| **AFTERA ORAL TABLET 1.5 MG** | Covered | QL (6 EA per 365 days) |
| **ELLA ORAL TABLET 30 MG** | Covered | QL (6 EA per 365 days); AL (Max 55 Years) |
| *levonorgestrel oral tablet 1.5 mg* | Covered | QL (6 EA per 365 days) |
| **MY WAY ORAL TABLET 1.5 MG** | Covered | QL (6 EA per 365 days) |
| **OPCICON ONE-STEP ORAL TABLET 1.5 MG** | Covered | QL (6 EA per 365 days) |
| ***EXTENDED-CYCLE CONTRACEPTIVES - ORAL***** | | |
| **ASHLYNA ORAL TABLET 0.15-0.03 &0.01 MG** | Covered | AL (Max 55 Years) |
| **CAMRESE LO ORAL TABLET 0.1-0.02 & 0.01 MG** | Covered | AL (Max 55 Years) |
| **CAMRESE ORAL TABLET 0.15-0.03 &0.01 MG** | Covered | AL (Max 55 Years) |
| **DAYSEE ORAL TABLET 0.15-0.03 &0.01 MG** | Covered | AL (Max 55 Years) |
| **ICLEVIA ORAL TABLET 0.15-0.03 MG** | Covered | AL (Max 55 Years) |
| **INTROVALE ORAL TABLET 0.15-0.03 MG** | Covered | AL (Max 55 Years) |
| **JAIMIESS ORAL TABLET 0.15-0.03 &0.01 MG** | Covered | AL (Max 55 Years) |
| **JOLESSA ORAL TABLET 0.15-0.03 MG** | Covered | AL (Max 55 Years) |
| *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* | Covered | AL (Max 55 Years) |
| **LOJAIMIESS ORAL TABLET 0.1-0.02 & 0.01 MG** | Covered | AL (Max 55 Years) |
| **SIMPESSE ORAL TABLET 0.15-0.03 &0.01 MG** | Covered | AL (Max 55 Years) |
| ***PROGESTIN CONTRACEPTIVES - IMPLANTS***** | | |
| **NEXPLANON SUBCUTANEOUS IMPLANT 68 MG** | Covered | QL (1 EA per 3 Years); AL (Max 55 Years) |
| ***PROGESTIN CONTRACEPTIVES - INJECTABLE***** | | |
| **DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML** | Covered | |
| *medroxyprogesterone acetate intramuscular suspension 150 mg/ml* | Covered | AL (Max 55 Years) |
| ***PROGESTIN CONTRACEPTIVES - IUD***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| **KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG** | Covered | |
| **MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY** | Covered | AL (Max 55 Years) |
| **SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG** | Covered | |
| ***PROGESTIN CONTRACEPTIVES - ORAL***** | | |
| **CAMILA ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **DEBLITANE ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **ERRIN ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **HEATHER ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **JENCYCLA ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **LYLEQ ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **LYZA ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **NORA-BE ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| *norethindrone oral tablet 0.35 mg* | Covered | AL (Max 55 Years) |
| **NORLYROC ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| **OPILL ORAL TABLET 0.075 MG** | Covered | |
| **SHAROBEL ORAL TABLET 0.35 MG** | Covered | AL (Max 55 Years) |
| ***TRIPHASIC CONTRACEPTIVES - ORAL***** | | |
| *alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg* | Covered | |
| **ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG** | Covered | |
| **DASETTA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG** | Covered | |
| **ENPRESSE-28 ORAL TABLET 50-30/75-40/ 125-30 MCG** | Covered | |
| **LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG** | Covered | |
| **LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG** | Covered | |
| *norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg* | Covered | |
| *norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg* | Covered | AL (Max 55 Years) |
| **NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG** | Covered | |
| **PIRMELLA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG** | Covered | |
| **TILIA FE ORAL TABLET 1-20/1-30/1-35 MG-MCG** | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| **TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG** | Covered | AL (Max 55 Years) |
| **TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG** | Covered | |
| **TRI-LINYAH ORAL TABLET 0.18/0.215/0.25 MG-35 MCG** | Covered | AL (Max 55 Years) |
| **TRI-LO-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG** | Covered | |
| **TRI-LO-MARZIA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG** | Covered | |
| **TRI-LO-MILI ORAL TABLET 0.18/0.215/0.25 MG-25 MCG** | Covered | |
| **TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG** | Covered | |
| **TRINESSA (28) ORAL TABLET 0.18/0.215/0.25 MG-35 MCG** | Covered | AL (Max 55 Years) |
| **TRI-NYMYO ORAL TABLET 0.18/0.215/0.25 MG-35 MCG** | Covered | AL (Max 55 Years) |
| **TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG** | Covered | AL (Max 55 Years) |
| **TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG** | Covered | |
| **TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG** | Covered | |
| **VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG** | Covered | |
| ***CORTICOSTEROIDS*** | | |
| ***GLUCOCORTICOSTEROIDS***** | | |
| *budesonide oral capsule delayed release particles 3 mg* | Covered | QL (448 EA per 365 days) |
| **DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML** | Covered | |
| *dexamethasone oral elixir 0.5 mg/5ml* | Covered | |
| *dexamethasone oral solution 0.5 mg/5ml* | Covered | |
| *dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg* | Covered | |
| *hydrocortisone oral tablet 10 mg, 20 mg, 5 mg* | Covered | |
| **MEDROL ORAL TABLET 2 MG** | Covered | |
| *methylprednisolone oral tablet 16 mg, 4 mg, 8 mg* | Covered | |
| *methylprednisolone oral tablet therapy pack 4 mg* | Covered | |
| *prednisolone oral solution 15 mg/5ml* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| *prednisolone sodium phosphate oral solution 15 mg/5ml, 6.7 (5 base) mg/5ml* | Covered | |
| *prednisone oral solution 5 mg/5ml* | Covered | |
| *prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg* | Covered | |
| **SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED 100 MG, 250 MG** | Covered | |
| ***MINERALOCORTICOIDS***** | | |
| *fludrocortisone acetate oral tablet 0.1 mg* | Covered | |
| ***COUGH/COLD/ALLERGY*** | | |
| ***ANTITUSSIVE - NONNARCOTIC***** | | |
| *benzonatate oral capsule 100 mg, 200 mg* | Covered | QL (90 EA per 30 days) |
| ***ANTITUSSIVE-EXPECTORANT***** | | |
| *chest congestion relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *chest congestion/cough relief oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *curanex dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs chest congestion relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *dextromethorphan-guaifenesin oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **FENESIN DM IR ORAL TABLET 20-400 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ft chest congestion relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp mucus relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gnp tab tussin dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *goodsense mucus relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| *mucus relief dm cough oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *mucus relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *pharbinex-dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *qc medifin dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *refenesen dm oral tablet 400-20 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sb mucus relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **SB TAB TUSSIN DM ORAL TABLET 20-400 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sm chest congestion relief dm oral tablet 20-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***DECONGESTANT W/ EXPECTORANT***** | | |
| *mucus relief d oral tablet 40-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *qc mucus relief sinus d oral tablet 40-400 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***MISC. RESPIRATORY INHALANTS***** | | |
| *nasal mist inhalation aerosol solution 0.9 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **SIMPLY SALINE BABY INHALATION AEROSOL SOLUTION 0.9 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sodium chloride inhalation nebulization solution 0.9 %, 7 %* | Covered | |
| ***MUCOLYTICS***** | | |
| *acetylcysteine inhalation solution 10 %, 20 %* | Covered | |
| ***NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *bio-rytuss oral liquid 5-2-10 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ed-a-hist dm oral liquid 10-4-15 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **GENCONTUSS ORAL LIQUID 5-2-10 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **GILTUSS ALLERGY CGH&CONG CHILD ORAL LIQUID 5-2-10 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **GILTUSS ALLERGY COUGH & CONGES ORAL LIQUID 5-2-10 MG/5ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *nohist-dm oral liquid 10-4-15 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***DERMATOLOGICALS*** | | |
| ***ACNE ANTIBIOTICS***** | | |
| *clindamycin phosphate external gel 1 %* | Covered | QL (60 GM per 30 days) |
| *clindamycin phosphate external lotion 1 %* | Covered | QL (60 ML per 30 days) |
| *clindamycin phosphate external solution 1 %* | Covered | |
| *clindamycin phosphate external swab 1 %* | Covered | |
| *dapsone external gel 5 %, 7.5 %* | Covered | |
| *erythromycin external gel 2 %* | Covered | |
| *erythromycin external solution 2 %* | Covered | |
| ***ACNE COMBINATIONS***** | | |
| *benzoyl peroxide-erythromycin external gel 5-3 %* | Covered | |
| *sulfacetamide sodium-sulfur external cream 10-5 %* | Covered | |
| *sulfacetamide sodium-sulfur external lotion 10-5 %* | Covered | |
| *sulfacetamide sodium-sulfur external suspension 10-5 %* | Covered | |
| ***ACNE PRODUCTS***** | | |
| *adapalene external cream 0.1 %* | Covered | 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. **Approval length if criteria is met: 1 year; AL (Max 40 Years) |

| Drug Name | Tier | Notes |
|---|---|---|
| **AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG** | Covered | Length of therapy is limited to 24 weeks. Prior authorization is required for treatment beyond this.; QL (60 EA per 30 days) |
| *benzoyl peroxide external gel 10 %, 2.5 %, 5 %* | Covered | |
| *benzoyl peroxide wash external liquid 10 %, 5 %* | Covered | |
| **CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG** | Covered | Length of therapy is limited to 24 weeks. Prior authorization is required for treatment beyond this.; QL (60 EA per 30 days) |
| **DIFFERIN EXTERNAL GEL 0.1 %** | Covered | 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. **Approval length if criteria is met: 1 year; AL (Max 40 Years) |
| *isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg* | Covered | Length of therapy is limited to 24 weeks. Prior authorization is required for treatment beyond this.; QL (60 EA per 30 days) |
| *tretinoin external cream 0.025 %, 0.05 %, 0.1 %* | Covered | Details: 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. **Approval length if criteria is met: 1 year; QL (45 GM per 30 days); AL (Max 40 Years) |
| *tretinoin external gel 0.01 %, 0.025 %* | Covered | Details: 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. **Approval length if criteria is met: 1 year; QL (45 GM per 30 days); AL (Max 40 Years) |
| **ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG** | Covered | Length of therapy is limited to 24 weeks. Prior authorization is required for treatment beyond this.; QL (60 EA per 30 days) |
| ***ANTIBIOTICS - TOPICAL***** | | |
| *bacitracin external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *bacitracin zinc external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *bacitracin zinc-aloe external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs bacitracin zinc external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *eq bacitracin zinc external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *eql bacitracin zinc external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *gentamicin sulfate external cream 0.1 %* | Covered | |
| *gentamicin sulfate external ointment 0.1 %* | Covered | |
| *gnp bacitracin zinc external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *mupirocin external ointment 2 %* | Covered | |
| *ra bacitracin external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra bacitracin zinc first aid external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sm antibiotic external ointment 500 unit/gm* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***ANTIFUNGALS - TOPICAL COMBINATIONS***** | | |
| *clotrimazole-betamethasone external cream 1-0.05 %* | Covered | |
| *clotrimazole-betamethasone external lotion 1-0.05 %* | Covered | |
| *nystatin-triamcinolone external cream 100000-0.1 unit/gm-%* | Covered | |
| *nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%* | Covered | |
| ***ANTIFUNGALS - TOPICAL***** | | |
| *ciclopirox external gel 0.77 %* | Covered | |
| *ciclopirox external solution 8 %* | Covered | QL (6.6 ML per 30 days) |
| *ciclopirox olamine external cream 0.77 %* | Covered | |
| *ciclopirox olamine external suspension 0.77 %* | Covered | |
| **NYAMYC EXTERNAL POWDER 100000 UNIT/GM** | Covered | |
| *nystatin external cream 100000 unit/gm* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *nystatin external ointment 100000 unit/gm* | Covered | |
| *nystatin external powder 100000 unit/gm* | Covered | |
| **NYSTOP EXTERNAL POWDER 100000 UNIT/GM** | Covered | |
| ***ANTI-INFLAMMATORY AGENTS - TOPICAL***** | | |
| *diclofenac sodium external gel 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (300 GM per 30 days) |
| ***ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL***** | | |
| *fluorouracil external cream 5 %* | Covered | |
| *fluorouracil external solution 2 %, 5 %* | Covered | |
| ***ANTIPSORIATICS - SYSTEMIC***** | | |
| *acitretin oral capsule 10 mg, 17.5 mg, 25 mg* | Covered | PA; QL (60 EA per 30 days); SP |
| **COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML** | Covered | PA; QL (2 ML per 28 days); SP |
| Cosentyx Intravenous Solution 125 MG/5ML | MB | PA |
| **COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML** | Covered | PA; QL (2 ML per 28 days); SP |
| **COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML** | Covered | PA; QL (1 ML per 28 days); SP |
| **COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML** | Covered | PA; QL (1 ML per 28 days); SP |
| **COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML** | Covered | PA; QL (0.5 ML per 28 days); SP |
| **SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML** | Covered | PA; QL (1 ML per 12 weekss); SP |
| **SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML** | Covered | PA; QL (1 ML per 12 weekss); SP |
| **STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML** | Covered | PA; QL (0.5 ML per 12 Weeks); SP |
| **STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML** | Covered | PA; QL (0.5 ML per 12 Weeks); SP |
| **STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML** | Covered | PA; QL (1 ML per 8 Weeks); SP |
| **TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML** | Covered | PA; QL (1 ML per 28 days); SP |
| **TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML** | Covered | PA; QL (1 ML per 28 days); SP |
| ***ANTIPSORIATICS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *calcipotriene external cream 0.005 %* | Covered | |
| *calcipotriene external ointment 0.005 %* | Covered | |
| *calcipotriene external solution 0.005 %* | Covered | |
| **CALCITRENE EXTERNAL OINTMENT 0.005 %** | Covered | |
| ***ANTISEBORRHEIC PRODUCTS***** | | |
| *anti-dandruff external shampoo 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *selenium sulfide external lotion 2.5 %* | Covered | |
| ***ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES***** | | |
| **DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML** | Covered | PA; QL (2.28 ML per 28 days); SP |
| **DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML** | Covered | PA; QL (4 ML per 28 days); SP |
| **DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML** | Covered | PA; QL (2.28 ML per 28 days); SP |
| **DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML** | Covered | PA; QL (4 ML per 28 days); SP |
| ***BURN PRODUCTS***** | | |
| *silver sulfadiazine external cream 1 %* | Covered | |
| ***CORTICOSTEROIDS - TOPICAL***** | | |
| *alclometasone dipropionate external ointment 0.05 %* | Covered | |
| **AQUANIL HC EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *beta hc external lotion 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *betamethasone dipropionate aug external cream 0.05 %* | Covered | |
| *betamethasone dipropionate aug external gel 0.05 %* | Covered | |
| *betamethasone dipropionate aug external lotion 0.05 %* | Covered | |
| *betamethasone dipropionate aug external ointment 0.05 %* | Covered | |
| *betamethasone dipropionate external cream 0.05 %* | Covered | |
| *betamethasone dipropionate external lotion 0.05 %* | Covered | |
| *betamethasone dipropionate external ointment 0.05 %* | Covered | |
| *betamethasone valerate external cream 0.1 %* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *betamethasone valerate external lotion 0.1 %* | Covered | |
| *betamethasone valerate external ointment 0.1 %* | Covered | |
| *clobetasol propionate e external cream 0.05 %* | Covered | |
| *clobetasol propionate external cream 0.05 %* | Covered | QL (60 GM per 30 days) |
| *clobetasol propionate external gel 0.05 %* | Covered | |
| *clobetasol propionate external ointment 0.05 %* | Covered | |
| *clobetasol propionate external solution 0.05 %* | Covered | |
| **CORTIBALM EXTERNAL STICK 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **CORTIZONE-10 COOLING EXTERNAL GEL 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **CORTIZONE-10 DIABETICS SKIN EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **CORTIZONE-10 ECZEMA EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **CORTIZONE-10 EXTERNAL GEL 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **CORTIZONE-10 HYDRATENSIVE EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **CORTIZONE-10 PSORIASIS EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs cortisone maximum strength external gel 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs cortisone maximum strength external lotion 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **DERMAREST ECZEMA EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *fluocinolone acetonide body external oil 0.01 %* | Covered | |
| *fluocinolone acetonide external cream 0.01 %, 0.025 %* | Covered | |
| *fluocinolone acetonide external ointment 0.025 %* | Covered | |
| *fluocinolone acetonide external solution 0.01 %* | Covered | |
| *fluocinolone acetonide scalp external oil 0.01 %* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *fluocinonide external cream 0.05 %* | Covered | |
| *fluocinonide external gel 0.05 %* | Covered | |
| *fluocinonide external ointment 0.05 %* | Covered | |
| *fluocinonide external solution 0.05 %* | Covered | |
| *fluticasone propionate external cream 0.05 %* | Covered | |
| *fluticasone propionate external ointment 0.005 %* | Covered | |
| *hydrocortisone external cream 0.5 %, 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *hydrocortisone external cream 2.5 %* | Covered | |
| *hydrocortisone external lotion 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *hydrocortisone external lotion 2.5 %* | Covered | |
| *hydrocortisone external ointment 0.5 %, 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *hydrocortisone external ointment 2.5 %* | Covered | |
| *hydrocortisone valerate external cream 0.2 %* | Covered | |
| **MG217 PSORIASIS ANIT-ITCH EXTERNAL GEL 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *mometasone furoate external cream 0.1 %* | Covered | |
| *mometasone furoate external ointment 0.1 %* | Covered | |
| *mometasone furoate external solution 0.1 %* | Covered | |
| **SARNOL-HC EXTERNAL LOTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *scalp relief maximum strength external solution 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **SCALPICIN MAXIMUM STRENGTH EXTERNAL SOLUTION 1 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %* | Covered | |
| *triamcinolone acetonide external lotion 0.025 %, 0.1 %* | Covered | |
| *triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %* | Covered | |
| ***IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *clotrimazole anti-fungal external cream 1 %* | Covered | |
| *econazole nitrate external cream 1 %* | Covered | |
| *ketoconazole external cream 2 %* | Covered | |
| *ketoconazole external shampoo 2 %* | Covered | |
| ***IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL***** | | |
| *imiquimod external cream 5 %* | Covered | QL (12 EA per 28 days) |
| ***KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS***** | | |
| *podofilox external solution 0.5 %* | Covered | |
| ***LOCAL ANESTHETICS - TOPICAL***** | | |
| **ANECREAM EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **ASPERCREME LIDOCAINE EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **ASPERCREME LIDOCAINE EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| **ASPERCREME W/LIDOCAINE EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **ASPERFLEX LIDOCAINE EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *asperflex max st external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| **ASPERFLEX PAIN RELIEVING EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| **BENGAY LIDOCAINE EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **BLUE-EMU PAIN RELIEF DRY EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *cvs lidocaine maximum strength external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *cvs pain relief external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *cvs pain relief external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *eq lidocaine pain relieving external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *eq pain relieving external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **FIRST CARE PAIN RELIEF EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *gnp lidocaine pain relief external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 Days) |
| *gnp lidocaine pain relieving external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **GOLD BOND MULTI-SYMPTOM EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **GOLD BOND PAIN & ITCH RELIEF EXTERNAL CREAM 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **HEALTHWISE PAIN RELIEF EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| **LIDO KING EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *lidocaine external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *lidocaine external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *lidocaine hcl external cream 3 %* | Covered | |
| *lidocaine hcl external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *lidocaine max st 24 hours external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *lidocaine pain relief external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *lidocaine pain relief max st external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *lidocaine pain relief max st external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *lidocaine pain relieving external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *lidocaine plus external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *lidocanna external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *lidocore external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *pain relief maximum strength external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *pain relieving + lidocaine external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *pain relieving lidocaine external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 Days) |
| **PHARMACIST CHOICE PAIN RELIEF EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *qc lidocaine pain relief external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 Days) |
| *qc pain relieving + lidocaine external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra lidocaine pain relieving external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 Days) |
| *ra pain relief external cream 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra pain relieving external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |

| Drug Name | Tier | Notes |
|---|---|---|
| **RE-LIEVED MAXIMUM STRENGTH EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| **SALONPAS PAIN RELIEVING EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| *theracare pain relief external patch 4 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 Days) |
| **WELMATE LIDOCAINE PAIN RELIEV EXTERNAL PATCH 4 %** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (30 EA per 30 days) |
| ***MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL***** | | |
| *pimecrolimus external cream 1 %* | Covered | **Approval length if criteria met: 2 months; QL (120 GM per 365 days); AL (Min 2 Years) |
| *tacrolimus external ointment 0.03 %* | Covered | Continuous long-term use of Protopic is not recommended by the FDA. The length of treatment will be limited to 60 days. **Approval length if criteria met: 60 days; AL (Min 2 Years) |
| *tacrolimus external ointment 0.1 %* | Covered | Continuous long-term use of Protopic is not recommended by the FDA. The length of treatment will be limited to 60 days. **Approval length if criteria met: 60 days.; AL (Min 2 Years) |
| ***ROSACEA AGENTS***** | | |
| *azelaic acid external gel 15 %* | Covered | ST |
| **FINACEA EXTERNAL FOAM 15 %** | Covered | ST |
| *metronidazole external cream 0.75 %* | Covered | |
| *metronidazole external gel 0.75 %* | Covered | |
| *metronidazole external lotion 0.75 %* | Covered | |
| ***SCABICIDES & PEDICULICIDES***** | | |
| *ivermectin external lotion 0.5 %* | Covered | ST; OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *permethrin external cream 5 %* | Covered | |
| ***TOPICAL ANESTHETIC COMBINATIONS***** | | |
| *lidocaine-prilocaine external cream 2.5-2.5 %* | Covered | |
| ***DIAGNOSTIC PRODUCTS*** | | |
| ***DIAGNOSTIC TESTS***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| **ACCU-CHEK AVIVA PLUS IN VITRO STRIP** | Covered | 100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days) |
| **ACCU-CHEK GUIDE IN VITRO STRIP** | Covered | 100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days) |
| **ACCU-CHEK SMARTVIEW IN VITRO STRIP** | Covered | 100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days) |
| **CLEARBLUE DIGITAL PLUS IN VITRO DIAGNOSTIC TEST** | Covered | |
| **CLEARBLUE DIGITAL PREGNANCY IN VITRO DIAGNOSTIC TEST** | Covered | |
| **CLEARBLUE PLUS PREGNANCY IN VITRO DIAGNOSTIC TEST** | Covered | |
| **EPT DIGITAL IN VITRO DIAGNOSTIC TEST** | Covered | |
| **EPT IN VITRO DIAGNOSTIC TEST** | Covered | |
| **KETOSTIX IN VITRO STRIP** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *one step pregnancy in vitro diagnostic test* | Covered | |
| **PRECISION XTRA KETONE IN VITRO STRIP** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***INFECTION TESTS***** | | |
| **BINAXNOW COVID-19 AG HOME TEST IN VITRO KIT** | Covered | QL (8 EA per 30 days) |
| **FLOWFLEX COVID-19 AG HOME TEST IN VITRO KIT** | Covered | QL (8 EA per 30 days) |
| **IHEALTH COVID-19 RAPID TEST IN VITRO KIT** | Covered | QL (8 EA per 30 days) |
| **PILOT COVID-19 AT-HOME TEST IN VITRO KIT** | Covered | QL (8 EA per 30 days) |
| ***MULTIPLE URINE TESTS***** | | |
| **CHEMSTRIP UGK IN VITRO STRIP** | Covered | |
| ***DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS*** | | |
| ***NUTRITIONAL SUPPLEMENTS***** | | |
| **BOOST ORAL LIQUID** | Covered | PA |
| ***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** | Covered | |
| **PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT** | Covered | |
| ***DIURETICS*** | | |
| ***CARBONIC ANHYDRASE INHIBITORS***** | | |
| *acetazolamide er oral capsule extended release 12 hour 500 mg* | Covered | |
| *acetazolamide oral tablet 125 mg, 250 mg* | Covered | |
| *methazolamide oral tablet 25 mg, 50 mg* | Covered | |
| ***DIURETIC COMBINATIONS***** | | |
| *amiloride-hydrochlorothiazide oral tablet 5-50 mg* | Covered | |
| *spironolactone-hctz oral tablet 25-25 mg* | Covered | |
| *triamterene-hctz oral capsule 37.5-25 mg* | Covered | |
| *triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg* | Covered | |
| ***LOOP DIURETICS***** | | |
| *bumetanide oral tablet 0.5 mg, 1 mg, 2 mg* | Covered | |
| *ethacrynic acid oral tablet 25 mg* | Covered | PA |
| *furosemide oral solution 10 mg/ml, 8 mg/ml* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *furosemide oral tablet 20 mg, 40 mg, 80 mg* | Covered | |
| *torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg* | Covered | |
| ***POTASSIUM SPARING DIURETICS***** | | |
| *amiloride hcl oral tablet 5 mg* | Covered | |
| *spironolactone oral tablet 100 mg, 25 mg, 50 mg* | Covered | |
| *triamterene oral capsule 100 mg, 50 mg* | Covered | |
| ***THIAZIDES AND THIAZIDE-LIKE DIURETICS***** | | |
| *chlorthalidone oral tablet 25 mg, 50 mg* | Covered | |
| *hydrochlorothiazide oral capsule 12.5 mg* | Covered | |
| *hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg* | Covered | |
| *indapamide oral tablet 1.25 mg, 2.5 mg* | Covered | |
| *metolazone oral tablet 10 mg, 2.5 mg, 5 mg* | Covered | |
| ***ENDOCRINE AND METABOLIC AGENTS - MISC.*** | | |
| ***ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS***** | | |
| *mifepristone oral tablet 200 mg* | Covered | |
| ***BISPHOSPHONATES***** | | |
| *alendronate sodium oral tablet 10 mg, 5 mg* | Covered | |
| *alendronate sodium oral tablet 35 mg, 70 mg* | Covered | QL (4 EA per 28 days) |
| *ibandronate sodium oral tablet 150 mg* | Covered | ST; QL (1 EA per 28 days) |
| ***CALCIMIMETIC AGENTS***** | | |
| *cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg* | Covered | PA |
| ***CALCITONINS***** | | |
| *calcitonin (salmon) nasal solution 200 unit/act* | Covered | |
| ***DOPAMINE RECEPTOR AGONISTS***** | | |
| *cabergoline oral tablet 0.5 mg* | Covered | QL (56 EA per 28 days) |
| ***GNRH/LHRH ANTAGONISTS***** | | |
| **ORILISSA ORAL TABLET 150 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| **ORILISSA ORAL TABLET 200 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| ***GROWTH HORMONES***** | | |
| **OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG** | Covered | PA; SP |
| ***HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *calcitriol oral capsule 0.25 mcg, 0.5 mcg* | Covered | |
| *calcitriol oral solution 1 mcg/ml* | Covered | |
| *doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg* | Covered | |
| ***HYPOPHOSPHATASIA (HPP) AGENTS***** | | |
| **STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML** | Covered | PA; LA |
| ***INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)***** | | |
| **INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML** | Covered | PA; SP |
| ***LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS***** | | |
| Lupron Depot-Ped (3-Month) Intramuscular Kit 11.25 MG, 30 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| ***PARATHYROID HORMONE AND DERIVATIVES***** | | |
| *teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml* | Covered | PA; SP |
| **TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML** | Covered | PA; SP |
| ***PHENYLKETONURIA TREATMENT - AGENTS***** | | |
| **PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML** | Covered | PA; LA; QL (7 ML per 28 days) |
| **PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML** | Covered | PA; LA; QL (3 ML per 35 days) |
| **PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML** | Covered | PA; LA; QL (28 ML per 28 days) |
| *sapropterin dihydrochloride oral packet 100 mg, 500 mg* | Covered | PA; LA |
| *sapropterin dihydrochloride oral tablet 100 mg* | Covered | PA; LA |
| ***RANK LIGAND (RANKL) INHIBITORS***** | | |
| Prolia Subcutaneous Solution Prefilled Syringe 60 MG/ML | MB | |
| ***SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)***** | | |
| *raloxifene hcl oral tablet 60 mg* | Covered | |
| ***SOMATOSTATIC AGENTS***** | | |
| SandoSTATIN LAR Depot Intramuscular Kit 10 MG, 20 MG, 30 MG | MB | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***UREA CYCLE DISORDER - AGENTS***** | | |
| **PHEBURANE ORAL PELLET 483 MG/GM** | Covered | PA; QL (20 GM per 1 day); SP |
| ***VASOPRESSIN***** | | |
| *desmopressin acetate oral tablet 0.1 mg, 0.2 mg* | Covered | |
| *desmopressin acetate spray nasal solution 0.01 %* | Covered | |
| ***ESTROGENS*** | | |
| ***ESTROGEN & PROGESTIN***** | | |
| **COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY** | Covered | ST; QL (8 EA per 28 days) |
| *estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg* | Covered | |
| **JINTELI ORAL TABLET 1-5 MG-MCG** | Covered | |
| **MIMVEY ORAL TABLET 1-0.5 MG** | Covered | |
| **PREMPHASE ORAL TABLET 0.625-5 MG** | Covered | |
| **PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-5 MG** | Covered | |
| ***ESTROGEN-PROGESTIN-GNRH ANTAGONIST***** | | |
| **ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG** | Covered | 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** | Covered | QL (8 EA per 28 days) |
| **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** | Covered | QL (8 EA per 28 Days) |
| *estradiol oral tablet 0.5 mg, 1 mg, 2 mg* | Covered | |
| *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* | Covered | 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* | Covered | |
| **LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR** | Covered | QL (8 EA per 28 days) |
| **MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG** | Covered | |
| **PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG** | Covered | |
| ***FLUOROQUINOLONES*** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***FLUOROQUINOLONES***** | | |
| **CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%)** | Covered | |
| *ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg* | Covered | |
| *levofloxacin oral solution 25 mg/ml* | Covered | |
| *levofloxacin oral tablet 250 mg, 500 mg, 750 mg* | Covered | |
| *moxifloxacin hcl oral tablet 400 mg* | Covered | |
| ***GASTROINTESTINAL AGENTS - MISC.*** | | |
| ***GALLSTONE SOLUBILIZING AGENTS***** | | |
| *ursodiol oral capsule 300 mg* | Covered | |
| *ursodiol oral tablet 250 mg, 500 mg* | Covered | |
| ***GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS***** | | |
| *lubiprostone oral capsule 24 mcg, 8 mcg* | Covered | ST; QL (60 EA per 30 days) |
| ***GASTROINTESTINAL STIMULANTS***** | | |
| *metoclopramide hcl oral solution 5 mg/5ml* | Covered | |
| *metoclopramide hcl oral tablet 10 mg, 5 mg* | Covered | |
| ***IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS***** | | |
| *alosetron hcl oral tablet 0.5 mg, 1 mg* | Covered | |
| ***INFLAMMATORY BOWEL AGENTS***** | | |
| *balsalazide disodium oral capsule 750 mg* | Covered | |
| *mesalamine er oral capsule extended release 24 hour 0.375 gm* | Covered | ST; QL (120 EA per 30 days) |
| *mesalamine oral capsule delayed release 400 mg* | Covered | ST; QL (180 EA per 30 days) |
| *mesalamine oral tablet delayed release 1.2 gm* | Covered | ST; QL (120 EA per 30 days) |
| *mesalamine rectal enema 4 gm* | Covered | |
| *mesalamine rectal suppository 1000 mg* | Covered | QL (30 EA per 30 days) |
| *sulfasalazine oral tablet 500 mg* | Covered | |
| *sulfasalazine oral tablet delayed release 500 mg* | Covered | |
| ***INTERLEUKIN ANTAGONISTS***** | | |
| Skyrizi Intravenous Solution 600 MG/10ML | MB | PA; QL (30 ML per 365 days); SP |
| **SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML** | Covered | PA; QL (1.2 ML per 56 days); SP |
| **SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML** | Covered | PA; QL (2.4 ML per 8 weeks); SP |
| ***INTESTINAL ACIDIFIERS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *lactulose encephalopathy oral solution 10 gm/15ml* | Covered | |
| ***PHOSPHATE BINDER AGENTS***** | | |
| **AURYXIA ORAL TABLET 1 GM 210 MG(FE)** | Covered | PA; QL (12 EA per 1 day) |
| *calcium acetate oral tablet 667 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *lanthanum carbonate oral tablet chewable 1000 mg, 500 mg* | Covered | PA; QL (3 EA per 1 day) |
| *lanthanum carbonate oral tablet chewable 750 mg* | Covered | PA; QL (6 EA per 1 day) |
| *sevelamer carbonate oral tablet 800 mg* | Covered | |
| ***TRYPTOPHAN HYDROXYLASE INHIBITORS***** | | |
| **XERMELO ORAL TABLET 250 MG** | Covered | PA; LA; QL (90 EA per 30 days) |
| ***TUMOR NECROSIS FACTOR ALPHA BLOCKERS***** | | |
| Avsola Intravenous Solution Reconstituted 100 MG | MB | PA |
| **CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML** | Covered | PA; QL (1 kit per 28 days); SP |
| **CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML** | Covered | PA; QL (3 kit per 28 days); SP |
| **CIMZIA SUBCUTANEOUS KIT 2 X 200 MG** | Covered | PA; QL (1 kit per 28 days); SP |
| ***GENITOURINARY AGENTS - MISCELLANEOUS*** | | |
| ***5-ALPHA REDUCTASE INHIBITORS***** | | |
| *dutasteride oral capsule 0.5 mg* | Covered | ST; QL (30 EA per 30 days) |
| *finasteride oral tablet 5 mg* | Covered | |
| ***ALPHA 1-ADRENOCEPTOR ANTAGONISTS***** | | |
| *alfuzosin hcl er oral tablet extended release 24 hour 10 mg* | Covered | QL (30 EA per 30 days) |
| *tamsulosin hcl oral capsule 0.4 mg* | Covered | |
| ***ANTI-INFECTIVE GENITOURINARY IRRIGANTS***** | | |
| *neomycin-polymyxin b gu irrigation solution 40-200000* | Covered | |
| ***CITRATES***** | | |
| *cytra-2 oral solution 500-334 mg/5ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| **ORACIT ORAL SOLUTION 490-640 MG/5ML** | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| *potassium citrate er oral tablet extended release 10 meq (1080 mg), 5 meq (540 mg)* | Covered | |
| **UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG)** | Covered | |
| ***INTERSTITIAL CYSTITIS AGENTS***** | | |
| **ELMIRON ORAL CAPSULE 100 MG** | Covered | PA; QL (90 EA per 30 days) |
| ***URINARY ANALGESICS***** | | |
| *phenazopyridine hcl oral tablet 100 mg, 200 mg* | Covered | |
| ***URINARY STONE AGENTS***** | | |
| *tiopronin oral tablet 100 mg* | Covered | PA; LA; QL (300 EA per 30 days) |
| ***GOUT AGENTS*** | | |
| ***GOUT AGENT COMBINATIONS***** | | |
| *colchicine-probenecid oral tablet 0.5-500 mg* | Covered | |
| ***GOUT AGENTS***** | | |
| *allopurinol oral tablet 100 mg, 300 mg* | Covered | |
| *colchicine oral tablet 0.6 mg* | Covered | |
| *febuxostat oral tablet 40 mg, 80 mg* | Covered | PA; QL (30 EA per 30 days) |
| ***URICOSURICS***** | | |
| *probenecid oral tablet 500 mg* | Covered | |
| ***HEMATOLOGICAL AGENTS - MISC.*** | | |
| ***ANTIHEMOPHILIC PRODUCTS***** | | |
| Advate Intravenous Solution Reconstituted 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT | MB | |
| AlphaNine SD Intravenous Solution Reconstituted 1000 UNIT, 1500 UNIT, 500 UNIT | MB | |
| Alprolix Intravenous Solution Reconstituted 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT | MB | |
| BeneFIX Intravenous Kit 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |
| Corifact Intravenous Kit 1000-1600 UNIT | MB | |
| Hemofil M Intravenous Solution Reconstituted 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT | MB | |
| Humate-P Intravenous Solution Reconstituted 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT | MB | |
| Ixinity Intravenous Solution Reconstituted 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |


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| Drug Name | Tier | Notes |
|---|---|---|
| Koate Intravenous Solution Reconstituted 1000 UNIT, 250 UNIT, 500 UNIT | MB | |
| Koate-DVI Intravenous Solution Reconstituted 1000 UNIT, 500 UNIT | MB | |
| Kogenate FS Intravenous Kit 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |
| Novoeight Intravenous Solution Reconstituted 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |
| NovoSeven RT Intravenous Solution Reconstituted 1 MG, 2 MG, 5 MG, 8 MG | MB | |
| Nuwiq Intravenous Kit 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT | MB | |
| Nuwiq Intravenous Solution Reconstituted 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT | MB | |
| Obizur Intravenous Solution Reconstituted 500 UNIT | MB | |
| Profilnine Intravenous Solution Reconstituted 1000 UNIT, 1500 UNIT, 500 UNIT | MB | |
| Recombinate Intravenous Solution Reconstituted 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT | MB | |
| RiaSTAP Intravenous Solution Reconstituted | MB | |
| Rixubis Intravenous Solution Reconstituted 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |
| Wilate Intravenous Kit 1000-1000 UNIT, 500-500 UNIT | MB | |
| Xyntha Intravenous Kit 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT | MB | |
| Xyntha Solofuse Intravenous Kit 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |
| ***C1 ESTERASE INHIBITORS***** | | |
| Haegarda Subcutaneous Solution Reconstituted 2000 UNIT, 3000 UNIT | MB | PA; SP |
| ***COMPLEMENT C5 INHIBITORS***** | | |
| Ultomiris Intravenous Solution 1100 MG/11ML, 300 MG/3ML | MB | PA |
| ***DIRECT-ACTING P2Y12 INHIBITORS***** | | |
| **BRILINTA ORAL TABLET 60 MG** | Covered | PA; QL (60 EA per 30 days) |
| **BRILINTA ORAL TABLET 90 MG** | Covered | PA; Maximum of 730 tablets per lifetime; QL (60 EA per 30 days) |
| ***HEMATORHEOLOGIC AGENTS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *pentoxifylline er oral tablet extended release 400 mg* | Covered | |
| ***PHOSPHODIESTERASE III INHIBITORS***** | | |
| *cilostazol oral tablet 100 mg, 50 mg* | Covered | |
| ***PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES***** | | |
| **TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML** | Covered | PA; QL (2 vials per 28 days); SP |
| **TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML** | Covered | PA; QL (2 ML per 28 days); SP |
| **TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML** | Covered | PA; QL (4 ML per 28 days); SP |
| ***PLATELET AGGREGATION INHIBITORS***** | | |
| *dipyridamole oral tablet 25 mg, 50 mg, 75 mg* | Covered | |
| ***QUINAZOLINE AGENTS***** | | |
| *anagrelide hcl oral capsule 0.5 mg, 1 mg* | Covered | |
| ***THIENOPYRIDINE DERIVATIVES***** | | |
| *clopidogrel bisulfate oral tablet 75 mg* | Covered | |
| *prasugrel hcl oral tablet 10 mg, 5 mg* | Covered | PA; QL (30 EA per 30 days) |
| ***HEMATOPOIETIC AGENTS*** | | |
| ***ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)***** | | |
| Retacrit Injection Solution 10000 UNIT/ML | MB | PA; QL (12 ML per 28 days); SP |
| Retacrit Injection Solution 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML | MB | PA; QL (12 ML per 28 days) |
| Retacrit Injection Solution 40000 UNIT/ML | MB | PA; QL (4 ML per 28 days) |
| ***FOLIC ACID/FOLATES***** | | |
| *folic acid oral tablet 1 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *folic acid oral tablet 400 mcg, 800 mcg* | Covered | 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; SP |
| Neulasta Onpro Subcutaneous Prefilled Syringe Kit 6 MG/0.6ML | MB | PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; SP |

| Drug Name | Tier | Notes |
|---|---|---|
| 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; SP |
| Ziextenzo Subcutaneous Solution Prefilled Syringe 6 MG/0.6ML | MB | PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; SP |
| ***IRON***** | | |
| **BPROTECTED PEDIA IRON ORAL SOLUTION 75 (15 FE) MG/ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **EZFE 200 ORAL CAPSULE 434.8 (200 FE) MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| Feraheme Intravenous Solution 510 MG/17ML | MB | PA |
| **FERREX 150 ORAL CAPSULE 150 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ferric x-150 oral capsule 150 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **FERRIMIN 150 ORAL TABLET 150 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ferrous gluconate oral tablet 240 (27 fe) mg, 324 (38 fe) mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ferrous sulfate oral solution 300 (60 fe) mg/5ml, 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| Ferumoxytol Intravenous Solution 510 MG/17ML | MB | PA |
| *fe-vite iron oral solution 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **IFEREX 150 ORAL CAPSULE 150 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| Injectafer Intravenous Solution 100 MG/2ML | MB | PA |
| *iron (ferrous sulfate) oral solution 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *iron infant & toddler oral solution 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *iron infant/toddler oral solution 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *iron supplement childrens oral solution 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *iron supplement oral solution 15 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **NU-IRON ORAL CAPSULE 150 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *pc pediatric iron drops oral solution 75 (15 fe) mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **POLY-IRON 150 ORAL CAPSULE 150 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *polysaccharide iron complex oral capsule 150 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *polysaccharide-iron complex oral capsule 150 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **PROFE ORAL CAPSULE 391.3 (180 FE) MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **PROFERRIN ES ORAL TABLET 12 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***THROMBOPOIETIN (TPO) RECEPTOR AGONISTS***** | | |
| **MULPLETA ORAL TABLET 3 MG** | Covered | PA; QL (7 EA per 7 Days); SP |
| ***HEMOSTATICS*** | | |
| ***HEMOSTATICS - SYSTEMIC***** | | |
| *aminocaproic acid oral solution 0.25 gm/ml* | Covered | PA; AL (Max 12 Years) |
| *aminocaproic acid oral tablet 1000 mg, 500 mg* | Covered | |
| *tranexamic acid oral tablet 650 mg* | Covered | QL (30 EA per 30 days) |
| Tranexamic Acid-NaCl Intravenous Solution 1000-0.7 MG/100ML-% | MB | |
| ***HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS*** | | |
| ***ANTIHISTAMINE HYPNOTICS***** | | |
| *gnp sleep aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| *kls sleep aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ra night sleep aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ra sleep aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *sleep aid (doxylamine) oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *sleep aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *sleep-aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *sm sleep aid oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *wal-som oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***BARBITURATE HYPNOTICS***** | | |
| *phenobarbital oral elixir 20 mg/5ml* | Covered | |
| *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg* | Covered | |
| ***BENZODIAZEPINE HYPNOTICS***** | | |
| *flurazepam hcl oral capsule 15 mg, 30 mg* | Covered | QL (30 EA per 30 days) |
| *midazolam hcl (pf) injection solution 10 mg/2ml, 2 mg/2ml, 5 mg/ml* | Covered | ST |
| *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* | Covered | ST |
| *temazepam oral capsule 15 mg* | Covered | QL (60 EA per 30 days) |
| *temazepam oral capsule 30 mg* | Covered | QL (30 EA per 30 days) |
| *triazolam oral tablet 0.125 mg, 0.25 mg* | Covered | QL (60 EA per 30 days) |
| ***NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS***** | | |
| *eszopiclone oral tablet 1 mg, 2 mg, 3 mg* | Covered | QL (30 EA per 30 days) |
| *zaleplon oral capsule 10 mg, 5 mg* | Covered | QL (60 EA per 30 days) |
| *zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg* | Covered | PA; QL (30 EA per 30 days) |

| Drug Name | Tier | Notes |
|---|---|---|
| *zolpidem tartrate oral tablet 10 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| ***OREXIN RECEPTOR ANTAGONISTS***** | | |
| **BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG** | Covered | PA; QL (30 EA per 30 days) |
| **DAYVIGO ORAL TABLET 10 MG, 5 MG** | Covered | PA; QL (30 EA per 30 days) |
| ***SELECTIVE MELATONIN RECEPTOR AGONISTS***** | | |
| *ramelteon oral tablet 8 mg* | Covered | PA; QL (30 EA per 30 Days) |
| ***LAXATIVES*** | | |
| ***BOWEL EVACUANT COMBINATIONS***** | | |
| **GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM** | Covered | QL (8000 ML per 365 days) |
| **GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM** | Covered | QL (8000 ML per 365 days) |
| *peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm* | Covered | QL (8000 ML per 365 days); AL (Min 50 Years) |
| *peg-3350/electrolytes oral solution reconstituted 236 gm* | Covered | QL (8000 ML per 365 days) |
| ***LAXATIVES - MISCELLANEOUS***** | | |
| *constulose oral solution 10 gm/15ml* | Covered | |
| *lactulose oral solution 10 gm/15ml* | Covered | |
| *polyethylene glycol 3350 oral powder 17 gm/scoop* | Covered | |
| ***SURFACTANT LAXATIVES***** | | |
| *docusate sodium oral capsule 100 mg, 250 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (60 EA per 30 days) |
| **DOK ORAL TABLET 100 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ft stool softener oral tablet 100 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **HEALTHY MAMA MOVE IT ALONG ORAL TABLET 100 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **PEDIA-LAX ORAL LIQUID 50 MG/15ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (900 ML per 30 days) |
| **PROMOLAXIN ORAL TABLET 100 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| *sm stool softener oral tablet 100 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *stool softener oral capsule 100 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (60 EA per 30 days) |
| *stool softener oral tablet 100 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***LOCAL ANESTHETICS-PARENTERAL*** | | |
| ***LOCAL ANESTHETICS - AMIDES***** | | |
| Exparel Injection Suspension 1.3 % | MB | |
| ***MACROLIDES*** | | |
| ***AZITHROMYCIN***** | | |
| *azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml* | Covered | |
| *azithromycin oral tablet 250 mg, 500 mg, 600 mg* | Covered | |
| ***CLARITHROMYCIN***** | | |
| *clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml* | Covered | |
| *clarithromycin oral tablet 250 mg, 500 mg* | Covered | |
| ***ERYTHROMYCINS***** | | |
| **E.E.S. 400 ORAL TABLET 400 MG** | Covered | |
| **E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML** | Covered | AL (Max 12 Years) |
| **ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML** | Covered | AL (Max 12 Years) |
| **ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML** | Covered | AL (Max 12 Years) |
| **ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG** | Covered | |
| **ERYTHROCIN STEARATE ORAL TABLET 250 MG** | Covered | |
| *erythromycin base oral tablet 250 mg, 500 mg* | Covered | |
| *erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml* | Covered | AL (Max 12 Years) |
| *erythromycin ethylsuccinate oral tablet 400 mg* | Covered | |
| *erythromycin stearate oral tablet 250 mg* | Covered | |
| ***FIDAXOMICIN***** | | |
| **DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML** | Covered | PA; QL (136 ML per 30 days) |

| Drug Name | Tier | Notes |
|---|---|---|
| ***MEDICAL DEVICES AND SUPPLIES*** | | |
| ***CERVICAL CAPS***** | | |
| **FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM** | Covered | AL (Max 55 Years) |
| ***CONDOMS - MALE***** | | |
| *condoms* | Covered | |
| ***DIAPHRAGMS***** | | |
| **CAYA VAGINAL DIAPHRAGM** | Covered | AL (Max 55 Years) |
| **OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| **WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 %** | Covered | AL (Max 55 Years) |
| ***GLUCOSE MONITORING TEST SUPPLIES***** | | |
| **ACCU-CHEK FASTCLIX LANCETS** | Covered | 102 lancets per 30 days or 306 lancets for 90 days are covered for members who are not on insulin. 204 lancets per 30 days or 612 lancets per 90 days are covered for members who are receiving insulin. 51 lancets per 30 days or 153 lancets per 90 days are covered for members on a continuous glucose monitoring system.; QL (102 EA per 30 days) |
| **ACCU-CHEK GUIDE KIT W/DEVICE** | Covered | QL (1 EA per 180 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| **ACCU-CHEK SOFTCLIX LANCETS** | Covered | 100 lancets per 30 days or 300 lancets for 90 days are covered for members who are not on insulin. 200 lancets per 30 days or lancets per 90 days are covered for members who are receiving insulin. 50 lancets per 30 days or 150 lancets per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days) |
| **DEXCOM G6 RECEIVER DEVICE** | Covered | PA; QL (1 EA per 365 days) |
| **DEXCOM G6 SENSOR** | Covered | PA; QL (3 EA per 30 days) |
| **DEXCOM G6 TRANSMITTER** | Covered | PA; QL (1 EA per 90 days) |
| **DEXCOM G7 RECEIVER DEVICE** | Covered | PA; QL (1 EA per 365 Days) |
| **DEXCOM G7 SENSOR** | Covered | PA; QL (3 EA per 30 Days) |
| **FREESTYLE LIBRE 14 DAY READER DEVICE** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (1 EA per 365 days) |
| **FREESTYLE LIBRE 14 DAY SENSOR** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (2 EA per 28 days) |
| **FREESTYLE LIBRE 2 READER DEVICE** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (1 EA per 365 days) |
| **FREESTYLE LIBRE 2 SENSOR** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (6 EA per 84 days) |
| **FREESTYLE LIBRE 3 READER DEVICE** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (1 EA per 365 days) |
| **FREESTYLE LIBRE 3 SENSOR** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (6 EA per 84 days) |
| **FREESTYLE LIBRE READER DEVICE** | Covered | Use of 30-day supply of insulin in the past 120 days required for new starts and continuations; QL (1 EA per 365 days) |
| **GUARDIAN 4 GLUCOSE SENSOR** | Covered | PA; QL (5 EA per 30 days) |
| **GUARDIAN 4 TRANSMITTER** | Covered | PA; QL (1 EA per 365 days) |
| **GUARDIAN LINK 3 TRANSMITTER** | Covered | PA; QL (1 EA per 365 days) |
| **GUARDIAN SENSOR (3)** | Covered | PA; QL (5 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *guardian sensor 3* | Covered | PA; QL (5 EA per 30 days) |
| ***INSULIN ADMINISTRATION SUPPLIES***** | | |
| **OMNIPOD 5 G6 INTRO (GEN 5) KIT** | Covered | PA; QL (1 EA per 365 days) |
| **OMNIPOD 5 G6 PODS (GEN 5)** | Covered | PA; QL (15 Pods per 30 days) |
| **OMNIPOD CLASSIC PODS (GEN 3)** | Covered | PA; QL (15 EA per 365 days) |
| **OMNIPOD DASH INTRO (GEN 4) KIT** | Covered | PA; QL (1 EA per 365 days) |
| **OMNIPOD DASH PODS (GEN 4)** | Covered | PA; QL (15 Pods per 30 days) |
| ***NEEDLES & SYRINGES***** | | |
| **BD INSULIN SYRINGE 27.5G X 5/8" 2 ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **BD PEN NEEDLE MICRO U/F 32G X 6 MM** | Covered | QL (200 EA per 30 days) |
| **BD PEN NEEDLE MINI U/F 31G X 5 MM** | Covered | QL (200 EA per 30 days) |
| **BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM** | Covered | QL (200 EA per 30 days) |
| **BD PEN NEEDLE NANO U/F 32G X 4 MM** | Covered | QL (200 EA per 30 days) |
| **BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM** | Covered | QL (200 EA per 30 days) |
| **BD PEN NEEDLE SHORT U/F 31G X 8 MM** | Covered | QL (200 EA per 30 days) |
| ***PEAK FLOW METERS***** | | |
| **ASSESS PEAK FLOW METER DEVICE** | Covered | |
| ***SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES***** | | |
| **OPTICHAMBER DIAMOND** | Covered | QL (2 EA per 180 days) |
| **OPTICHAMBER DIAMOND-MD MASK** | Covered | QL (2 EA per 180 days) |
| **OPTICHAMBER DIAMOND-SM MASK** | Covered | QL (2 EA per 180 days) |
| **POCKET CHAMBER DEVICE** | Covered | QL (2 EA per 180 days) |
| **VORTEX VALVED HOLDING CHAMBER DEVICE** | Covered | QL (2 EA per 180 days) |
| ***MIGRAINE PRODUCTS*** | | |
| ***CGRP RECEPTOR ANTAGONISTS - MONOCOLONAL ANTIBODIES***** | | |
| **AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML** | Covered | PA; QL (1 ML per 28 days); SP |
| ***ERGOT COMBINATIONS***** | | |
| *ergotamine-caffeine oral tablet 1-100 mg* | Covered | QL (40 EA per 30 days) |
| ***SELECTIVE SEROTONIN AGONISTS 5-HT(1)***** | | |
| *naratriptan hcl oral tablet 1 mg, 2.5 mg* | Covered | QL (18 EA per 30 days) |
| *rizatriptan benzoate oral tablet 10 mg, 5 mg* | Covered | QL (18 EA per 30 days) |
| *rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg* | Covered | QL (18 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *sumatriptan nasal solution 20 mg/act, 5 mg/act* | Covered | QL (6 EA per 30 days) |
| *sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg* | Covered | QL (18 EA per 30 days) |
| *sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml* | Covered | QL (2 ML per 30 days) |
| *sumatriptan succinate subcutaneous solution 6 mg/0.5ml* | Covered | QL (2 ML per 30 days) |
| *sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml* | Covered | QL (2 ML per 30 days) |
| ***MINERALS & ELECTROLYTES*** | | |
| ***CALCIUM COMBINATIONS***** | | |
| *calcium 500 + d oral tablet 500-3.125 mg-mcg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *calcium-vitamin d oral tablet 600-3.125 mg-mcg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *oyster shell calcium/d oral tablet 250-3.125 mg-mcg, 250-6.25 mg-mcg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *oyster shell calcium/vitamin d oral tablet 250-3.125 mg-mcg, 500-5 mg-mcg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***FLUORIDE***** | | |
| *sodium fluoride oral solution 1.1 (0.5 f) mg/ml* | Covered | 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* | Covered | AL (Max 6 Years) |
| ***PHOSPHATE***** | | |
| **PHOSPHA 250 NEUTRAL ORAL TABLET 155-852-130 MG** | Covered | |
| ***POTASSIUM***** | | |
| **K-BICARB ORAL CAPSULE 99 MG** | Covered | |
| **KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ** | Covered | |
| **KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ** | Covered | |
| **KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ** | Covered | |
| **KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ** | Covered | |
| **KLOR-CON ORAL PACKET 20 MEQ** | Covered | |
| **KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ** | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| **KLOR-CON/EF ORAL TABLET EFFERVESCENT 25 MEQ** | Covered | |
| *potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq* | Covered | |
| *potassium chloride er oral capsule extended release 10 meq, 8 meq* | Covered | |
| *potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq* | Covered | |
| *potassium chloride oral packet 20 meq* | Covered | |
| ***MISCELLANEOUS THERAPEUTIC CLASSES*** | | |
| ***ANTILEPROTICS***** | | |
| **THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG** | Covered | PA; SP |
| ***B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS***** | | |
| Benlysta Intravenous Solution Reconstituted 120 MG, 400 MG | MB | PA |
| **BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML** | Covered | PA; QL (4 ML per 28 days); SP |
| **BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML** | Covered | PA; QL (4 ML per 28 days) |
| ***CHELATING AGENTS***** | | |
| *penicillamine oral tablet 250 mg* | Covered | PA; QL (240 EA per 30 days) |
| ***CYCLOSPORINE ANALOGS***** | | |
| *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg* | Covered | |
| *cyclosporine modified oral solution 100 mg/ml* | Covered | |
| *cyclosporine oral capsule 100 mg, 25 mg* | Covered | |
| **GENGRAF ORAL CAPSULE 100 MG, 25 MG** | Covered | |
| **GENGRAF ORAL SOLUTION 100 MG/ML** | Covered | |
| **SANDIMMUNE ORAL SOLUTION 100 MG/ML** | Covered | |
| ***ENZYMES***** | | |
| Hylenex Injection Solution 150 UNIT/ML | MB | PA |
| ***IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES***** | | |
| *lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg* | Covered | PA; LA |
| *lenalidomide oral capsule 2.5 mg, 20 mg* | Covered | PA; SP |

| Drug Name | Tier | Notes |
|---|---|---|
| ***INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS***** | | |
| *mycophenolate mofetil oral capsule 250 mg* | Covered | |
| *mycophenolate mofetil oral suspension reconstituted 200 mg/ml* | Covered | PA; AL (Max 12 Years) |
| *mycophenolate mofetil oral tablet 500 mg* | Covered | |
| ***MACROLIDE IMMUNOSUPPRESSANTS***** | | |
| **ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG** | Covered | PA; QL (30 EA per 30 days) |
| **ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG** | Covered | PA; QL (120 EA per 30 days) |
| **ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG** | Covered | PA; QL (90 EA per 30 days) |
| *everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg* | Covered | PA; SP |
| *everolimus oral tablet 1 mg* | Covered | PA |
| *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg* | Covered | |
| ***MONOCLONAL ANTIBODIES***** | | |
| Gamifant Intravenous Solution 10 MG/2ML, 50 MG/10ML | MB | PA |
| ***POTASSIUM REMOVING AGENTS***** | | |
| **LOKELMA ORAL PACKET 10 GM** | Covered | PA; QL (30 EA per 30 days) |
| **LOKELMA ORAL PACKET 5 GM** | Covered | PA; QL (90 EA per 30 days) |
| *sodium polystyrene sulfonate oral powder* | Covered | |
| **VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM** | Covered | PA; QL (30 EA per 30 days) |
| ***PURINE ANALOGS***** | | |
| *azathioprine oral tablet 50 mg* | Covered | |
| ***MOUTH/THROAT/DENTAL AGENTS*** | | |
| ***ANTI-INFECTIVES - THROAT***** | | |
| *clotrimazole mouth/throat troche 10 mg* | Covered | |
| *nystatin mouth/throat suspension 100000 unit/ml* | Covered | |
| ***ANTISEPTICS - MOUTH/THROAT***** | | |
| *chlorhexidine gluconate mouth/throat solution 0.12 %* | Covered | |
| **PERIOGARD MOUTH/THROAT SOLUTION 0.12 %** | Covered | |
| ***FLUORIDE DENTAL PRODUCTS***** | | |
| **CLINPRO 5000 DENTAL PASTE 1.1 %** | Covered | |
| *sf dental gel 1.1 %* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***SALIVA STIMULANTS***** | | |
| *pilocarpine hcl oral tablet 5 mg, 7.5 mg* | Covered | QL (90 EA per 30 days) |
| ***STEROIDS - MOUTH/THROAT/DENTAL***** | | |
| **ORALONE MOUTH/THROAT PASTE 0.1 %** | Covered | QL (5 GM per 30 days) |
| *triamcinolone acetonide mouth/throat paste 0.1 %* | Covered | QL (5 GM per 30 days) |
| ***MULTIVITAMINS*** | | |
| ***B-COMPLEX W/ C & FOLIC ACID***** | | |
| *b complex-c-folic acid oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *b-complex balanced oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *b-complex/vitamin c oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *b-complex-c (w/folic acid) oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **DIALYVITE ORAL TABLET** | Covered | |
| *eql super b complex/vitamin c oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *kp b complex-c oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **NEPHRONEX ORAL TABLET** | Covered | |
| **RENAL ORAL CAPSULE 1 MG** | Covered | |
| *rena-vite oral tablet* | Covered | |
| *rena-vite rx oral tablet 1 mg* | Covered | |
| *reno caps oral capsule 1 mg* | Covered | |
| *sm b super vitamin complex oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *sm b-complex/vitamin c oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *stress formula (folic acid) oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *super b complex/fa/vit c oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *super b-complex/vit c/fa oral tablet* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***B-COMPLEX W/ C***** | | |
| *super b complex/vitamin c oral tablet* | Covered | |
| ***PED MULTI VITAMINS W/FL & FE***** | | |
| *multi-vit/iron/fluoride oral solution 0.25-10 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *multi-vitamin/fluoride/iron oral solution 0.25-10 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***PED MV W/ FLUORIDE***** | | |
| *multivitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *multi-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **QUFLORA PEDIATRIC ORAL SOLUTION 0.5 MG/ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***PRENATAL MV & MIN W/FE-FA***** | | |
| **CO-NATAL FA ORAL TABLET** | Covered | |
| **INATAL GT ORAL TABLET** | Covered | |
| *m-natal plus oral tablet 27-1 mg* | Covered | |
| *multi prenatal oral tablet 27-0.8 mg* | Covered | AL (Max 55 Years) |
| *neonatal complete oral tablet 27-1 mg* | Covered | |
| **NEONATAL PLUS ORAL TABLET 27-1 MG** | Covered | |
| **NIVA-PLUS ORAL TABLET 27-1 MG** | Covered | |
| **OBTREX ORAL TABLET** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *one vite womens plus oral tablet 27-1 mg* | Covered | |
| *pnv prenatal plus multivitamin oral tablet 27-1 mg* | Covered | |
| **PRENATABS RX ORAL TABLET 29-1 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |

| Drug Name | Tier | Notes |
|---|---|---|
| *prenatal 19 oral tablet chewable , 29-1 mg* | Covered | |
| *prenatal one daily oral tablet 27-0.8 mg* | Covered | AL (Max 55 Years) |
| *prenatal oral tablet 27-0.8 mg* | Covered | AL (Max 55 Years) |
| *prenatal oral tablet 27-1 mg* | Covered | |
| *prenatal plus oral tablet 27-1 mg* | Covered | |
| *prenatal plus vitamin/mineral oral tablet 27-1 mg* | Covered | |
| **PRENATAL-U ORAL CAPSULE 106.5-1 MG** | Covered | |
| **PRENATRIX ORAL TABLET 27-1 MG** | Covered | |
| **PRENATRYL ORAL TABLET 27-1 MG** | Covered | |
| **RIGHT STEP PRENATAL ORAL TABLET 27-0.8 MG** | Covered | AL (Max 55 Years) |
| *se-natal 19 oral tablet chewable 29-1 mg* | Covered | |
| **THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *thrivite rx oral tablet 29-1 mg* | Covered | |
| **VITATHELY WITH GINGER ORAL TABLET 27-1 MG** | Covered | |
| *westab plus oral tablet 27-1 mg* | Covered | |
| ***MUSCULOSKELETAL THERAPY AGENTS*** | | |
| ***CENTRAL MUSCLE RELAXANTS***** | | |
| *baclofen oral tablet 10 mg, 20 mg* | Covered | |
| *chlorzoxazone oral tablet 500 mg* | Covered | |
| *cyclobenzaprine hcl oral tablet 10 mg, 5 mg* | Covered | |
| *methocarbamol oral tablet 500 mg, 750 mg* | Covered | |
| *tizanidine hcl oral tablet 2 mg, 4 mg* | Covered | |
| ***VISCOSUPPLEMENTS***** | | |
| Durolane Intra-Articular Prefilled Syringe 60 MG/3ML | MB | PA |
| ***NASAL AGENTS - SYSTEMIC AND TOPICAL*** | | |
| ***NASAL ANTICHOLINERGICS***** | | |
| *ipratropium bromide nasal solution 0.03 %, 0.06 %* | Covered | |
| ***NASAL ANTIHISTAMINES***** | | |
| *azelastine hcl nasal solution 0.1 %* | Covered | |
| ***NASAL MAST CELL STABILIZERS***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *cromolyn sodium nasal aerosol solution 5.2 mg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***NASAL STEROIDS***** | | |
| *allergy spray 24 hour nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *cvs nasal allergy spray nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *eq nasal allergy nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| **FLONASE ALLERGY RELIEF NASAL SUSPENSION 50 MCG/ACT** | Covered | |
| *fluticasone propionate nasal suspension 50 mcg/act* | Covered | |
| *gnp 24 hour nasal allergy nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *goodsense nasal allergy spray nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *hm 24 hour nasal allergy nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *nasal allergy 24 hour nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *ra nasal allergy nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *triamcinolone acetonide nasal aerosol 55 mcg/act* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***NUTRIENTS*** | | |
| ***LIPIDS***** | | |
| **MCT OIL ORAL OIL** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *organic mct oil oral oil* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***OPHTHALMIC AGENTS*** | | |
| ***ARTIFICIAL TEAR AND LUBRICANT COMBINATIONS***** | | |

| Drug Name | Tier | Notes |
|---|---|---|
| *eq lubricant eye drops ophthalmic solution 0.4-0.3 %* | Covered | |
| *lubricant eye drops ophthalmic solution 0.4-0.3 %* | Covered | |
| *sm lubricant eye drops ophthalmic solution 0.4-0.3 %* | Covered | |
| **SYSTANE NIGHTTIME OPHTHALMIC OINTMENT** | Covered | |
| ***BETA-BLOCKERS - OPHTHALMIC COMBINATIONS***** | | |
| *dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %* | Covered | |
| ***BETA-BLOCKERS - OPHTHALMIC***** | | |
| *betaxolol hcl ophthalmic solution 0.5 %* | Covered | ST |
| **BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 %** | Covered | ST |
| *carteolol hcl ophthalmic solution 1 %* | Covered | |
| *levobunolol hcl ophthalmic solution 0.5 %* | Covered | |
| *timolol maleate ophthalmic solution 0.25 %, 0.5 %* | Covered | |
| ***CYCLOPLEGIC MYDRIATICS***** | | |
| *atropine sulfate ophthalmic ointment 1 %* | Covered | |
| *atropine sulfate ophthalmic solution 1 %* | Covered | |
| **HOMATROPAIRE OPHTHALMIC SOLUTION 5 %** | Covered | |
| *phenylephrine hcl ophthalmic solution 10 %* | Covered | |
| *tropicamide ophthalmic solution 0.5 %, 1 %* | Covered | |
| ***MIOTICS - CHOLINESTERASE INHIBITORS***** | | |
| **PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 %** | Covered | |
| ***MIOTICS - DIRECT ACTING***** | | |
| *pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %* | Covered | |
| ***OPHTHALMIC ANTIALLERGIC***** | | |
| *cromolyn sodium ophthalmic solution 4 %* | Covered | |
| *ketotifen fumarate ophthalmic solution 0.035 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***OPHTHALMIC ANTIBIOTICS***** | | |
| *bacitracin ophthalmic ointment 500 unit/gm* | Covered | |
| *ciprofloxacin hcl ophthalmic solution 0.3 %* | Covered | |
| *erythromycin ophthalmic ointment 5 mg/gm* | Covered | AL (Max 1 Years) |
| *gentamicin sulfate ophthalmic solution 0.3 %* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *ofloxacin ophthalmic solution 0.3 %* | Covered | |
| *tobramycin ophthalmic solution 0.3 %* | Covered | |
| ***OPHTHALMIC ANTI-INFECTIVE COMBINATIONS***** | | |
| *bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm* | Covered | |
| *neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000* | Covered | |
| *neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025* | Covered | |
| *polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%* | Covered | |
| ***OPHTHALMIC ANTIVIRALS***** | | |
| *trifluridine ophthalmic solution 1 %* | Covered | |
| ***OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS***** | | |
| *brinzolamide ophthalmic suspension 1 %* | Covered | |
| *dorzolamide hcl ophthalmic solution 2 %* | Covered | |
| ***OPHTHALMIC IMMUNOMODULATORS***** | | |
| *cyclosporine ophthalmic emulsion 0.05 %* | Covered | QL (60 EA per 30 days) |
| ***OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS***** | | |
| *diclofenac sodium ophthalmic solution 0.1 %* | Covered | |
| *ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %* | Covered | |
| ***OPHTHALMIC RHO KINASE INHIBITORS***** | | |
| **RHOPRESSA OPHTHALMIC SOLUTION 0.02 %** | Covered | ST |
| ***OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS***** | | |
| *brimonidine tartrate ophthalmic solution 0.1 %, 0.15 %, 0.2 %* | Covered | |
| ***OPHTHALMIC STEROID COMBINATIONS***** | | |
| *bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %* | Covered | |
| *neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1* | Covered | |
| *neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1* | Covered | |
| ***OPHTHALMIC STEROIDS***** | | |
| **ALREX OPHTHALMIC SUSPENSION 0.2 %** | Covered | ST |
| *dexamethasone sodium phosphate ophthalmic solution 0.1 %* | Covered | |
| *fluorometholone ophthalmic suspension 0.1 %* | Covered | |
| **FML FORTE OPHTHALMIC SUSPENSION 0.25 %** | Covered | |
| **LOTEMAX SM OPHTHALMIC GEL 0.38 %** | Covered | ST |
| *loteprednol etabonate ophthalmic gel 0.5 %* | Covered | ST |
| *loteprednol etabonate ophthalmic suspension 0.5 %* | Covered | ST |
| **PRED MILD OPHTHALMIC SUSPENSION 0.12 %** | Covered | |
| *prednisolone acetate ophthalmic suspension 1 %* | Covered | |
| *prednisolone sodium phosphate ophthalmic solution 1 %* | Covered | |
| ***OPHTHALMIC SULFONAMIDES***** | | |
| *sulfacetamide sodium ophthalmic solution 10 %* | Covered | |
| ***PROSTAGLANDINS - OPHTHALMIC***** | | |
| *latanoprost ophthalmic solution 0.005 %* | Covered | |
| **LUMIGAN OPHTHALMIC SOLUTION 0.01 %** | Covered | ST |
| ***VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS***** | | |
| Eylea HD Intravitreal Solution 8 MG/0.07ML | MB | |
| ***OTIC AGENTS*** | | |
| ***OTIC AGENTS - MISCELLANEOUS***** | | |
| *acetic acid otic solution 2 %* | Covered | |
| ***OTIC ANTI-INFECTIVES***** | | |
| *ofloxacin otic solution 0.3 %* | Covered | |
| ***OTIC STEROID-ANTI-INFECTIVE COMBINATIONS***** | | |
| *ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %* | Covered | ST; QL (7.5 ML per 30 days); AL (Max 12 Years) |
| *neomycin-polymyxin-hc otic solution 3.5-10000-1* | Covered | |
| *neomycin-polymyxin-hc otic suspension 3.5-10000-1* | Covered | |
| ***OTIC STEROIDS***** | | |
| *fluocinolone acetonide otic oil 0.01 %* | Covered | |
| *hydrocortisone-acetic acid otic solution 1-2 %* | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| ***OXYTOCICS*** | | |
| ***OXYTOCICS***** | | |
| *methylergonovine maleate oral tablet 0.2 mg* | Covered | |
| ***PASSIVE IMMUNIZING AND TREATMENT AGENTS*** | | |
| ***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 |
| ***PENICILLINS*** | | |
| ***AMINOPENICILLINS***** | | |
| *amoxicillin oral capsule 250 mg, 500 mg* | Covered | |
| *amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml* | Covered | |
| *amoxicillin oral tablet 500 mg, 875 mg* | Covered | |
| *amoxicillin oral tablet chewable 125 mg, 250 mg* | Covered | |
| *ampicillin oral capsule 500 mg* | Covered | |
| ***NATURAL PENICILLINS***** | | |
| *penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml* | Covered | |
| *penicillin v potassium oral tablet 250 mg, 500 mg* | Covered | |
| ***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* | Covered | |
| *amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg* | Covered | |
| *amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg* | Covered | |
| ***PENICILLINASE-RESISTANT PENICILLINS***** | | |
| *dicloxacillin sodium oral capsule 250 mg, 500 mg* | Covered | |
| ***PHARMACEUTICAL ADJUVANTS*** | | |
| ***THICKENING AGENTS***** | | |
| *cvs instant food thickener oral powder* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| **THICK & EASY ORAL PACKET** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **THICK & EASY ORAL POWDER** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **THICK NOW ORAL POWDER** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **THICK-IT ORAL PACKET** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***PROGESTINS*** | | |
| ***PROGESTINS***** | | |
| *medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg* | Covered | |
| *megestrol acetate oral suspension 625 mg/5ml* | Covered | PA |
| *norethindrone acetate oral tablet 5 mg* | Covered | |
| *progesterone oral capsule 100 mg, 200 mg* | Covered | |
| ***PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*** | | |
| ***ALCOHOL DETERRENTS***** | | |
| *acamprosate calcium oral tablet delayed release 333 mg* | Covered | QL (180 EA per 30 days) |
| *disulfiram oral tablet 250 mg, 500 mg* | Covered | |
| ***ANTI-CATAPLECTIC AGENTS***** | | |
| *sodium oxybate oral solution 500 mg/ml* | Covered | PA; LA; QL (540 ML per 30 days); AL (Min 7 Years) |
| ***CHOLINOMIMETICS - ACHE INHIBITORS***** | | |
| *donepezil hcl oral tablet 10 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| *donepezil hcl oral tablet dispersible 10 mg, 5 mg* | Covered | PA; QL (30 EA per 30 days) |
| *galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg* | Covered | |
| *galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg* | Covered | |
| *rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg* | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***MOVEMENT DISORDER DRUG THERAPY***** | | |
| **AUSTEDO ORAL TABLET 12 MG** | Covered | PA; QL (120 EA per 30 days); SP |

| Drug Name | Tier | Notes |
|---|---|---|
| **AUSTEDO ORAL TABLET 6 MG, 9 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| *tetrabenazine oral tablet 12.5 mg* | Covered | PA; QL (90 EA per 30 days); SP |
| *tetrabenazine oral tablet 25 mg* | Covered | PA; QL (120 EA per 30 days); SP |
| ***MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS***** | | |
| *teriflunomide oral tablet 14 mg, 7 mg* | Covered | QL (30 EA per 30 days); SP |
| ***MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES***** | | |
| **MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (20 EA per 326 days); SP |
| **MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (8 EA per 326 days); SP |
| **MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (10 EA per 326 days); SP |
| **MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (12 EA per 326 days); SP |
| **MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (14 EA per 326 days); SP |
| **MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (16 EA per 326 days); SP |
| **MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG** | Covered | PA; QL (18 EA per 326 days); SP |
| ***MULTIPLE SCLEROSIS AGENTS - INTERFERONS***** | | |
| **AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML** | Covered | QL (1 EA per 28 days); SP |
| **AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML** | Covered | QL (1 EA per 28 days); SP |
| **EXTAVIA SUBCUTANEOUS KIT 0.3 MG** | Covered | QL (1 EA per 30 days); SP |
| **REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML** | Covered | QL (6 ML per 28 days); SP |
| **REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG** | Covered | QL (1 Kit per 28 days); SP |
| **REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML** | Covered | QL (6 ML per 28 days); SP |
| **REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG** | Covered | QL (1 Kit per 28 days); SP |
| ***MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS***** | | |
| *dimethyl fumarate oral capsule delayed release 120 mg, 240 mg* | Covered | QL (60 EA per 30 days); SP |

| Drug Name | Tier | Notes |
|---|---|---|
| ***MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS***** | | |
| *dalfampridine er oral tablet extended release 12 hour 10 mg* | Covered | QL (60 EA per 30 days) |
| ***MULTIPLE SCLEROSIS AGENTS***** | | |
| **GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML** | Covered | QL (30 ML per 30 days); SP |
| **GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML** | Covered | QL (12 ML per 28 days); 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* | Covered | ST; QL (30 EA per 30 days) |
| *memantine hcl oral tablet 10 mg, 5 mg* | Covered | 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* | Covered | |
| ***PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS***** | | |
| *fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg* | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***PSEUDOBULBAR AFFECT AGENT COMBINATIONS***** | | |
| **NUEDEXTA ORAL CAPSULE 20-10 MG** | Covered | PA; QL (60 EA per 30 days) |
| ***PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.***** | | |
| *ergoloid mesylates oral tablet 1 mg* | Covered | |
| *pimozide oral tablet 1 mg* | Covered | PA; QL (60 EA per 30 days); AL (Min 2 Years) |
| *pimozide oral tablet 2 mg* | Covered | PA; QL (150 EA per 30 days); AL (Min 2 Years) |
| ***SMOKING DETERRENTS***** | | |
| *bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg* | Covered | |
| *goodsense nicotine mouth/throat gum 2 mg* | Covered | |
| *nicotine polacrilex mouth/throat gum 2 mg, 4 mg* | Covered | |
| *nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg* | Covered | |
| *nicotine transdermal kit 21-14-7 mg/24hr* | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr* | Covered | |
| **NICOTROL INHALATION INHALER 10 MG** | Covered | |
| **NICOTROL NS NASAL SOLUTION 10 MG/ML** | Covered | |
| *varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42* | Covered | |
| *varenicline tartrate oral tablet 0.5 mg, 1 mg* | Covered | |
| ***SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS***** | | |
| **MAYZENT ORAL TABLET 0.25 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **MAYZENT ORAL TABLET 2 MG** | Covered | PA; QL (30 EA per 30 days); SP |
| ***THIENBENZODIAZEPINES & OPIOID ANTAGONISTS***** | | |
| **LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG** | Covered | PA; QL (30 EA per 30 days) |
| ***THIENBENZODIAZEPINES & SSRIS***** | | |
| *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg* | Covered | PA; QL (30 EA per 30 days); AL (Min 18 Years) |
| ***RESPIRATORY AGENTS - MISC.*** | | |
| ***CFTR POTENTIATORS***** | | |
| **KALYDECO ORAL PACKET 13.4 MG** | Covered | PA; QL (2 packets per 1 day); AL (Max 6 Years); SP |
| **KALYDECO ORAL PACKET 25 MG** | Covered | PA; QL (60 EA per 30 days); AL (Min 4 Years and Max 6 Years); SP |
| **KALYDECO ORAL PACKET 50 MG, 75 MG** | Covered | PA; QL (60 EA per 30 days); AL (Min 4 Years); SP |
| **KALYDECO ORAL TABLET 150 MG** | Covered | PA; QL (60 EA per 30 days); AL (Min 6 Years); SP |
| ***CYSTIC FIBROSIS AGENT - COMBINATIONS***** | | |
| **ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG** | Covered | PA; QL (120 EA per 30 days); SP |
| **SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| **SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG** | Covered | PA; QL (60 Tablets per 30 Days); AL (Min 6 Years and Max 12 Years); SP |
| **TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG** | Covered | PA; QL (90 EA per 30 days); SP |
| **TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG** | Covered | PA; QL (2 packets per 1 day) |
| ***HYDROLYTIC ENZYMES***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| **PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML** | Covered | LA |
| ***PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS***** | | |
| **OFEV ORAL CAPSULE 100 MG, 150 MG** | Covered | PA; QL (60 EA per 30 days); SP |
| ***TETRACYCLINES*** | | |
| ***TETRACYCLINES***** | | |
| *doxycycline hyclate oral tablet 20 mg* | Covered | QL (60 EA per 30 days) |
| *doxycycline monohydrate oral capsule 100 mg, 50 mg* | Covered | |
| *minocycline hcl oral capsule 100 mg, 50 mg, 75 mg* | Covered | |
| *tetracycline hcl oral capsule 250 mg, 500 mg* | Covered | |
| **VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML** | Covered | |
| ***THYROID AGENTS*** | | |
| ***ANTITHYROID AGENTS***** | | |
| *methimazole oral tablet 10 mg, 5 mg* | Covered | |
| *propylthiouracil oral tablet 50 mg* | Covered | |
| ***THYROID HORMONES***** | | |
| **EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG** | Covered | |
| *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* | Covered | |
| **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** | Covered | |
| *liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg* | Covered | |
| **NP THYROID ORAL TABLET 15 MG, 30 MG, 60 MG, 90 MG** | Covered | |
| **UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG** | Covered | |
| ***TOXOIDS*** | | |
| ***TOXOID COMBINATIONS***** | | |
| **ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5** | Covered | |
| **BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5** | Covered | |

| Drug Name | Tier | Notes |
|---|---|---|
| **BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5** | Covered | |
| *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml* | Covered | |
| ***ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS*** | | |
| ***ANTISPASMODICS***** | | |
| Dicyclomine HCl Intramuscular Solution 10 MG/ML | MB | |
| *dicyclomine hcl oral capsule 10 mg* | Covered | |
| *dicyclomine hcl oral solution 10 mg/5ml* | Covered | |
| *dicyclomine hcl oral tablet 20 mg* | Covered | |
| ***BELLADONNA ALKALOIDS***** | | |
| *hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg* | Covered | |
| *hyoscyamine sulfate oral elixir 0.125 mg/5ml* | Covered | |
| *hyoscyamine sulfate oral solution 0.125 mg/ml* | Covered | |
| *hyoscyamine sulfate oral tablet 0.125 mg* | Covered | |
| *hyoscyamine sulfate oral tablet dispersible 0.125 mg* | Covered | |
| *hyoscyamine sulfate sublingual tablet sublingual 0.125 mg* | Covered | |
| ***H-2 ANTAGONISTS***** | | |
| *cimetidine oral tablet 300 mg, 400 mg, 800 mg* | Covered | |
| *famotidine oral suspension reconstituted 40 mg/5ml* | Covered | |
| *famotidine oral tablet 20 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *famotidine oral tablet 40 mg* | Covered | |
| ***MISC. ANTI-ULCER***** | | |
| *sucralfate oral suspension 1 gm/10ml* | Covered | QL (1200 ML per 30 days); AL (Max 12 Years) |
| *sucralfate oral tablet 1 gm* | Covered | |
| ***PROTON PUMP INHIBITORS***** | | |
| *esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg* | Covered | QL (30 EA per 30 days) |
| *lansoprazole oral capsule delayed release 15 mg* | Covered | ST; OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (60 EA per 30 days) |
| *lansoprazole oral capsule delayed release 30 mg* | Covered | ST; QL (60 EA per 30 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| *lansoprazole oral tablet delayed release dispersible 15 mg* | Covered | PA; OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans; QL (60 EA per 30 days); AL (Max 1 Years) |
| *lansoprazole oral tablet delayed release dispersible 30 mg* | Covered | PA; QL (60 EA per 30 days); AL (Max 1 Years) |
| *omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg* | Covered | QL (60 EA per 30 days) |
| Pantoprazole Sodium Intravenous Solution Reconstituted 40 MG | MB | |
| *pantoprazole sodium oral tablet delayed release 20 mg, 40 mg* | Covered | QL (60 EA per 30 days) |
| *rabeprazole sodium oral tablet delayed release 20 mg* | Covered | ST; QL (60 EA per 30 days) |
| ***QUATERNARY ANTICHOLINERGICS***** | | |
| *glycopyrrolate injection solution 0.2 mg/ml, 0.4 mg/2ml, 1 mg/5ml, 4 mg/20ml* | Covered | |
| *glycopyrrolate oral tablet 1 mg, 2 mg* | Covered | QL (120 EA per 30 days) |
| ***ULCER DRUGS - PROSTAGLANDINS***** | | |
| *misoprostol oral tablet 100 mcg, 200 mcg* | Covered | |
| ***URINARY ANTISPASMODICS*** | | |
| ***URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)***** | | |
| *oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg* | Covered | |
| *oxybutynin chloride oral tablet 5 mg* | Covered | |
| **OXYTROL FOR WOMEN TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR** | Covered | QL (8 EA per 28 days) |
| *solifenacin succinate oral tablet 10 mg, 5 mg* | Covered | QL (30 EA per 30 days) |
| *tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg* | Covered | ST; QL (30 EA per 30 days) |
| *tolterodine tartrate oral tablet 1 mg, 2 mg* | Covered | ST |
| *trospium chloride er oral capsule extended release 24 hour 60 mg* | Covered | QL (30 EA per 30 days) |
| *trospium chloride oral tablet 20 mg* | Covered | |
| ***URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS***** | | |
| *bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg* | Covered | |
| ***VACCINES*** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| ***BACTERIAL VACCINES***** | | |
| **MENQUADFI INTRAMUSCULAR SOLUTION** | Covered | |
| **MENVEO INTRAMUSCULAR SOLUTION** | Covered | |
| **MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED** | Covered | |
| **PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED** | Covered | |
| **PNEUMOVAX 23 INJECTION INJECTABLE 25 MCG/0.5ML** | Covered | |
| **PREVNAR 13 INTRAMUSCULAR SUSPENSION** | Covered | |
| **PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | QL (0.5 ML per 1 Lifetime) |
| **TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE** | Covered | |
| **VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | |
| ***VIRAL VACCINE COMBINATIONS***** | | |
| **M-M-R II INJECTION SOLUTION RECONSTITUTED** | Covered | |
| **TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML** | Covered | |
| ***VIRAL VACCINES***** | | |
| **ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML** | Covered | AL (Min 60 Years) |
| **AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION** | Covered | QL (0.5 ML per 180 days) |
| **AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | QL (0.5 ML per 180 days) |
| **AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML** | Covered | AL (Min 60 Years) |
| **COMIRNATY INTRAMUSCULAR SUSPENSION 30 MCG/0.3ML** | Covered | QL (0.3 ML per 21 days); AL (Min 12 Years) |
| **COMIRNATY INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 30 MCG/0.3ML** | Covered | |
| **ENGERIX-B INJECTION SUSPENSION 20 MCG/ML** | Covered | |
| **ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML** | Covered | |
| **FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE 0.5 ML** | Covered | |
| **FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | QL (0.5 ML per 180 days) |
| **FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML** | Covered | PA; QL (0.5 ML per 180 days) |


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| Drug Name | Tier | Notes |
|---|---|---|
| **FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION** | Covered | QL (0.5 ML per 180 days) |
| **FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | QL (0.5 ML per 180 days) |
| **FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | QL (0.5 ML per 180 days) |
| **FLUMIST QUADRIVALENT NASAL SUSPENSION** | Covered | QL (1 EA per 180 days); AL (Min 2 Years and Max 49 Years) |
| **FLUZONE HIGH-DOSE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.7 ML** | Covered | QL (0.7 ML per 180 days); AL (Min 65 Years) |
| **FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION** | Covered | QL (0.5 ML per 180 days) |
| **FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML** | Covered | QL (0.5 ML per 180 days) |
| **GARDASIL 9 INTRAMUSCULAR SUSPENSION** | Covered | AL (Min 9 Years and Max 45 Years) |
| **GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE** | Covered | AL (Min 9 Years and Max 45 Years) |
| **HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML** | Covered | |
| **HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML** | Covered | |
| **IPOL INJECTION INJECTABLE** | Covered | |
| **MODERNA COVID-19 VAC 6M-11Y INTRAMUSCULAR SUSPENSION 25 MCG/0.25ML** | Covered | |
| *novavax covid-19 vaccine intramuscular suspension 5 mcg/0.5ml* | Covered | Max 2 doses in 365 days; QL (0.5 ML per 21 days); AL (Min 12 Years) |
| **PFIZER COVID-19 VAC-TRIS 5-11Y INTRAMUSCULAR SUSPENSION 10 MCG/0.3ML** | Covered | |
| *pfizer covid-19 vac-tris 6m-4y intramuscular suspension 3 mcg/0.3ml* | Covered | |
| **RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML** | Covered | |
| **RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML** | Covered | |
| **SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML** | Covered | QL (2 Vials per 1 Lifetime); AL (Min 50 Years) |
| **SPIKEVAX INTRAMUSCULAR SUSPENSION 50 MCG/0.5ML** | Covered | Max 3 doses in 365 days; QL (0.5 ML per 28 days); AL (Min 6 Years) |
| **SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML** | Covered | |
| **VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML** | Covered | |


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| Drug Name | Tier | Notes |
|---|---|---|
| **VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML** | Covered | |
| ***VAGINAL AND RELATED PRODUCTS*** | | |
| ***IMIDAZOLE-RELATED ANTIFUNGALS***** | | |
| *clotrimazole vaginal cream 1 %* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *terconazole vaginal cream 0.4 %, 0.8 %* | Covered | |
| *terconazole vaginal suppository 80 mg* | Covered | |
| ***SPERMICIDES***** | | |
| **ENCARE VAGINAL SUPPOSITORY 100 MG** | Covered | AL (Max 55 Years) |
| **OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 %** | Covered | AL (Max 55 Years) |
| **TODAY SPONGE VAGINAL 1000 MG** | Covered | |
| **VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 %** | Covered | AL (Max 55 Years) |
| **VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 %** | Covered | AL (Max 55 Years) |
| ***VAGINAL ANTI-INFECTIVES***** | | |
| **CLEOCIN VAGINAL SUPPOSITORY 100 MG** | Covered | |
| *clindamycin phosphate vaginal cream 2 %* | Covered | |
| *metronidazole vaginal gel 0.75 %* | Covered | |
| ***VAGINAL ESTROGENS***** | | |
| *estradiol vaginal cream 0.1 mg/gm* | Covered | |
| *estradiol vaginal tablet 10 mcg* | Covered | |
| **PREMARIN VAGINAL CREAM 0.625 MG/GM** | Covered | |
| **YUVAFEM VAGINAL TABLET 10 MCG** | Covered | |
| ***VAGINAL PROGESTINS***** | | |
| **CRINONE VAGINAL GEL 8 %** | Covered | PA |
| ***VASOPRESSORS*** | | |
| ***ANAPHYLAXIS THERAPY AGENTS***** | | |
| *epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml* | Covered | |
| ***VASOPRESSORS***** | | |
| *midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg* | Covered | |
| ***VITAMINS*** | | |
| ***VITAMIN B-3***** | | |


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| Drug Name | Tier | Notes |
|---|---|---|
| *kp niacin oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *niacin er oral capsule extended release 250 mg, 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *niacin er oral tablet extended release 1000 mg, 250 mg, 500 mg, 750 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *niacin oral tablet 100 mg, 250 mg, 50 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| *niacin oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *plain niacin oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra niacin oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ra no flush niacin oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *true vitamin b3 oral tablet 500 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***VITAMIN B-6***** | | |
| *pyridoxine hcl oral tablet 25 mg* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - Not covered for ABP plans |
| ***VITAMIN D***** | | |
| *aqueous vitamin d oral liquid 10 mcg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| **BPROTECTED PEDIA D-VITE ORAL LIQUID 10 MCG/ML** | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *d-vite pediatric oral liquid 10 mcg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *ergocalciferol oral capsule 1.25 mg (50000 ut)* | Covered | |
| *pharmacist choice d-vitamin oral liquid 400 unit/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |


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| Drug Name | Tier | Notes |
|---|---|---|
| *vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)* | Covered | |
| *vitamin d infant oral liquid 10 mcg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *vitamin d oral liquid 10 mcg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| *vitamin d3 oral liquid 10 mcg/ml* | Covered | OTC - Benefit Exclusion for ABP Plans; OTC - not covered for ABP plans |
| ***VITAMIN K***** | | |
| *phytonadione oral tablet 5 mg* | Covered | |


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**Medical Benefit**

| Drug Name | Tier | Notes |
|---|---|---|
| Abraxane Intravenous Suspension Reconstituted 100 MG | MB | |
| Actimmune Subcutaneous Solution 2000000 UNIT/0.5ML | MB | SP |
| Adcetris Intravenous Solution Reconstituted 50 MG | MB | PA |
| Afstyla Intravenous Kit 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT | MB | |
| Alimta Intravenous Solution Reconstituted 100 MG, 500 MG | MB | PA |
| Aliqopa Intravenous Solution Reconstituted 60 MG | MB | PA |
| Ameluz External Gel 10 % | MB | |
| Aranesp (Albumin Free) Injection Solution 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML | MB | PA |
| BCG Vaccine Injection Solution Reconstituted 50 MG | MB | |
| Beleodaq Intravenous Solution Reconstituted 500 MG | MB | PA |
| Berinert Intravenous Kit 500 UNIT | MB | PA; SP |
| Besponsa Intravenous Solution Reconstituted 0.9 MG | MB | PA |
| Betamethasone Combo Injection Suspension 6 (3-3) MG/ML | MB | |
| Betamethasone Sod Phos & Acet Injection Suspension 6 (3-3) MG/ML | MB | |
| Bexsero Intramuscular Suspension Prefilled Syringe | MB | |
| Blincyto Intravenous Solution Reconstituted 35 MCG | MB | PA |
| Botox Injection Solution Reconstituted 100 UNIT, 200 UNIT | MB | PA |
| Caspofungin Acetate Intravenous Solution Reconstituted 50 MG, 70 MG | MB | |
| Cidofovir Intravenous Solution 75 MG/ML | MB | |
| Cinryze Intravenous Solution Reconstituted 500 UNIT | MB | PA; SP |
| Cinvanti Intravenous Emulsion 130 MG/18ML | MB | PA |
| Crysvita Subcutaneous Solution 10 MG/ML, 20 MG/ML, 30 MG/ML | MB | PA |
| Cubicin RF Intravenous Solution Reconstituted 500 MG | MB | |
| Cyramza Intravenous Solution 100 MG/10ML, 500 MG/50ML | MB | PA |
| Dysport Intramuscular Solution Reconstituted 300 UNIT, 500 UNIT | MB | PA |
| Eligard Subcutaneous Kit 22.5 MG, 7.5 MG | MB | |
| Eligard Subcutaneous Kit 30 MG, 45 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |


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| Drug Name | Tier | Notes |
|---|---|---|
| Enhertu Intravenous Solution Reconstituted 100 MG | MB | PA |
| Entyvio Intravenous Solution Reconstituted 300 MG | MB | PA; QL (1 Vial per 56 days); SP |
| Ethyol Intravenous Solution Reconstituted 500 MG | MB | PA |
| Euflexxa Intra-Articular Solution Prefilled Syringe 20 MG/2ML | MB | PA |
| Eylea Intravitreal Solution 2 MG/0.05ML | MB | |
| Eylea Intravitreal Solution Prefilled Syringe 2 MG/0.05ML | MB | |
| Ferrlecit Intravenous Solution 12.5 MG/ML | MB | PA |
| Firazyr Subcutaneous Solution Prefilled Syringe 30 MG/3ML | MB | PA; SP |
| Flebogamma DIF Intravenous Solution 10 GM/200ML, 20 GM/400ML, 5 GM/100ML | MB | PA |
| FluPHENAZine HCl Injection Solution 2.5 MG/ML | MB | |
| 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 | |
| **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** | Covered | PA; QL (30 Syringes per 30 days) |
| Fulvestrant Intramuscular Solution Prefilled Syringe 250 MG/5ML | MB | |
| 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 |
| Gazyva Intravenous Solution 1000 MG/40ML | MB | PA |
| Heparin Sod (Porcine) in D5W Intravenous Solution 100 UNIT/ML | MB | |
| Imfinzi Intravenous Solution 120 MG/2.4ML, 500 MG/10ML | MB | PA |
| Imipenem-Cilastatin Intravenous Solution Reconstituted 500 MG | MB | |
| Infed Injection Solution 50 MG/ML | MB | PA |
| Injectafer Intravenous Solution 750 MG/15ML | MB | PA |
| Isoproterenol HCl Injection Solution 0.2 MG/ML | MB | |
| Jelmyto Solution Reconstituted 80 (2 x 40) MG | MB | PA; QL (17 Doses per 1 Lifetime) |
| Kadcyla Intravenous Solution Reconstituted 100 MG, 160 MG | MB | PA |
| Kalbitor Subcutaneous Solution 10 MG/ML | MB | PA |
| Keytruda Intravenous Solution 100 MG/4ML | MB | PA |


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| Drug Name | Tier | Notes |
|---|---|---|
| Kovaltry Intravenous Solution Reconstituted 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT | MB | |
| Kyprolis Intravenous Solution Reconstituted 10 MG, 30 MG, 60 MG | MB | PA |
| Lupron Depot-Ped (1-Month) Intramuscular Kit 11.25 MG, 15 MG, 7.5 MG | MB | PA required if billed with Dx codes F64.1 - F64.9. |
| Micafungin Sodium Intravenous Solution Reconstituted 100 MG, 50 MG | MB | |
| Myobloc Intramuscular Solution 10000 UNIT/2ML, 2500 UNIT/0.5ML, 5000 UNIT/ML | MB | |
| Na Ferric Gluc Cplx in Sucrose Intravenous Solution 12.5 MG/ML | MB | PA |
| Ocrevus Intravenous Solution 300 MG/10ML | MB | PA; SP |
| Onpattro Intravenous Solution 10 MG/5ML | MB | PA |
| Opdivo Intravenous Solution 100 MG/10ML, 240 MG/24ML, 40 MG/4ML | MB | PA |
| Padcev Intravenous Solution Reconstituted 20 MG, 30 MG | MB | PA |
| Palonosetron HCl Intravenous Solution 0.25 MG/5ML | MB | QL (5 ML per 5 days) |
| Pentam Injection Solution Reconstituted 300 MG | MB | |
| Perjeta Intravenous Solution 420 MG/14ML | MB | PA |
| Poteligeo Intravenous Solution 20 MG/5ML | MB | PA |
| Retrovir Intravenous Solution 10 MG/ML | MB | |
| romiDEPsin Intravenous Solution 27.5 MG/5.5ML | MB | PA |
| Sarclisa Intravenous Solution 100 MG/5ML, 500 MG/25ML | MB | PA |
| Soliris Intravenous Solution 300 MG/30ML | MB | PA |
| Spravato (56 MG Dose) Nasal Solution Therapy Pack 28 MG/DEVICE | MB | PA |
| Spravato (84 MG Dose) Nasal Solution Therapy Pack 28 MG/DEVICE | MB | PA |
| Tecentriq Intravenous Solution 1200 MG/20ML, 840 MG/14ML | MB | PA |
| Testopel Implant Pellet 75 MG | MB | PA; QL (6 EA per 90 days) |
| Trodelvy Intravenous Solution Reconstituted 180 MG | MB | PA |
| Trogarzo Intravenous Solution 200 MG/1.33ML | MB | |
| Tysabri Intravenous Concentrate 300 MG/15ML | MB | PA |
| Udenyca Subcutaneous Solution Prefilled Syringe 6 MG/0.6ML | MB | PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; SP |
| Unituxin Intravenous Solution 17.5 MG/5ML | MB | PA |
| Valrubicin Intravesical Solution 40 MG/ML | MB | |


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| Drug Name | Tier | Notes |
|---|---|---|
| VariZIG Intramuscular Solution 125 UNIT/1.2ML | MB | PA |
| Venofer Intravenous Solution 20 MG/ML | MB | PA |
| Voriconazole Intravenous Solution Reconstituted 200 MG | MB | PA |
| Xgeva Subcutaneous Solution 120 MG/1.7ML | MB | PA |
| Xolair Subcutaneous Solution Prefilled Syringe 150 MG/ML, 75 MG/0.5ML | MB | PA |
| Xolair Subcutaneous Solution Reconstituted 150 MG | MB | PA |
| Yervoy Intravenous Solution 200 MG/40ML, 50 MG/10ML | MB | PA |
| Zaltrap Intravenous Solution 100 MG/4ML, 200 MG/8ML | MB | PA |
| Zinc Sulfate Intravenous Solution 3 MG/ML | MB | |
| 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 | |
| Zoledronic Acid Intravenous Solution 4 MG/100ML, 5 MG/100ML | MB | |


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## Disclaimer

The Presbyterian Turquoise Care Preferred Drug List (also called a “Formulary”) may change at any time. Please visit our website for the most up-to-date list at **www.phs.org/formsanddocuments**. You can also contact our local Pharmacy Services team at:

| Pharmacy Services Team | | | | |
|---|---|---|---|---|
| **Presbyterian Turquoise Care** | **Main Line:** | (505) 923-5200 or 1-888-977-2333 (TTY 711) | **Navajo/Diné Line:** | (505) 923-5157 or 1-888-806-8793 (TTY 711) |
| **Children in State Custody Members** | **Main Line:** | (505) 923-8417 or 1-844-233-4887 (TTY 711) | **Navajo/Diné Line:** | (505) 923-5157 or 1-888-806-8793 (TTY 711) |
| ***Applies to both*** | **Hours:** | 8 a.m. to 5 p.m. Monday – Friday (except holidays) | **Email:** | **info@phs.org** |

## About this Formulary

- This is not a full list.
- It does not give a promise of coverage (payment by your insurance).
- Coverage for some drugs listed may be only for certain dosage forms and/or strengths.
- Drugs that are not in the Formulary will **not** be covered unless you have tried all of the Formulary drugs first and your doctor has written that they do not work.
- The Presbyterian Turquoise Care drug benefit requires that generic drugs be substituted for a brand drug when possible.
- Drugs that come from living sources (biologic) may be substituted by drugs considered clinically similar in build and use (biosimilar) or by FDA-approved brand drugs marketed without the brand on their label (authorized brand alternatives).
- Certain classes of drugs are excluded from coverage and cannot be covered such as:
  - Drugs used for weight loss.
  - Drugs used to treat sexual dysfunction.
  - Drugs used to treat infertility.
  - Drugs used to treat hair loss.
  - Drugs used to treat cosmetic conditions.
  - Certain compounded drug items.
  - Cough and cold drugs for members under the age of four.
  - Drugs considered experimental and investigational.
  - Drugs determined through the Drug Efficacy Study Implementation (DESI) proceedings to be Less Than Effective (LTE).

Your benefit design determines what is covered and your copayment. Please refer to your benefit materials for your specific coverage information.


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## Explanation of Terms

1. **Age Limit (AG)** – The member must be a certain age for the drug to be covered.
2. **Drug Efficacy Study Implementation (DESI)** -- The FDA's Drug Efficacy Study Implementation evaluates the effectiveness of those drugs that had been previously approved between 1938 and 1962 on safety grounds alone. Drugs determined through the DESI proceedings to be Less Than Effective (LTE), designation five or six, are excluded from coverage under your plan.
3. **Medical Drugs (MED)** -- A Medical Drug is any drug given by a Health Care provider and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization (permission) and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require Prior Authorization please see the Presbyterian Pharmacy website at **www.phs.org**.
4. **Medical Exception (ME)** – Permission to use a drug that is not on the Presbyterian Turquoise Care Formulary. You may get a Medical Exception to use a non-Formulary drug if you have any allergy or bad reaction to all of the Formulary drugs or if the Formulary drugs do not work. You or your doctor can ask for a Medical Exception by fax, phone, or email. Your doctor must give a reason for asking for the Medical Exception.
5. **Over-the-Counter (OTC)** – You must have a doctor's prescription for these drugs to be covered. Note: Listed OTC drugs for Alternative Benefit Package recipients are covered only for members age 19 and 20.
6. **Prior Authorization (PA**) – You or your doctor must get permission (an OK) from Presbyterian Turquoise Care before you fill your drug prescription. If you don't get Prior Authorization, Presbyterian Turquoise Care may not pay for the drug. You or your doctor can ask for permission by fax, phone, or email.
7. **Quantity Limit (QL)** – A limit to the amount of drug Presbyterian Turquoise Care will pay for in a period of time.
8. **Specialty Pharmaceuticals (SP)** – Self-administered Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member, or a caregiver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Specialty Pharmaceuticals are often high cost, typically greater than $600 for up to a 30-day supply.
    a. Specialty Pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply.
    b. Most Specialty Pharmaceuticals must be obtained through the specialty pharmacy network.
    c. Certain Specialty Pharmaceuticals may have additional day supply limitations.
    d. Most Specialty Pharmaceuticals require Prior Authorization.
9. **Step Edit (ST)** – You must first try certain drugs to treat a medical health problem before a different drug will be covered for the same health problem. For example, if Drug A and Drug B both treat your medical health problem, Presbyterian Turquoise Care may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan may then cover Drug B.

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