



Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Presbyterian Health Plan and Presbyterian Insurance Company Commercial 4-Tier Formulary

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

What Is A Formulary?

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

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

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

How Is the Formulary Managed?

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

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

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

“Step therapy” promotes the appropriate use of equally effective but lower-cost Formulary drugs first. With this program, prior use of one or more “prerequisite” drugs is required before a step-therapy medication will be covered. Prerequisite drugs are Food and Drug Administration (FDA)-approved and treat the same condition as the corresponding step-therapy drugs.

Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your provider and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian Health Plan and Presbyterian Insurance Company uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following:

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

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

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






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





Presbyterian Insurance Company Commercial: (505) 923 -6980 or 1-800-923-6980

You can also send pharmacy inquiries to AskPharmacy@phs.org.







Some medications may be excluded as determined by benefit.










Definition of Status



Icon	Status	Definition
	Tier 1	Tier 1 Preferred Generic.
	Tier 2	Tier 2 Preferred Brand.
	Tier 3	Tier 3 Non-Preferred Drug.
	Tier 4	Tier 4 Self-Administered Specialty Pharmaceutical.
	Medical Benefit	A medical drug is any drug administered by a healthcare professional and is typically given in the member's home, provider's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical drugs may require a prior authorization and some must be obtained through the Specialty Pharmacy network. For a complete list of medical drugs to determine which require prior authorization please see the Presbyterian Health Plan Pharmacy Services website at www.phs.org .

Icon	Status	Definition
	\$0	Zero Dollar Copay
	Medical Exception	A process to request an exception to Formulary/Preferred Drug List (PDL) drug limitations and restrictions such as coverage of a non-Formulary drug, quantity limits and step-therapy requirements. The request can be made by a prescriber, a member or their appointed representative. The prescriber must provide information to support the medical exception request by fax, phone or mail.
	Benefit Exclusion	Benefit Exclusion not a covered benefit.
	Non-Formulary	Non-Formulary drugs require an exception to the Formulary due to allergy, adverse reactions or no response to all Formulary drugs. Medical exception policies provide access to non-formulary medications when Medical Necessity is established.

Definition of Restrictions

Icon	Restriction	Definition
	Age Restriction	A coverage limit based on minimum or maximum age of the member in order to ensure safety and effectiveness of treatments and drug dosage.
	Behavioral Health	<p>Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.</p>
	Sexually Transmitted Infections	<p>Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.</p>
	Diagnosis Code	Diagnosis Code.
	Excluded Drug	Benefit Exclusion Not a Covered Benefit.
	Generic Indicator	A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand name drug. Generally, generic drugs cost less than brand name drugs.

Icon	Restriction	Definition
	Insulin for Diabetes Cost Sharing Cap	<p>The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply.</p> <p>* High Deductible Health Plan copays/coinsurances will be applied towards the deductible <u>but your copay</u> will not exceed a total \$25.00* per thirty-day supply.</p>
	Limited Access	Limited Access.
	Non-Extended Day Supply	This drug is limited to a one-month supply.
	Note	Note
	Prior Authorization	Prior authorization is a clinical evaluation process to determine if the requested healthcare service is medically necessary, a covered benefit and if it is being delivered in the most appropriate health care setting. Our Medical Director or other clinical professional will review the requested healthcare service and, if it meets our requirements for coverage and medical necessity, it is authorized (approved) before those services are provided.
	Quantity Limit	<p>Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your doctor and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian Health Plan and Presbyterian Insurance Company uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following:</p> <ul style="list-style-type: none"> • Maximum Daily Dose limits quantities to a maximum number of dosage units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a single day. Limits are based on daily dosages shown to be safe and effective, and that are approved by the FDA.
	Quantity Limit (Over Time)	Quantity Limits Over Time limits quantities to number of units (i.e., tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time
	Schedule II Max Days	Schedule II maximum of 30-day supply.
	Specialty Pharmacy	Most Specialty pharmaceuticals require prior authorization and must be obtained through the Specialty Pharmacy network. Specialty pharmaceuticals are often high cost, typically greater than \$600 for up to a 30-day supply. Specialty pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply. Certain Specialty

Icon	Restriction	Definition
		pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.
	Split Fill - New Starts	Certain specialty pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.
	Step Therapy	Step therapy promotes the appropriate use of equally effective but lower-cost Formulary drugs first. With this program, prior use of one or more "prerequisite" drugs is required before a Step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drug.

Can the Formulary change during the year?

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

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

If we remove drugs from our Formulary, add quantity limits, prior authorization, and/or step therapy restrictions on a drug; or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective.

What if my drug is not Covered?

You or your doctor can ask us to make an exception (**prior authorization**) to our coverage rules. We will work with your prescriber to get additional information to support your request. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our Formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

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

Prior Authorization Request Processing Times

Standard Pharmacy Prior Authorization Requests

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

Expedited Pharmacy Prior Authorization Requests

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

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

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

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

Disclaimers

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

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

Presbyterian Insurance Company Commercial: (505) 923 -6980 or 1-800-923-6980

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

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

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

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

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

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

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

Drug Name	Tier	Notes
*ANTI-OBESITY AGENT COMBINATIONS**		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG	3	QL (120 EA per 30 days)
*DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)***		
SUNOSI ORAL TABLET 150 MG, 75 MG	4	PA; QL (30 EA per 30 days); AL (Min 18 Years)
*HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS***		
WAKIX ORAL TABLET 17.8 MG	4	PA; LA; QL (60 EA per 30 days); AL (Min 6 Years); NDS
WAKIX ORAL TABLET 4.45 MG	4	PA; LA; QL (14 EA per 7 days); AL (Min 6 Years); NDS
*STIMULANTS - MISC.***		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg</i>	1	PA; QL (30 EA per 30 days)
<i>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</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	1	QL (30 EA per 30 days); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg</i>	1	QL (30 EA per 30 days); AL (Min 6 Years)
<i>methylphenidate hcl er (osm) oral tablet extended release 36 mg</i>	1	QL (60 EA per 30 days); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release 10 mg</i>	1	QL (60 EA per 30 days); AL (Min 6 Years)
<i>methylphenidate hcl er oral tablet extended release 20 mg</i>	1	QL (90 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
<i>methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 36 mg, 54 mg</i>	1	QL (30 EA per 30 days); AL (Min 6 Years)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	1	PA; QL (450 ML per 30 days); AL (Min 6 Years and Max 12 Years)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	1	PA; QL (180 ML per 30 days); AL (Min 6 Years and Max 12 Years)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	1	QL (90 EA per 30 days); AL (Min 3 Years)
<i>modafinil oral tablet 100 mg, 200 mg</i>	1	QL (30 EA per 30 days)
AMINOGLYCOSIDES		
*AMINOGLYCOSIDES***		
<i>neomycin sulfate oral tablet 500 mg</i>	1	
<i>paromomycin sulfate oral capsule 250 mg</i>	3	
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	4	NDS; SP
ANALGESICS - ANTI-INFLAMMATORY		
*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS***		
RINVOQ LQ ORAL SOLUTION 1 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (360 ML per 30 days); NDS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 365 days); NDS; SP
XELJANZ ORAL SOLUTION 1 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (300 ML per 30 days); AL (Min 2 Years and Max 12 Years); NDS; SP
XELJANZ ORAL TABLET 10 MG, 5 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG	4	PA; DX (Diagnosis Validation Required); QL (112 EA per 180 days); NDS; SP
*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES***		

Drug Name	Tier	Notes
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	4	PA; Coverage applies to approved products only. Covered NDCs: 55513-0482-01 and 555130482-02; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML	4	PA; Coverage applies to approved products only. Covered NDCs: 72511-0400-01 and 72511-0400-02.; DX (Diagnosis Validation Required); QL (3.2 EA per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	4	PA; Coverage applies to approved products only. Covered NDCs: 55513-0481-01 and 55513-0481-02; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	4	PA; Coverage applies to approved products only. Covered NDCs: 55513-0479-01 and 55513-0479-02; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML	4	PA; DX (Diagnosis Validation Required); QL (0.4 ML per 28 days); NDS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	4	PA; DX (Diagnosis Validation Required); QL (0.4 ML per 28 days); NDS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML	4	PA; DX (Diagnosis Validation Required); QL (0.8 EA per 28 days); NDS; SP
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	4	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; DX (Diagnosis Validation Required); QL (1 Kit per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (1 Kit per 28 days); NDS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML	4	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP

Drug Name	Tier	Notes
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-PED>=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-PED>=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (2 EA per 28 days); NDS; SP
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	4	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA-PSORIASIS/UEVIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	4	PA; QL (2 EA per 28 days); NDS; SP
*CYCLOOXYGENASE 2 (COX-2) INHIBITORS***		
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	1	QL (60 EA per 30 days)
*GOLD COMPOUNDS***		
RIDAURA ORAL CAPSULE 3 MG	2	
*INTERLEUKIN-6 RECEPTOR INHIBITORS***		
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML	4	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	4	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML	MB	PA; DX (Diagnosis Validation Required); SP
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	4	PA; DX (Diagnosis Validation Required); QL (3.6 ML per 28 days); NDS; SP
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	4	PA; DX (Diagnosis Validation Required); QL (3.6 ML per 28 days); NDS; SP
*NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS***		
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	3	

Drug Name	Tier	Notes
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)***		
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	1	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	1	
FENOPROFEN CALCIUM ORAL TABLET 600 MG	2	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	1	
<i>ibuprofen junior strength oral tablet chewable 100 mg</i>	1	
<i>ibuprofen lysine intravenous solution 10 mg/ml</i>	MB	
<i>ibuprofen oral suspension 100 mg/5ml</i>	1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	
<i>indomethacin er oral capsule extended release 75 mg</i>	1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	1	
<i>ketoprofen er oral capsule extended release 24 hour 200 mg</i>	1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	1	QL (20 EA per 30 days)
<i>meclofenamate sodium oral capsule 100 mg</i>	2	
MECLOFENAMATE SODIUM ORAL CAPSULE 50 MG	2	
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	
MOTRIN IB ORAL TABLET 200 MG	1	
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	
<i>naproxen oral suspension 125 mg/5ml</i>	1	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	
<i>oxaprozin oral tablet 600 mg</i>	1	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	1	
<i>sulindac oral tablet 150 mg, 200 mg</i>	1	
TOLMETIN SODIUM ORAL CAPSULE 400 MG	2	
TOLMETIN SODIUM ORAL TABLET 600 MG	2	
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS***		

Drug Name	Tier	Notes
OTEZLA ORAL TABLET 30 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
*PYRIMIDINE SYNTHESIS INHIBITORS***		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	1	
*SELECTIVE COSTIMULATION MODULATORS***		
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 30 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML	4	PA; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML	4	PA; DX (Diagnosis Validation Required); QL (2.8 ML per 28 days); NDS; SP
*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS***		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (2 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (2 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ANALGESICS - NONNARCOTIC		
*ANALGESICS OTHER***		
DURACLON EPIDURAL SOLUTION 100 MCG/ML	MB	
*ANALGESICS-SEDATIVES***		
<i>butalbital-apap-cafeine oral tablet 50-325-40 mg</i>	1	QL (6 EA per 1 day)
*SALICYLATES***		

Drug Name	Tier	Notes
aspirin 81 oral tablet chewable 81 mg	\$0	AL (Min 45 Years)
aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
<i>aspirin oral tablet chewable 81 mg</i>	1	AL (Min 45 Years and Max 79 Years)
aspirin oral tablet delayed release 325 mg, 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
Bayer Aspirin Oral Tablet 325 MG	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
childrens aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
cvs aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
<i>diflunisal oral tablet 500 mg</i>	1	
eq aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
gnp aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
gnp aspirin oral tablet delayed release 325 mg, 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
hm aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
hm aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
kp aspirin oral tablet delayed release 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
Medi-First Aspirin Oral Tablet 325 MG	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
Medique Aspirin Oral Tablet 325 MG	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
px aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
px aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
px enteric aspirin oral tablet delayed release 325 mg, 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
qc aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
qc aspirin oral tablet delayed release 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
qc childrens aspirin oral tablet chewable 81 mg	\$0	AL (Min 45 Years)
ra aspirin oral tablet 325 mg	\$0	AL (Min 45 Years)
<i>salsalate oral tablet 500 mg, 750 mg</i>	1	
sb aspirin oral tablet 325 mg	\$0	AL (Min 45 Years)
sb aspirin oral tablet delayed release 81 mg	\$0	AL (Min 45 Years)
sb childrens aspirin oral tablet chewable 81 mg	\$0	AL (Min 45 Years)

Drug Name	Tier	Notes
sm aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
sm childrens aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
St Joseph Aspirin Oral Tablet Delayed Release 81 MG	\$0	\$0 copay per PPACA guidelines.; AL (Min 45 Years)
ANALGESICS - OPIOID		
*CODEINE COMBINATIONS***		
<i>acetaminophen-codeine #2 oral tablet 300-15 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (13 EA per 1 day); AL (Min 12 Years)
<i>acetaminophen-codeine #3 oral tablet 300-30 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (13 EA per 1 day); AL (Min 12 Years)
<i>acetaminophen-codeine #4 oral tablet 300-60 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (13 EA per 1 day); AL (Min 12 Years)
<i>acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (166 ML per 1 day); AL (Min 12 Years)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (13 EA per 1 day); AL (Min 12 Years)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (6 EA per 1 day); AL (Min 12 Years)
<i>butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (6 EA per 1 day); AL (Min 12 Years)
*HYDROCODONE COMBINATIONS***		
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	1	QL (180 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	QL (12 EA per 1 day)
*OPIOID AGONISTS***		

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

Drug Name	Tier	Notes
<i>tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg</i>	3	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (30 EA per 30 days); AL (Min 12 Years)
<i>tramadol hcl oral tablet 50 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (240 EA per 30 days); AL (Min 12 Years)
*OPIOID COMBINATIONS***		
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	QL (12 EA per 1 day)
<i>oxycodone-aspirin oral tablet 4.8355-325 mg</i>	1	QL (180 EA per 30 days)
*OPIOID PARTIAL AGONISTS***		
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION REFILLED SYRINGE 16 MG/0.32ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.28 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION REFILLED SYRINGE 24 MG/0.48ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.92 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION REFILLED SYRINGE 32 MG/0.64ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.56 ML per 28 days)

Drug Name	Tier	Notes
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.16ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.64 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.36 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 64 MG/0.18ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.18 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 96 MG/0.27ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.27 ML per 28 days)
BUPRENEX INJECTION SOLUTION 0.3 MG/ML	MB	
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	3	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3 EA per 1 day); AL (Min 16 Years)

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

Drug Name	Tier	Notes
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 16 Years)
<i>butorphanol tartrate injection solution 1 mg/ml</i>	MB	
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	3	
<i>nalbuphine hcl injection solution 10 mg/ml, 20 mg/ml</i>	1	
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.5 ML per 30 days); NDS
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/1.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.5 ML per 30 days); NDS
*TRAMADOL COMBINATIONS***		
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; QL (300 EA per 30 days); AL (Min 12 Years)
ANDROGENS-ANABOLIC		
*ANDROGENS***		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR	3	PA; QL (60 EA per 30 days)
ANDRODERM TRANSDERMAL PATCH 24 HOUR 4 MG/24HR	3	PA; QL (30 EA per 30 days)
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	1	

Drug Name	Tier	Notes
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	1	
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	2	
<i>testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%)</i>	3	QL (150 GM per 30 days)
<i>testosterone transdermal gel 10 mg/act (2%)</i>	3	QL (120 GM per 30 days)
<i>testosterone transdermal gel 12.5 mg/act (1%), 50 mg/5gm (1%)</i>	1	QL (300 GM per 30 days)
<i>testosterone transdermal gel 20.25 mg/1.25gm (1.62%)</i>	3	QL (75 GM per 30 days)
<i>testosterone transdermal gel 25 mg/2.5gm (1%)</i>	1	QL (75 GM per 30 days)
ANORECTAL AND RELATED PRODUCTS		
*INTRARECTAL STEROIDS***		
<i>hydrocortisone rectal enema 100 mg/60ml</i>	1	
*RECTAL ANESTHETIC/STEROIDS***		
<i>lidocaine-hydrocort (perianal) external cream 3-0.5 %</i>	1	
PROCTOFOAM HC EXTERNAL FOAM 1-1 %	2	
*RECTAL STEROIDS***		
<i>hydrocortisone (perianal) external cream 2.5 %</i>	1	
PROCTO-MED HC EXTERNAL CREAM 2.5 %	1	
PROCTOZONE-HC EXTERNAL CREAM 2.5 %	1	
ANTHELMINTICS		
*ANTHELMINTICS***		
<i>albendazole oral tablet 200 mg</i>	4	
BILTRICIDE ORAL TABLET 600 MG	3	
<i>ivermectin oral tablet 3 mg</i>	3	QL (30 EA per 90 days)
ANTIANGINAL AGENTS		
*ANTIANGINALS-OTHER***		
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	3	ST
*NITRATES***		
DILATRATE-SR ORAL CAPSULE EXTENDED RELEASE 40 MG	2	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>isosorbide dinitrate oral tablet 30 mg</i>	2	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	1	

Drug Name	Tier	Notes
MINITRAN TRANSDERMAL PATCH 24 HOUR 0.6 MG/HR	1	
NITRO-BID TRANSDERMAL OINTMENT 2 %	2	
<i>nitroglycerin er oral capsule extended release 2.5 mg</i>	2	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg</i>	1	
<i>nitroglycerin sublingual tablet sublingual 0.6 mg</i>	2	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr</i>	1	
ANTIANXIETY AGENTS		
*ANTIANXIETY AGENTS - MISC.***		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

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

Drug Name	Tier	Notes
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
<i>alprazolam oral tablet 2 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (135 EA per 30 days)
<i>alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>alprazolam xr oral tablet extended release 24 hour 3 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)

Drug Name	Tier	Notes
<i>clorazepate dipotassium oral tablet 15 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
<i>diazepam oral tablet 10 mg, 2 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
<i>diazepam oral tablet 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); NDS
<i>lorazepam injection solution 2 mg/ml, 4 mg/ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.5 ML per 1 day)

Drug Name	Tier	Notes
<i>lorazepam oral concentrate 2 mg/ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
ANTIARRHYTHMICS		
*ANTIARRHYTHMICS - MISC.***		
ADENOCARD INTRAVENOUS SOLUTION 6 MG/2ML	MB	
*ANTIARRHYTHMICS TYPE I-A***		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	1	
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	1	
QUINIDINE SULFATE ORAL TABLET 200 MG, 300 MG	1	
*ANTIARRHYTHMICS TYPE I-B***		
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	1	
*ANTIARRHYTHMICS TYPE I-C***		
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	1	
*ANTIARRHYTHMICS TYPE III***		
<i>amiodarone hcl intravenous solution 150 mg/3ml</i>	1	

Drug Name	Tier	Notes
<i>amiodarone hcl oral tablet 200 mg, 400 mg</i>	1	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	3	
MULTAQ ORAL TABLET 400 MG	3	PA; QL (60 EA per 30 days)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
*5-LIPOXYGENASE INHIBITORS***		
<i>zileuton er oral tablet extended release 12 hour 600 mg</i>	4	PA; QL (120 EA per 30 days); NDS; SP
*ADRENERGIC COMBINATIONS***		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	2	QL (60 EA per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	3	QL (8 GM per 30 days)
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT	3	ST; QL (13 GM per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	3	QL (60 EA per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act</i>	2	QL (1 EA per 30 days)
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	2	QL (4 GM per 30 days)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT	2	QL (10.2 GM per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	2	PA; QL (60 EA per 30 days)
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	3	QL (60 EA per 30 days)
*ANTI-IGE MONOCLONAL ANTIBODIES***		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; NDS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; NDS; SP
*ANTI-INFLAMMATORY AGENTS***		
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	
*BETA ADRENERGICS***		
<i>albuterol sulfate er oral tablet extended release 12 hour 4 mg, 8 mg</i>	1	

Drug Name	Tier	Notes
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	1	Formulary NDCs/Manufactures: Ventolin HFA: 00173-0682-20 (Glaxo Smith Kline)Generic Proventil HFA: 69097-0142-60 (Cipla US); 00254-1007-52 (PAR Pharmaceutical) / Generic Proair HFA: 00093-3174-31(Teva); 68180-0963-01 (Lupin Pharmaceuticals); 45802-0088-01 (Perrigo Pharmaceuticals)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml</i>	1	
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	1	
<i>isoproterenol hcl injection solution 0.2 mg/ml</i>	MB	
<i>levalbuterol tartrate inhalation aerosol 45 mcg/act</i>	3	QL (30 GM per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/DOSE	2	
<i>terbutaline sulfate injection solution 1 mg/ml</i>	1	
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	1	
VENTOLIN HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION	2	Formulary NDCs/Manufactures: Ventolin HFA: 00173-0682-20 (Glaxo Smith Kline)Generic Proventil HFA: 69097-0142-60 (Cipla US); 00254-1007-52 (PAR Pharmaceutical) / Generic Proair HFA: 00093-3174-31(Teva); 68180-0963-01 (Lupin Pharmaceuticals); 45802-0088-01 (Perrigo Pharmaceuticals)
*BRONCHODILATORS - ANTICHOLINERGICS***		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	2	
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	2	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	2	
*LEUKOTRIENE RECEPTOR ANTAGONISTS***		
<i>montelukast sodium oral tablet 10 mg</i>	1	QL (30 EA per 30 days)
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	1	QL (30 EA per 30 days)
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	1	
*SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS***		

Drug Name	Tier	Notes
<i>roflumilast oral tablet 500 mcg</i>	2	PA; QL (30 EA per 30 days)
*STEROID INHALANTS***		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	2	QL (30 EA per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1	QL (120 ML per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act</i>	2	
<i>fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act</i>	2	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT	3	
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT	3	QL (10.6 GM per 30 days)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT	3	QL (21.2 GM per 30 days)
*XANTHINES***		
<i>aminophylline intravenous solution 25 mg/ml</i>	MB	
ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML	2	
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	2	
<i>theophylline er oral tablet extended release 12 hour 450 mg</i>	1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	
ANTICOAGULANTS		
*COUMARIN ANTICOAGULANTS***		
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	
*DIRECT FACTOR XA INHIBITORS***		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	2	QL (74 EA per 365 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	2	QL (60 EA per 30 days)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	2	
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	2	QL (30 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG	2	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	2	QL (102 EA per 365 days)
*HEPARINS AND HEPARINOID-LIKE AGENTS***		

Drug Name	Tier	Notes
BD HEPARIN POSIFLUSH INTRAVENOUS SOLUTION 10 UNIT/ML, 100 UNIT/ML	1	
<i>heparin na (pork) lock flush intravenous solution 1 unit/ml, 10 unit/ml, 100 unit/ml</i>	1	
<i>heparin sod (pork) lock flush intravenous solution 1 unit/ml, 10 unit/ml, 100 unit/ml</i>	1	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml</i>	1	
<i>heparin sodium (porcine) injection solution 20000 unit/ml</i>	3	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml</i>	1	
*LOW MOLECULAR WEIGHT HEPARINS***		
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	1	PA
<i>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</i>	1	PA
<i>enoxaparin sodium subcutaneous solution 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</i>	1	PA
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNIT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML	4	PA; QL (30 Syringes per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML	4	PA; QL (30 ML per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNIT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML	4	PA; QL (30 Syringes per 30 days)
*SYNTHETIC HEPARINOID-LIKE AGENTS***		
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	4	PA
*THROMBIN INHIBITORS - HIRUDIN TYPE***		
ANGIOMAX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	4	
*THROMBIN INHIBITORS - SELECTIVE DIRECT & REVERSIBLE***		
<i>argatroban in sodium chloride intravenous solution 50-0.9 mg/50ml-%</i>	MB	
ANTICONSULSANTS		

Drug Name	Tier	Notes
*ANTICONVULSANTS - BENZODIAZEPINES***		
<i>clobazam oral suspension 2.5 mg/ml</i>	3	ST; QL (8 ML per 1 day)
<i>clobazam oral tablet 10 mg, 20 mg</i>	3	ST; QL (2 EA per 1 day)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	QL (90 EA per 30 days)
<i>clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	QL (90 EA per 30 days)
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	2	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (5 EA per 30 days); AL (Max 17 Years)
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	4	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (10 Delivery Systems per 30 days)
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	4	ST; QL (10 EA per 30 days); AL (Min 2 Years)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML	4	ST; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML	4	PA; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML	4	PA; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML	4	ST; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	4	ST; QL (10 EA per 30 days); AL (Min 2 Years)
*ANTICONVULSANTS - MISC.***		

Drug Name	Tier	Notes
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>carbamazepine oral suspension 100 mg/5ml</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>carbamazepine oral tablet 200 mg</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>carbamazepine oral tablet chewable 100 mg, 200 mg</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>

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

Drug Name	Tier	Notes
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	3	QL (120 EA per 30 days)
<i>levetiracetam oral solution 100 mg/ml, 500 mg/5ml</i>	1	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	1	
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>primidone oral tablet 250 mg, 50 mg</i>	1	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	
*CARBAMATES***		
<i>felbamate oral suspension 600 mg/5ml</i>	3	QL (900 ML per 30 days)
<i>felbamate oral tablet 400 mg</i>	3	QL (90 EA per 30 days)
<i>felbamate oral tablet 600 mg</i>	4	QL (180 EA per 30 days)
*GABA MODULATORS***		
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	3	
*HYDANTOINS***		

Drug Name	Tier	Notes
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG	2	
DILANTIN ORAL CAPSULE 30 MG	3	
<i>phenytoin oral suspension 125 mg/5ml</i>	1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	1	
*SUCCINIMIDES***		
<i>ethosuximide oral capsule 250 mg</i>	1	
<i>ethosuximide oral solution 250 mg/5ml</i>	1	
*VALPROIC ACID***		
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>valproic acid oral capsule 250 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDEPRESSANTS		
*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)***		

Drug Name	Tier	Notes
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*ANTIDEPRESSANTS - MISC.***		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
MAPROTILINE HCL ORAL TABLET 25 MG, 50 MG, 75 MG	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*MONOAMINE OXIDASE INHIBITORS (MAOIS)***		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>phenelzine sulfate oral tablet 15 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>tranylcypromine sulfate oral tablet 10 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
*N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS***		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	MB	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); NDS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	MB	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); NDS
*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)***		
<i>citalopram hydrobromide oral solution 10 mg/5ml, 20 mg/10ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (600 ML per 30 days)
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

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

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

Drug Name	Tier	Notes
<i>paroxetine hcl oral tablet 40 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
<i>sertraline hcl oral concentrate 20 mg/ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>sertraline hcl oral tablet 100 mg, 25 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>sertraline hcl oral tablet 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
*SEROTONIN MODULATORS***		
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)***		
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)

Drug Name	Tier	Notes
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 37.5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 EA per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3 EA per 1 day)
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*TRICYCLIC AGENTS***		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

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

Drug Name	Tier	Notes
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDIABETICS		
*ALPHA-GLUCOSIDASE INHIBITORS***		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	1	
*ANTIDIABETIC - AMYLIN ANALOGS***		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML	3	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML	3	PA
*BIGUANIDES***		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	1	
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	1	
*DIABETIC OTHER***		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	2	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	2	
GVOKE HYOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	2	
GVOKE HYOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	2	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML	2	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML	2	
*DIEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS***		
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	2	ST; QL (30 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	2	ST; QL (30 EA per 30 days)
<i>saxagliptin hcl oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (30 EA per 30 days)
*DIEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS***		

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

Drug Name	Tier	Notes
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
HUMALOG MIX 75/25 PEN SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
HUMALOG MIX 75/25 PEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
HUMALOG PEN SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
HUMALOG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
HUMALOG SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	ST; QL (45 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	ST; QL (50 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	ST; QL (45 ML per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	ST; QL (50 ML per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	3	ST; QL (50 ML per 30 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	3	PA; QL (1 ML per 1 day)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	3	PA; QL (18 ML per 30 days)
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i>	2	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total \$25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

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

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

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

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

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

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

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

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

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

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

Drug Name	Tier	Notes
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	3	
*SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS***		
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG	2	ST; QL (30 EA per 30 days)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS***		
FARXIGA ORAL TABLET 10 MG, 5 MG	2	ST; QL (30 EA per 30 days)
STEGLATRO ORAL TABLET 15 MG, 5 MG	2	ST; QL (30 EA per 30 days)
*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB***		
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG	2	ST; QL (60 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG	2	ST; QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	2	ST; QL (60 EA per 30 days)
*SULFONYLUREA-BIGUANIDE COMBINATIONS***		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
*SULFONYLUREAS***		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	1	
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	1	
TOLBUTAMIDE ORAL TABLET 500 MG	2	
*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS***		
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	1	ST
*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS***		
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	ST
*THIAZOLIDINEDIONES***		
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	1	QL (30 EA per 30 days)
ANTIDIARRHEAL/PROBIOTIC AGENTS		

Drug Name	Tier	Notes
*ANTIPERISTALTIC AGENTS***		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	2	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	1	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
*ANTIDOTES AND SPECIFIC ANTAGONISTS***		
ACETADOTE INTRAVENOUS SOLUTION 200 MG/ML	MB	
ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	
<i>bal in oil intramuscular solution 100 mg/ml</i>	MB	
<i>calcium disodium versenate injection solution 1 gm/5ml</i>	MB	
DESFERAL INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
DIGIFAB INTRAVENOUS SOLUTION RECONSTITUTED 40 MG	MB	
<i>fomepizole intravenous solution 1.5 gm/1.5ml</i>	MB	
*OPIOID ANTAGONISTS***		
<i>naloxone hcl injection solution 0.4 mg/ml</i>	1	<p>Naloxone injectable used with nasal atomizer is covered.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 ML per 30 days)</p>
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>

Drug Name	Tier	Notes
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>naltrexone hcl oral tablet 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 28 days); NDS
ANTIEMETICS		
*5-HT3 RECEPTOR ANTAGONISTS***		
ANZEMET ORAL TABLET 100 MG, 50 MG	3	PA; QL (4 EA per 30 days)
<i>granisetron hcl oral tablet 1 mg</i>	1	ST; QL (20 EA per 30 days)
<i>ondansetron hcl oral solution 4 mg/5ml</i>	1	AL (Max 4 Years)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	QL (90 EA per 30 days)
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	1	QL (90 EA per 30 days)
<i>palonosetron hcl intravenous solution 0.25 mg/2ml</i>	MB	QL (2 ML per 5 days)
*ANTIEMETICS - ANTICHOLINERGIC***		
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	3	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	1	
*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS***		
<i>aprepitant oral capsule 125 mg, 40 mg</i>	3	PA; QL (1 EA per 30 days)
<i>aprepitant oral capsule 80 & 125 mg, 80 mg</i>	3	PA; QL (3 EA per 30 days)
CINVANTI INTRAVENOUS EMULSION 130 MG/18ML	MB	PA

Drug Name	Tier	Notes
EMEND INTRAVENOUS SOLUTION RECONSTITUTED 150 MG	MB	PA
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML	4	PA; QL (6 EA per 28 days)
ANTIFUNGALS		
*ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)***		
<i>caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg</i>	MB	
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG	MB	
<i>micafungin sodium intravenous solution reconstituted 100 mg</i>	MB	
*ANTIFUNGALS***		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	MB	
AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG	MB	
<i>amphotericin b liposome intravenous suspension reconstituted 50 mg</i>	MB	
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	1	
<i>nystatin oral tablet 500000 unit</i>	1	
<i>terbinafine hcl oral tablet 250 mg</i>	1	QL (90 EA per 365 days)
*IMIDAZOLES***		
<i>ketoconazole oral tablet 200 mg</i>	1	
*TRIAZOLES***		
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%</i>	MB	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>itraconazole oral capsule 100 mg</i>	3	ST; QL (168 EA per 365 days)
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	3	PA; QL (150 ML per 14 days)
<i>voriconazole oral tablet 200 mg</i>	3	PA; QL (60 EA per 30 days)
<i>voriconazole oral tablet 50 mg</i>	1	PA; QL (60 EA per 30 days)

Drug Name	Tier	Notes
ANTI HISTAMINES		
*ANTI HISTAMINES - ETHANOLAMINES***		
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*ANTI HISTAMINES - PHENOTHIAZINES***		
<i>promethazine hcl injection solution 25 mg/ml, 50 mg/ml</i>	1	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	
*ANTI HISTAMINES - PIPERIDINES***		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	
ANTI HYPERLIPIDEMICS		
*ANTI HYPERLIPIDEMICS - MISC.***		
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	3	QL (120 EA per 30 days)
*BILE ACID SEQUESTRANTS***		
<i>cholestyramine light oral packet 4 gm</i>	1	
<i>cholestyramine light oral powder 4 gm/dose</i>	1	
<i>cholestyramine oral packet 4 gm</i>	1	
<i>cholestyramine oral powder 4 gm/dose</i>	1	
<i>colesevelam hcl oral packet 3.75 gm</i>	4	QL (30 EA per 30 days)
<i>colesevelam hcl oral tablet 625 mg</i>	1	
PREVALITE ORAL PACKET 4 GM	1	
PREVALITE ORAL POWDER 4 GM/DOSE	1	
*FIBRIC ACID DERIVATIVES***		
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	1	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	1	
<i>gemfibrozil oral tablet 600 mg</i>	1	
*HMG COA REDUCTASE INHIBITORS***		

Drug Name	Tier	Notes
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	\$0	QL (30 EA per 30 days)
fluvastatin sodium oral capsule 20 mg, 40 mg	3	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	\$0	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	\$0	
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	\$0	
*INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB***		
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	3	
*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS***		
ezetimibe oral tablet 10 mg	1	
*NICOTINIC ACID DERIVATIVES***		
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	1	
*PCSK9 INHIBITORS***		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML	2	PA; QL (3.5 ML per 28 days); NDS
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	2	PA; QL (2 ML per 28 days); NDS
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	2	PA; QL (2 ML per 30 days); NDS
ANTIHYPERTENSIVES		
*ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS***		
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	
*ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE***		
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	1	
CAPTOPRIL-HYDROCHLOROTHIAZIDE ORAL TABLET 25-15 MG, 25-25 MG, 50-15 MG, 50-25 MG	2	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	

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

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

Drug Name	Tier	Notes
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	1	
ANTI-INFECTIVE AGENTS - MISC.		
*ANTI-INFECTIVE AGENTS - MISC.***		
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
PENTAM INJECTION SOLUTION RECONSTITUTED 300 MG	4	NDS
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	3	QL (1 Vial per 28 days)
<i>trimethoprim oral tablet 100 mg</i>	1	
XIFAXAN ORAL TABLET 200 MG	4	PA; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	4	PA; QL (60 EA per 30 days)
*ANTI-INFECTIVE MISC. - COMBINATIONS***		
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*ANTIPROTOZOAL AGENTS***		

Drug Name	Tier	Notes
<i>atovaquone oral suspension 750 mg/5ml</i>	1	
*CARBAPENEM COMBINATIONS***		
PRIMAXIN IV INTRAVENOUS SOLUTION RECONSTITUTED 500-500 MG	MB	
*CARBAPENEMS***		
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	MB	
INVANZ INJECTION SOLUTION RECONSTITUTED 1 GM	MB	
*CHLORAMPHENICALS***		
<i>chloramphenicol sod succinate intravenous solution reconstituted 1 gm</i>	MB	
*CYCLIC LIPOPEPTIDES***		
CUBICIN RF INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
*GLYCOPEPTIDES***		
<i>vancomycin hcl intravenous solution reconstituted 500 mg</i>	1	
<i>vancomycin hcl oral capsule 125 mg</i>	3	QL (56 EA per 14 days)
<i>vancomycin hcl oral capsule 250 mg</i>	3	PA; QL (80 EA per 30 days)
<i>vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml</i>	2	QL (300 ML per 14 days)
*LEPROSTATICS***		
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
*LINCOSAMIDES***		
<i>clindamycin hcl oral capsule 150 mg, 300 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>clindamycin hcl oral capsule 75 mg</i>	1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	1	
*MONOBACTAMS***		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	4	PA; QL (84 ML per 56 days); SP
*OXAZOLIDINONES***		

Drug Name	Tier	Notes
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	3	PA
<i>linezolid oral tablet 600 mg</i>	3	PA
*POLYMYXINS***		
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	MB	
*URINARY ANTI-INFECTIVES***		
<i>methenamine hippurate oral tablet 1 gm</i>	1	
METHENAMINE MANDELATE ORAL TABLET 0.5 GM	2	
<i>methenamine mandelate oral tablet 1 gm</i>	1	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	1	
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	3	QL (560 ML per 7 days); AL (Max 12 Years)
ANTIMALARIALS		
*ANTIMALARIALS***		
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	1	
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg, 26.3 mg</i>	2	
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
*ANTIMYASTHENIC/CHOLINERGIC AGENTS***		
FIRDAPSE ORAL TABLET 10 MG	4	PA; LA; QL (240 EA per 30 days); NDS; SP
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	3	
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	
ANTIMYCOBACTERIAL AGENTS		
*ANTIMYCOBACTERIAL AGENTS***		
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	1	
ISONIAZID ORAL SYRUP 50 MG/5ML	2	
<i>isoniazid oral tablet 100 mg</i>	1	
<i>isoniazid oral tablet 300 mg</i>	2	
PASER ORAL PACKET 4 GM	1	
PRIFTIN ORAL TABLET 150 MG	3	
<i>pyrazinamide oral tablet 500 mg</i>	2	
<i>rifabutin oral capsule 150 mg</i>	3	

Drug Name	Tier	Notes
<i>rifampin oral capsule 150 mg, 300 mg</i>	1	
TRECTOR ORAL TABLET 250 MG	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
*ALKYLATING AGENTS***		
MYLERAN ORAL TABLET 2 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED 4 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANDROGEN BIOSYNTHESIS INHIBITORS***		
<i>abiraterone acetate oral tablet 250 mg</i>	3	QL (120 EA per 30 days)
*ANTIADRENALS***		
LYSODREN ORAL TABLET 500 MG	4	
*ANTIANDROGENS***		
<i>bicalutamide oral tablet 50 mg</i>	1	DX (Diagnosis Validation Required)
ERLEADA ORAL TABLET 240 MG	4	PA; DX (Diagnosis Validation Required); QL (1 EA per 1 day); SP
ERLEADA ORAL TABLET 60 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
<i>flutamide oral capsule 125 mg</i>	1	DX (Diagnosis Validation Required)
NUBEQA ORAL TABLET 300 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
XTANDI ORAL CAPSULE 40 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP
XTANDI ORAL TABLET 40 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
XTANDI ORAL TABLET 80 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); SP
*ANTIESTROGENS***		
FARESTON ORAL TABLET 60 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	1	DX (Diagnosis Validation Required)
*ANTIMETABOLITES***		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	3	DX (Diagnosis Validation Required); NDS
DACOGEN INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA; DX (Diagnosis Validation Required)
<i>mercaptopurine oral tablet 50 mg</i>	1	DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
<i>methotrexate oral tablet 2.5 mg</i>	1	DX (Diagnosis Validation Required)
<i>methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml</i>	1	DX (Diagnosis Validation Required)
<i>methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml</i>	1	DX (Diagnosis Validation Required)
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	1	DX (Diagnosis Validation Required)
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	DX (Diagnosis Validation Required)
TABLOID ORAL TABLET 40 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	2	DX (Diagnosis Validation Required)
XATMEP ORAL SOLUTION 2.5 MG/ML	4	PA; DX (Diagnosis Validation Required); AL (Max 12 Years)
*ANTINEOPLASTIC - ALK INHIBITORS***		
ALECENSA ORAL CAPSULE 150 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (240 EA per 30 days); NDS
ALUNBRIG ORAL TABLET 180 MG, 90 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
ALUNBRIG ORAL TABLET 30 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS
LORBRENA ORAL TABLET 100 MG, 25 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
XALKORI ORAL CAPSULE 200 MG, 250 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); SP
*ANTINEOPLASTIC - ANTI-BCMA ANTIBODY-DRUG COMPLEX***		
BLENREP INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Diagnosis Validation Required)
*ANTINEOPLASTIC - ANTI-CCR4 ANTIBODIES***		
POTELIGEO INTRAVENOUS SOLUTION 20 MG/5ML	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES***		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	PA; DX (Diagnosis Validation Required); NDS

Drug Name	Tier	Notes
*ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES***		
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA; DX (Diagnosis Validation Required)
*ANTINEOPLASTIC - ANTI-CD22 ANTIBODIES***		
LUMOXITI INTRAVENOUS SOLUTION RECONSTITUTED 1 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX***		
BESPONSA INTRAVENOUS SOLUTION RECONSTITUTED 0.9 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX***		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED 4.5 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES***		
DARZALEX INTRAVENOUS SOLUTION 100 MG/5ML, 400 MG/20ML	MB	PA; DX (Diagnosis Validation Required)
SARCLISA INTRAVENOUS SOLUTION 100 MG/5ML, 500 MG/25ML	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX***		
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 140 MG	MB	PA; DX (Diagnosis Validation Required)
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 30 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-HER2 AGENTS***		
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	MB	DX (Diagnosis Validation Required)
TUKYSA ORAL TABLET 150 MG, 50 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS
*ANTINEOPLASTIC - ANTI-NECTIN-4 ANTIBODY-DRUG COMPLEX***		
PADCEV INTRAVENOUS SOLUTION RECONSTITUTED 20 MG, 30 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES***		
OPDIVO INTRAVENOUS SOLUTION 120 MG/12ML, 240 MG/24ML	MB	PA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
TEVIMBRA INTRAVENOUS SOLUTION 100 MG/10ML	MB	PA
*ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES***		
BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML	MB	PA; DX (Diagnosis Validation Required); NDS
IMFINZI INTRAVENOUS SOLUTION 120 MG/2.4ML, 500 MG/10ML	MB	PA; DX (Diagnosis Validation Required); NDS
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES***		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED 300 MG, 400 MG	MB	PA; DX (Diagnosis Validation Required)
*ANTINEOPLASTIC - BCL-2 INHIBITORS***		
VENCLEXTA ORAL TABLET 10 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days)
VENCLEXTA ORAL TABLET 100 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (1 PK per 28 days); NDS
*ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS***		
BOSULIF ORAL CAPSULE 100 MG	4	PA; QL (3 EA per 1 day); SP
BOSULIF ORAL TABLET 100 MG	4	PA; QL (90 EA per 30 days); SP
BOSULIF ORAL TABLET 400 MG, 500 MG	4	PA; QL (30 EA per 30 days); SP
<i>dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg</i>	4	PA; QL (30 EA per 30 days); NDS; SP
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	4	PA; LA; QL (30 EA per 30 days); NDS; SP
<i>imatinib mesylate oral tablet 100 mg, 400 mg</i>	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
<i>nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg</i>	4	PA; QL (120 EA per 30 days); NDS; SP
*ANTINEOPLASTIC - BRAF KINASE INHIBITORS***		
BRAFTOVI ORAL CAPSULE 75 MG	4	PA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
ZELBORAF ORAL TABLET 240 MG	4	PA; DX (Diagnosis Validation Required); QL (240 EA per 30 days); NDS; SP
*ANTINEOPLASTIC - BTK INHIBITORS***		
BRUKINSA ORAL CAPSULE 80 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
CALQUENCE ORAL CAPSULE 100 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
CALQUENCE ORAL TABLET 100 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (1 EA per 1 day); NDS
IMBRUVICA ORAL SUSPENSION 70 MG/ML	4	PA; LA; DX (Diagnosis Validation Required); QL (6 ML per 1 day); NDS
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (28 EA per 28 days); NDS
JAYPIRCA ORAL TABLET 100 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); SP
JAYPIRCA ORAL TABLET 50 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
*ANTINEOPLASTIC - EGFR INHIBITORS***		
ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML, 200 MG/100ML	MB	PA; DX (Diagnosis Validation Required)
<i>erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg</i>	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
<i>gefitinib oral tablet 250 mg</i>	4	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS
TAGRISSO ORAL TABLET 40 MG, 80 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP

Drug Name	Tier	Notes
*ANTINEOPLASTIC - FGFR KINASE INHIBITORS***		
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (14 EA per 21 days); NDS
*ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS***		
DAURISMO ORAL TABLET 100 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
DAURISMO ORAL TABLET 25 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); SP
ERIVEDGE ORAL CAPSULE 150 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
ODOMZO ORAL CAPSULE 200 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS***		
FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (6 EA per 21 days); NDS
ZOLINZA ORAL CAPSULE 100 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP
*ANTINEOPLASTIC - IMMUNOMODULATORS***		
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	4	PA; DX (Diagnosis Validation Required); QL (21 EA per 28 days); NDS; SP
*ANTINEOPLASTIC - KRAS INHIBITORS***		
KRAZATI ORAL TABLET 200 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS
LUMAKRAS ORAL TABLET 120 MG	4	PA; DX (Diagnosis Validation Required); QL (240 EA per 30 days); NDS; SP
LUMAKRAS ORAL TABLET 320 MG	4	PA; DX (Diagnosis Validation Required); QL (3 EA per 1 day); SP
*ANTINEOPLASTIC - MEK INHIBITORS***		

Drug Name	Tier	Notes
MEKINIST ORAL TABLET 0.5 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS; SP
MEKINIST ORAL TABLET 2 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
MEKTOVI ORAL TABLET 15 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS
*ANTINEOPLASTIC - MET INHIBITORS***		
TABRECTA ORAL TABLET 150 MG, 200 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
*ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS***		
TAZVERIK ORAL TABLET 200 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (240 EA per 30 days); NDS
*ANTINEOPLASTIC - MTOR KINASE INHIBITORS***		
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	4	PA; DX (Diagnosis Validation Required); SP
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	4	PA; DX (Diagnosis Validation Required); NDS; SP
<i>temsirolimus intravenous solution 25 mg/ml</i>	MB	DX (Diagnosis Validation Required)
*ANTINEOPLASTIC - MULTIKINASE INHIBITORS***		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
CAPRELSA ORAL TABLET 100 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS
CAPRELSA ORAL TABLET 300 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	4	PA; LA; DX (Diagnosis Validation Required); NDS
<i>lapatinib ditosylate oral tablet 250 mg</i>	4	PA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS; SP
NERLYNX ORAL TABLET 40 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS; SP
<i>pazopanib hcl oral tablet 200 mg</i>	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP

Drug Name	Tier	Notes
QINLOCK ORAL TABLET 50 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS
RYDAPT ORAL CAPSULE 25 MG	4	PA; QL for AML=120/30QL for ASM, SM, AHN, and MCL= 240/30; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
<i>sorafenib tosylate oral tablet 200 mg</i>	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP
STIVARGA ORAL TABLET 40 MG	4	PA; DX (Diagnosis Validation Required); QL (84 EA per 28 days); NDS; SP
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	4	PA; DX (Diagnosis Validation Required); SP
UKONIQ ORAL TABLET 200 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS
XOSPATA ORAL TABLET 40 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS
*ANTINEOPLASTIC - MULTIPLE RECEPTOR ANTIBODIES***		
RYBREVA NT INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; DX (Diagnosis Validation Required)
*ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS***		
AYVAKIT ORAL TABLET 100 MG, 200 MG, 300 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
*ANTINEOPLASTIC - PROTEASOME INHIBITORS***		
<i>bortezomib injection solution reconstituted 3.5 mg</i>	MB	DX (Diagnosis Validation Required)
*ANTINEOPLASTIC - RET INHIBITORS***		
RETEVMO ORAL CAPSULE 40 MG	4	PA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS; SP
RETEVMO ORAL CAPSULE 80 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (2 EA per 1 day); NDS
RETEVMO ORAL TABLET 40 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (3 EA per 1 day); NDS
*ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS***		

Drug Name	Tier	Notes
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	4	PA; DX (Diagnosis Validation Required); SP
*ANTINEOPLASTIC - XPO1 INHIBITORS***		
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (8 EA per 28 days); NDS
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 EA per 28 days); NDS
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (8 EA per 28 days); NDS
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	4	LA; DX (Diagnosis Validation Required); QL (4 EA per 28 days); NDS
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; LA; DX (Diagnosis Validation Required); NDS
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (4 packs per 28 days); NDS
*ANTINEOPLASTIC ANTIBIOTICS***		
<i>valrubicin intravesical solution 40 mg/ml</i>	MB	DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES***		
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC COMBINATIONS***		

Drug Name	Tier	Notes
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1800-30000 MG-UT/15ML	MB	PA; DX (Diagnosis Validation Required)
INQOVI ORAL TABLET 35-100 MG	4	PA; DX (Diagnosis Validation Required); QL (5 EA per 28 days); NDS; SP
KISQALI FEMARA (200 MG DOSE) TABLET THERAPY PACK 200 & 2.5 MG ORAL	4	PA; LA; QL (49 EA per 28 days); NDS
KISQALI FEMARA (400 MG DOSE) TABLET THERAPY PACK 200 & 2.5 MG ORAL	4	PA; LA; QL (70 EA per 28 days); NDS
KISQALI FEMARA (600 MG DOSE) TABLET THERAPY PACK 200 & 2.5 MG ORAL	4	PA; LA; QL (91 EA per 28 days); NDS
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	4	PA; DX (Diagnosis Validation Required); QL (40 EA per 28 days); NDS; SP
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 600-10000 MG-UT/5ML	MB	PA; DX (Diagnosis Validation Required)
TECENTRIQ HYBREZA SUBCUTANEOUS SOLUTION 1875-30000 MG-UT/15ML	MB	PA; DX (Diagnosis Validation Required)
*ANTINEOPLASTIC ENZYMES***		
ERWINAZE INJECTION SOLUTION RECONSTITUTED 10000 UNIT	MB	PA; DX (Diagnosis Validation Required); NDS
ONCASPAR INJECTION SOLUTION 750 UNIT/ML	MB	PA; DX (Diagnosis Validation Required); NDS
*ANTINEOPLASTIC RADIOPHARMACEUTICALS***		
AZEDRA DOSIMETRIC INTRAVENOUS SOLUTION 15 MCI/ML	MB	PA; QL (1 Vials per 30 days)
AZEDRA THERAPEUTIC INTRAVENOUS SOLUTION 15 MCI/ML	MB	PA; QL (2 EA per 30 days)
*ANTINEOPLASTICS MISC.***		
<i>hydroxyurea oral capsule 500 mg</i>	1	DX (Diagnosis Validation Required)
INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML	4	NDS; SP
INTRON A INJECTION SOLUTION RECONSTITUTED 18000000 UNIT, 50000000 UNIT	4	NDS; SP
MATULANE ORAL CAPSULE 50 MG	4	PA; DX (Diagnosis Validation Required); SP
TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML	MB	DX (Diagnosis Validation Required)
*AROMATASE INHIBITORS***		
<i>anastrozole oral tablet 1 mg</i>	1	DX (Diagnosis Code at point of sale accepted)
<i>exemestane oral tablet 25 mg</i>	3	DX (Diagnosis at point of sale accepted)
<i>letrozole oral tablet 2.5 mg</i>	1	DX (Diagnosis code at point of sale accepted)

Drug Name	Tier	Notes
*CARDIAC PROTECTIVE AGENTS***		
TOTECT INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS***		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	4	PA; DX (Diagnosis Validation Required); QL (21 EA per 28 days); NDS; SP
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	4	PA; DX (Diagnosis Validation Required); QL (21 EA per 28 days); NDS; SP
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (21 EA per 28 days); NDS
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (42 EA per 28 days); NDS
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (63 EA per 28 days); NDS
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
*ESTROGEN RECEPTOR ANTAGONIST***		
<i>fulvestrant intramuscular solution 250 mg/5ml</i>	MB	
*ESTROGENS-ANTINEOPLASTIC***		
EMCYT ORAL CAPSULE 140 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
*FOLIC ACID ANTAGONISTS RESCUE AGENTS***		
<i>leucovorin calcium injection solution reconstituted 100 mg, 200 mg, 350 mg, 50 mg, 500 mg</i>	MB	NDS
LEUCOVORIN CALCIUM ORAL TABLET 10 MG, 15 MG	2	
<i>leucovorin calcium oral tablet 25 mg, 5 mg</i>	1	
*IMIDAZOTETRAZINES***		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	3	PA; DX (Diagnosis Validation Required); NDS
*ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS***		
TIBSOVO ORAL TABLET 250 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS

Drug Name	Tier	Notes
*JANUS ASSOCIATED KINASE (JAK) INHIBITORS***		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); SP
*LHRH ANALOGS***		
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	MB	PA not required if billed with Dx codes F64.1 - F64.9.; DX (Diagnosis Validation Required); NDS
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	MB	PA; DX (Diagnosis Validation Required)
*MITOTIC INHIBITORS***		
<i>etoposide oral capsule 50 mg</i>	3	DX (Diagnosis Validation Required); NDS
*NITROGEN MUSTARDS AND RELATED ANALOGUES***		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	3	DX (Diagnosis Validation Required)
EVOMELA INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA; DX (Diagnosis Validation Required)
LEUKERAN ORAL TABLET 2 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
<i>melphalan oral tablet 2 mg</i>	1	DX (Diagnosis Validation Required)
*NITROSOUREAS***		
<i>carmustine intravenous solution reconstituted 100 mg, 300 mg, 50 mg</i>	MB	
*PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS***		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS
ITOVEBI ORAL TABLET 3 MG	4	PA; DX (Diagnosis Validation Required); QL (2 EA per 1 day); NDS; SP
ITOVEBI ORAL TABLET 9 MG	4	PA; DX (Diagnosis Validation Required); QL (1 EA per 1 day); NDS; SP
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
ZYDELIG ORAL TABLET 100 MG, 150 MG	4	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS
*POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS***		
LYNPARZA ORAL TABLET 100 MG, 150 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP
TALZENNA ORAL CAPSULE 0.1 MG, 0.35 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
ZEJULA ORAL CAPSULE 100 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); SP
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
*PROGESTINS-ANTINEOPLASTIC***		
<i>megestrol acetate oral suspension 40 mg/ml</i>	1	
<i>megestrol acetate oral suspension 400 mg/10ml</i>	1	PA
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	1	
*SELECTIVE ESTROGEN RECEPTOR DEGRADERS***		
ORSERDU ORAL TABLET 345 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
ORSERDU ORAL TABLET 86 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); SP
*SELECTIVE RETINOID X RECEPTOR AGONISTS***		
<i>bexarotene oral capsule 75 mg</i>	4	PA; DX (Diagnosis Validation Required); SP
*TOPOISOMERASE I INHIBITORS***		
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
*URINARY TRACT PROTECTIVE AGENTS***		
MESNEX ORAL TABLET 400 MG	4	

Drug Name	Tier	Notes
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS***		
INLYTA ORAL TABLET 1 MG, 5 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS; SP
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS; SP
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	4	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS; SP
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	4	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
ANTIPARKINSON AND RELATED THERAPY AGENTS		
*ANTIPARKINSON ANTICHOLINERGICS***		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>

Drug Name	Tier	Notes
COGENTIN INJECTION SOLUTION 1 MG/ML	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*ANTIPARKINSON DOPAMINERGICS***		
<i>amantadine hcl oral capsule 100 mg</i>	1	
<i>amantadine hcl oral syrup 50 mg/5ml</i>	1	
<i>amantadine hcl oral tablet 100 mg</i>	1	
<i>bromocriptine mesylate oral capsule 5 mg</i>	1	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	1	
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS***		
<i>selegiline hcl oral capsule 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>selegiline hcl oral tablet 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*LEVODOPA COMBINATIONS***		

Drug Name	Tier	Notes
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	1	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	1	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	1	
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	3	
*NONERGOLINE DOPAMINE RECEPTOR AGONISTS***		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML	MB	LA; NDS
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	4	PA; LA; QL (150 EA per 30 days); NDS
KYNMOBI TITRATION KIT SUBLINGUAL KIT 10&15&20&25&30 MG	4	PA; LA; QL (1 Kit per 180 days); NDS
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	1	
*PERIPHERAL COMT INHIBITORS***		
<i>entacapone oral tablet 200 mg</i>	1	
ONGENTYS ORAL CAPSULE 50 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
*ANTIMANIC AGENTS***		
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>lithium carbonate oral tablet 300 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
LITHIUM ORAL SOLUTION 8 MEQ/5ML	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*ANTIPSYCHOTICS - MISC.***		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	4	PA; QL (30 EA per 30 days); AL (Min 18 Years)
<i>lurasidone hcl oral tablet 120 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 13 Years)

Drug Name	Tier	Notes
<i>lurasidone hcl oral tablet 20 mg, 40 mg, 60 mg</i>	3	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 10 Years)</p>
<i>lurasidone hcl oral tablet 80 mg</i>	3	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 10 Years)</p>
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	4	<p>PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 1 day); AL (Min 18 Years)</p>
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	4	<p>PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (7 EA per 365 days); AL (Min 18 Years)</p>

Drug Name	Tier	Notes
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
*BENZISOXAZOLES***		
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.75 ML per 28 days); AL (Min 18 Years); NDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 ML per 28 days); AL (Min 18 Years); NDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.5 ML per 28 days); AL (Min 18 Years); NDS

Drug Name	Tier	Notes
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.25 ML per 28 days); AL (Min 18 Years); NDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.5 ML per 28 days); AL (Min 18 Years); NDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML, 273 MG/0.88ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.875 ML per 84 days); AL (Min 18 Years); NDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.315ML, 410 MG/1.32ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.315 ML per 84 days); AL (Min 18 Years); NDS

Drug Name	Tier	Notes
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.75 ML per 84 days); AL (Min 18 Years); NDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.625ML, 819 MG/2.63ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.625 ML per 84 days); AL (Min 18 Years); NDS
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 12 Years)
<i>risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 vials per 28 days); AL (Min 18 Years); NDS

Drug Name	Tier	Notes
<i>risperidone oral solution 1 mg/ml</i>	1	<p>PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (480 ML per 30 days); AL (Min 5 Years)</p>
<i>risperidone oral tablet 0.25 mg</i>	1	<p>PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 5 Years)</p>
<i>risperidone oral tablet 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	<p>PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 5 Years)</p>
<i>risperidone oral tablet 4 mg</i>	1	<p>PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 5 Years)</p>

Drug Name	Tier	Notes
<i>risperidone oral tablet dispersible 0.25 mg</i>	3	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 5 Years)
<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 3 mg</i>	3	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 5 Years)
<i>risperidone oral tablet dispersible 4 mg</i>	3	PA required for patients younger than 5 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 5 Years)
*BUTYROPHENONES***		
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Min 18 Years)

Drug Name	Tier	Notes
<i>haloperidol lactate injection solution 5 mg/ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*DIBENZODIAZEPINES***		
<i>clozapine oral tablet 100 mg</i>	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (270 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
<i>clozapine oral tablet 200 mg</i>	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (135 EA per 30 days); AL (Min 6 Years)
<i>clozapine oral tablet 25 mg, 50 mg</i>	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
*DIBENZO-OXEPINO PYRROLES***		
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 10 Years)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	4	PA; QL (30 EA per 30 days); AL (Min 18 Years)
*DIBENZOTHIAZEPINES***		
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

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

Drug Name	Tier	Notes
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*MUSCARINIC AGENT - COMBINATIONS***		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 EA per 1 day); AL (Min 18 Years)
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (56 EA per 365 days); AL (Min 18 Years)
*PHENOTHIAZINES***		
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
COMPRO RECTAL SUPPOSITORY 25 MG	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
FLUPHENAZINE HCL ORAL CONCENTRATE 5 MG/ML	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
FLUPHENAZINE HCL ORAL ELIXIR 2.5 MG/5ML	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>fluphenazine hcl oral tablet 5 mg</i>	1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
<i>prochlorperazine edisylate injection solution 10 mg/2ml</i>	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>prochlorperazine rectal suppository 25 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*QUINOLINONE DERIVATIVES***		

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

Drug Name	Tier	Notes
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	4	<p>PA; PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)</p>
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	4	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.4 ML per 30 days); AL (Min 18 Years)</p>
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	4	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3.9 ML per 56 days); AL (Min 18 Years); NDS</p>
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	4	<p>BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.6 ML per 28 days); AL (Min 18 Years); NDS</p>

Drug Name	Tier	Notes
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.4 ML per 28 days); AL (Min 18 Years); NDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3.2 ML per 28 days); AL (Min 18 Years); NDS
*THIENBENZODIAZEPINES***		
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	1	PA required for patients younger than 6 years of age.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
*THIOXANTHENES***		

Drug Name	Tier	Notes
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTISEPTICS & DISINFECTANTS		
*CHLORINE ANTISEPTICS***		
<i>chlorhexidine gluconate solution 20 %</i>	1	
ANTIVIRALS		
*ANTIRETROVIRAL COMBINATIONS***		
abacavir sulfate-lamivudine oral tablet 600-300 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Biktarvy Oral Tablet 30-120-15 MG, 50-200-25 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML	MB	PA
Cimduo Oral Tablet 300-300 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Delstrigo Oral Tablet 100-300-300 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Descovy Oral Tablet 120-15 MG	\$0	PA for New Starts; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
Descovy Oral Tablet 200-25 MG	\$0	<p>PA for New Starts; DX (Covered at a zero-dollar copay for the diagnosis of Pre-exposure prophylaxis (PrEP) per ACA); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
emtricitabine-tenofovir df oral tablet 167-250 mg, 200-300 mg	\$0	<p>DX (Covered at a zero-dollar copay for the diagnosis of Pre-exposure prophylaxis (PrEP) per ACA); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>

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

Drug Name	Tier	Notes
lamivudine-zidovudine oral tablet 150-300 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)</p>
lopinavir-ritonavir oral solution 400-100 mg/5ml	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)</p>
Odefsey Oral Tablet 200-25-25 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>

Drug Name	Tier	Notes
Prezcobix Oral Tablet 800-150 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
Stribild Oral Tablet 150-150-200-300 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
Symtuza Oral Tablet 800-150-200-10 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
Triumeq Oral Tablet 600-50-300 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>

Drug Name	Tier	Notes
trumeq pd oral tablet soluble 60-5-30 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)***		
maraviroc oral tablet 150 mg, 300 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
Selzentry Oral Solution 20 MG/ML	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
Selzentry Oral Tablet 25 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)

Drug Name	Tier	Notes
Selzentry Oral Tablet 75 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
*ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR***		
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML	MB	
*ANTIRETROVIRALS - FUSION INHIBITORS***		
Fuzeon Subcutaneous Solution Reconstituted 90 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
*ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR***		
Rukobia Oral Tablet Extended Release 12 Hour 600 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
*ANTIRETROVIRALS - INTEGRASE INHIBITORS***		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML	MB	

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

Drug Name	Tier	Notes
Isentress Oral Tablet Chewable 25 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)</p>
Tivicay Oral Tablet 10 MG, 25 MG, 50 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
Tivicay PD Oral Tablet Soluble 5 MG	\$0	<p>PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days); AL (Max 12 Years)</p>
*ANTIRETROVIRALS - PROTEASE INHIBITORS***		
Aptivus Oral Capsule 250 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)</p>

Drug Name	Tier	Notes
Aptivus Oral Solution 100 MG/ML	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (300 ML per 30 days)</p>
atazanavir sulfate oral capsule 150 mg, 200 mg, 300 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)</p>
Crixivan Oral Capsule 400 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)</p>
darunavir oral tablet 600 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)</p>

Drug Name	Tier	Notes
darunavir oral tablet 800 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
fosamprenavir calcium oral tablet 700 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)</p>
Invirase Oral Tablet 500 MG	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)</p>
Lexiva Oral Suspension 50 MG/ML	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>

Drug Name	Tier	Notes
Norvir Oral Solution 80 MG/ML	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (450 ML per 30 days)
Prezista Oral Suspension 100 MG/ML	\$0	QL (360 ML per 30 days)
Prezista Oral Tablet 150 MG, 75 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
Reyataz Oral Packet 50 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (150 EA per 30 days); AL (Max 8 Years)
ritonavir oral tablet 100 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (360 EA per 30 days)

Drug Name	Tier	Notes
Viracept Oral Tablet 250 MG, 625 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES***		
Edurant Oral Tablet 25 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
efavirenz oral capsule 200 mg, 50 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
efavirenz oral tablet 600 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

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

Drug Name	Tier	Notes
abacavir sulfate oral solution 20 mg/ml	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
abacavir sulfate oral tablet 300 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES***		
emtricitabine oral capsule 200 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
Emtriva Oral Solution 10 MG/ML	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
lamivudine oral solution 10 mg/ml	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)</p>
lamivudine oral tablet 150 mg, 300 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)</p>
*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES***		
stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)</p>
zidovudine oral capsule 100 mg	\$0	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)</p>

Drug Name	Tier	Notes
zidovudine oral syrup 50 mg/5ml	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
zidovudine oral tablet 300 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES***		
tenofovir disoproxil fumarate oral tablet 300 mg	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); NDS
Viread Oral Powder 40 MG/GM	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (225 GM per 30 days); NDS

Drug Name	Tier	Notes
Viread Oral Tablet 150 MG, 200 MG, 250 MG	\$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); NDS
*ANTIRETROVIRALS ADJUVANTS***		
TYBOST ORAL TABLET 150 MG	2	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
*ANTIVIRAL COMBINATIONS***		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	3	QL (40 EA per 365 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	3	QL (60 EA per 365 days)
PAXLOVID ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	3	QL (40 EA per 365 days)
PAXLOVID ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	3	QL (60 EA per 365 days)
*CMV AGENTS***		
<i>cidofovir intravenous solution 75 mg/ml</i>	MB	
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	4	PA; QL (540 ML per 30 days)
<i>valganciclovir hcl oral tablet 450 mg</i>	3	PA; QL (60 EA per 30 days)
*HEPATITIS B AGENTS***		
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	4	PA; QL (30 EA per 30 days); NDS; SP
EPIVIR HBV ORAL SOLUTION 5 MG/ML	2	
<i>lamivudine oral tablet 100 mg</i>	1	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	4	QL (30 EA per 30 days); NDS; SP
*HEPATITIS C AGENT - COMBINATIONS***		
MAVYRET ORAL PACKET 50-20 MG	4	PA; QL (150 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
MAVYRET ORAL TABLET 100-40 MG	4	PA; QL (3 EA per 1 day); NDS; SP
<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	4	PA; QL (84 EA per 365 days); NDS; SP
*HEPATITIS C AGENTS***		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	4	PA; NDS; SP
<i>ribavirin oral capsule 200 mg</i>	3	PA; NDS
<i>ribavirin oral tablet 200 mg</i>	3	PA; NDS
*HERPES AGENTS - PURINE ANALOGUES***		
<i>acyclovir oral capsule 200 mg</i>	1	
<i>acyclovir oral suspension 200 mg/5ml</i>	1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	1	
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	MB	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*HERPES AGENTS - THYMIDINE ANALOGUES***		
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*INFLUENZA AGENTS***		
<i>rimantadine hcl oral tablet 100 mg</i>	2	
*MISC. ANTIVIRALS***		
LAGEVRIO ORAL CAPSULE 200 MG	3	QL (80 EA per 365 days)
VEKLURY INTRAVENOUS SOLUTION 100 MG/20ML	MB	

Drug Name	Tier	Notes
VEKLURY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	
*NEURAMINIDASE INHIBITORS***		
<i>oseltamivir phosphate oral capsule 30 mg</i>	3	QL (20 EA per 180 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	3	QL (10 EA per 180 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	3	QL (180 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/BLISTER	3	QL (20 EA per 126 days)
BETA BLOCKERS		
*ALPHA-BETA BLOCKERS***		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	
<i>labetalol hcl intravenous solution 5 mg/ml</i>	1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	
*BETA BLOCKERS CARDIO-SELECTIVE***		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	
<i>esmolol hcl-sodium chloride intravenous solution 2000 mg/100ml</i>	MB	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	3	
*BETA BLOCKERS NON-SELECTIVE***		
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	1	
PROPRANOLOL HCL ORAL SOLUTION 20 MG/5ML, 40 MG/5ML	2	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	
TIMOLOL MALEATE ORAL TABLET 10 MG, 20 MG, 5 MG	2	
CALCIUM CHANNEL BLOCKERS		

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

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

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

Drug Name	Tier	Notes
AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>bekyree oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG	3	PA; Up to a six-month supply. *NMAC 13.10.32.(8)
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
*COMBINATION CONTRACEPTIVES - ORAL ***		
Afirmelle Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
alyacen 1/35 oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
apri oral tablet 0.15-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Aubra Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Aurovela Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Aurovela FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Aviane Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)

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

Drug Name	Tier	Notes
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Falmina Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
femynor oral tablet 0.25-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Hailey FE 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Hailey FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
isibloom oral tablet 0.15-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
JASMIEL ORAL TABLET 3-0.02 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
juleber oral tablet 0.15-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
junel fe 1/20 oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>kaitlib fe oral tablet chewable 0.8-25 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Kalliga Oral Tablet 0.15-30 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
kelnor 1/35 oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
KURVELO ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LARIN 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
larin fe 1/20 oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Larissia Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>layolis fe oral tablet chewable 0.8-25 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Lessina Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Loestrin Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
loestrin fe 1/20 oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
<i>loryna oral tablet 3-0.02 mg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
low-ogestrel oral tablet 0.3-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
LO-ZUMANDIMINE ORAL TABLET 3-0.02 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Lutera Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
MICROGESTIN 24 FE ORAL TABLET 1-20 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
microgestin fe 1/20 oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Mili Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
mono-lynyah oral tablet 0.25-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
necon 1/35 (28) oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
<i>nikki oral tablet 3-0.02 mg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
Nymyo Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
OCELLA ORAL TABLET 3-0.03 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Orsythia Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
PHILITH ORAL TABLET 0.4-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
pirmella 1/35 oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
previfem oral tablet 0.25-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
reclipsen oral tablet 0.15-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
solia oral tablet 0.15-30 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
sprintec 28 oral tablet 0.25-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Sronyx Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
SYEDA ORAL TABLET 3-0.03 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	Up to a six-month supply. *NMAC 13.10.32.(8)
tarina fe 1/20 oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
<i>vestura oral tablet 3-0.02 mg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Vienva Oral Tablet 0.1-20 MG-MCG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
VyLibra Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
WERA ORAL TABLET 0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
<i>wymzya fe oral tablet chewable 0.4-35 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
ZARAH ORAL TABLET 3-0.03 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>zovia 1/35e (28) oral tablet 1-35 mg-mcg</i>	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8)
ZUMANDIMINE ORAL TABLET 3-0.03 MG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
*COMBINATION CONTRACEPTIVES - TRANSDERMAL***		
<i>xulane transdermal patch weekly 150-35 mcg/24hr</i>	\$0	\$0 Copay per PPACA guidelines. ; Up to a six-month supply. *NMAC 13.10.32.(8); QL (3 EA per 28 days); AL (Max 55 Years)
Zafemy Transdermal Patch Weekly 150-35 MCG/24HR	\$0	\$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); QL (3 EA per 28 days); AL (Max 55 Years)
*COMBINATION CONTRACEPTIVES - VAGINAL***		
EluRyng Vaginal Ring 0.12-0.015 MG/24HR	\$0	Up to a six-month supply. *NMAC 13.10.32.(8); QL (1 EA per 28 days); AL (Max 55 Years)
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	\$0	Up to a six-month supply. *NMAC 13.10.32.(8); QL (1 EA per 28 days); AL (Max 55 Years)
*CONTINUOUS CONTRACEPTIVES - ORAL***		
<i>amethyst oral tablet 90-20 mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
<i>levonorgestrel-ethinyl estrad oral tablet 90-20 mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
*COPPER CONTRACEPTIVES - IUD***		
Paragard Intrauterine Copper Intrauterine Intrauterine Device	\$0	\$0 Copay per PPACA guidelines.; QL (1 EA per 10 Yearss); AL (Max 55 Years)
*EMERGENCY CONTRACEPTIVES***		
Aftera Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
EContra EZ Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
Ella Oral Tablet 30 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
levonorgestrel oral tablet 1.5 mg	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)

Drug Name	Tier	Notes
My Way Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
Opcicon One-Step Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
Take Action Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
*EXTENDED-CYCLE CONTRACEPTIVES - ORAL ***		
amethia oral tablet 0.15-0.03 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
ashlyna oral tablet 0.15-0.03 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
camrese lo oral tablet 0.1-0.02 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
camrese oral tablet 0.15-0.03 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
daysee oral tablet 0.15-0.03 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Iclevia Oral Tablet 0.15-0.03 MG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
introvale oral tablet 0.15-0.03 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
Jaimiess Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years); Up to a six-month supply. *NMAC 13.10.32.(8)
jolessa oral tablet 0.15-0.03 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
LoJaimiess Oral Tablet 0.1-0.02 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years); Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
setlakin oral tablet 0.15-0.03 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)

Drug Name	Tier	Notes
Simpesse Oral Tablet 0.15-0.03 & 0.01 MG	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
*PROGESTIN CONTRACEPTIVES - INJECTABLE***		
Depo-SubQ Provera 104 Subcutaneous Suspension Prefilled Syringe 104 MG/0.65ML	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	\$0	\$0 copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8); AL (Max 55 Years)
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	\$0	Up to a six-month supply. *NMAC 13.10.32.(8)
*PROGESTIN CONTRACEPTIVES - IUD***		
Kyleena Intrauterine Intrauterine Device 19.5 MG	\$0	
*PROGESTIN CONTRACEPTIVES - ORAL***		
Camila Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Deblitane Oral Tablet 0.35 MG	\$0	\$0 Copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Errin Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Heather Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Jencycla Oral Tablet 0.35 MG	\$0	\$0 Copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
Lyleq Oral Tablet 0.35 MG	\$0	\$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
lyza oral tablet 0.35 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Nora-BE Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
norethindrone oral tablet 0.35 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
norlyda oral tablet 0.35 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
norlyroc oral tablet 0.35 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Opill Oral Tablet 0.075 MG	\$0	
sharobel oral tablet 0.35 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
*TRIPHASIC CONTRACEPTIVES - ORAL ***		
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
caziant oral tablet 0.1/0.125/0.15 -0.025 mg	\$0	\$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
cesia oral tablet 0.1/0.125/0.15 -0.025 mg	\$0	\$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Cyclafem 7/7/7 Oral Tablet 0.5/0.75/1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
DASETTA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
enpresse-28 oral tablet 50-30/75-40/ 125-30 mcg	\$0	\$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
levonest oral tablet 50-30/75-40/ 125-30 mcg	\$0	\$0 Copayment per ACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
PIRMELLA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TILIA FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)

Drug Name	Tier	Notes
tri femynor oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
<i>tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg</i>	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LO-MARZIA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LO-MILI ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Tri-Mili Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
trinessa (28) oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
Tri-Nymyo Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
tri-previfem oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
trivora (28) oral tablet 50-30/75-40/ 125-30 mcg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	Up to a six-month supply. *NMAC 13.10.32.(8)
Tri-VyLibra Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 copay Per PPACA Guidelines; Up to a six-month supply. *NMAC 13.10.32.(8)
velivet oral tablet 0.1/0.125/0.15 -0.025 mg	\$0	\$0 Copay per PPACA guidelines.; Up to a six-month supply. *NMAC 13.10.32.(8)
CORTICOSTEROIDS		
*GLUCOCORTICOSTEROIDS***		

Drug Name	Tier	Notes
<i>budesonide oral capsule delayed release particles 3 mg</i>	3	QL (448 EA per 365 days)
DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML, 40 MG/ML, 80 MG/ML	MB	
<i>dexamethasone intensol oral concentrate 1 mg/ml</i>	2	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	1	
<i>dexamethasone sodium phosphate injection solution 20 mg/5ml</i>	MB	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	1	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	1	
<i>prednisolone oral solution 15 mg/5ml</i>	1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 5 mg/5ml</i>	1	
<i>prednisone oral solution 5 mg/5ml</i>	1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	1	
*MINERALOCORTICIDS***		
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	1	
*STEROID COMBINATIONS***		
<i>betamethasone sod phos & acet injection suspension 6 (3-3) mg/ml</i>	MB	
CELESTONE SOLUSPAN INJECTION SUSPENSION 6 (3-3) MG/ML	MB	
COUGH/COLD/ALLERGY		
*ANTITUSSIVE - NONNARCOTIC***		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	1	
*ANTITUSSIVE-EXPECTORANT***		
<i>g tussin ac oral solution 100-10 mg/5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
<i>guaiafenesin ac oral syrup 100-10 mg/5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)

Drug Name	Tier	Notes
<i>guaifenesin ac oral syrup 100-10 mg/5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
<i>guaifenesin-codeine oral solution 100-10 mg/5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
<i>virtussin a/c oral solution 100-10 mg/5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
*MISC. RESPIRATORY INHALANTS***		
<i>nasal mist inhalation aerosol solution 0.9 %</i>	1	
<i>sodium chloride inhalation nebulization solution 0.9 %, 7 %</i>	1	
*MUCOLYTICS***		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	
*OPIOID ANTITUSSIVE-ANTIHISTAMINE***		
<i>promethazine-codeine oral syrup 6.25-10 mg/5ml</i>	1	PA; Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years.; AL (Min 12 Years)
DERMATOLOGICALS		
*ACNE ANTIBIOTICS***		
<i>clindamycin phos (once-daily) external gel 1 %</i>	1	QL (60 GM per 30 days)
<i>clindamycin phos (twice-daily) external gel 1 %</i>	1	QL (60 GM per 30 days)
<i>clindamycin phosphate external gel 1 %</i>	1	QL (60 GM per 30 days)
<i>clindamycin phosphate external lotion 1 %</i>	1	QL (60 ML per 30 days)
<i>clindamycin phosphate external solution 1 %</i>	1	
<i>clindamycin phosphate external swab 1 %</i>	1	
<i>dapsone external gel 5 %, 7.5 %</i>	3	
<i>erythromycin external gel 2 %</i>	1	
<i>erythromycin external solution 2 %</i>	1	
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	3	
*ACNE COMBINATIONS***		
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	1	
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-5 %</i>	3	
<i>sss 10-5 external cream 10-5 %</i>	1	
<i>sulfacetamide sodium-sulfur external cream 10-5 %</i>	1	

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

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

Drug Name	Tier	Notes
*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL***		
<i>fluorouracil external cream 5 %</i>	1	
<i>fluorouracil external solution 2 %</i>	2	
*ANTIPSORIATICS - SYSTEMIC***		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	4	PA; QL (60 EA per 30 days); NDS; SP
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 56 days); SP
SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT 75 MG/0.83ML	4	PA; DX (Diagnosis Validation Required); QL (1 Kit per 84 days); NDS; SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO- INJECTOR 150 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 84 days); NDS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 84 days); NDS; SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 56 days); SP
TALTZ SUBCUTANEOUS SOLUTION AUTO- INJECTOR 80 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML	4	PA; DX (Diagnosis Validation Required); QL (0.25 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 28 days); NDS; SP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	4	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 ML per 56 days); SP
*ANTIPSORIATICS***		

Drug Name	Tier	Notes
<i>calcipotriene external cream 0.005 %</i>	3	
<i>calcipotriene external ointment 0.005 %</i>	3	
<i>calcipotriene external solution 0.005 %</i>	3	
CALCITRENE EXTERNAL OINTMENT 0.005 %	2	
<i>calcitriol external ointment 3 mcg/gm</i>	3	ST
<i>tazarotene external cream 0.05 %, 0.1 %</i>	3	ST; QL (60 GM per 30 days)
<i>tazarotene external gel 0.05 %, 0.1 %</i>	3	ST; QL (100 GM per 30 days)
TAZORAC EXTERNAL CREAM 0.05 %	3	ST; QL (60 GM per 30 days)
*ANTIVIRALS - TOPICAL***		
<i>penciclovir external cream 1 %</i>	2	QL (5 GM per 30 days)
*ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES***		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	4	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML	4	PA; QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML	4	PA; QL (4 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	4	PA; DX (Diagnosis Validation Required); QL (1.34 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML	4	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
*BURN PRODUCTS***		
<i>silver sulfadiazine external cream 1 %</i>	1	
*CORTICOSTEROIDS - TOPICAL***		
<i>alclometasone dipropionate external cream 0.05 %</i>	1	
<i>alclometasone dipropionate external ointment 0.05 %</i>	1	
AMCINONIDE EXTERNAL OINTMENT 0.1 %	3	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	1	
<i>betamethasone dipropionate aug external gel 0.05 %</i>	1	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	1	

Drug Name	Tier	Notes
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	1	
<i>betamethasone dipropionate external cream 0.05 %</i>	1	
<i>betamethasone dipropionate external lotion 0.05 %</i>	1	
<i>betamethasone dipropionate external ointment 0.05 %</i>	1	
<i>betamethasone valerate external cream 0.1 %</i>	1	
<i>betamethasone valerate external lotion 0.1 %</i>	1	
<i>betamethasone valerate external ointment 0.1 %</i>	1	
<i>clobetasol propionate e external cream 0.05 %</i>	1	
<i>clobetasol propionate external cream 0.05 %</i>	1	QL (60 GM per 30 days)
<i>clobetasol propionate external gel 0.05 %</i>	1	
<i>clobetasol propionate external ointment 0.05 %</i>	1	
<i>clobetasol propionate external solution 0.05 %</i>	1	
<i>desoximetasone external cream 0.25 %</i>	1	
<i>desoximetasone external gel 0.05 %</i>	1	
<i>fluocinolone acetonide body external oil 0.01 %</i>	1	
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	1	
<i>fluocinolone acetonide external ointment 0.025 %</i>	1	
<i>fluocinolone acetonide external solution 0.01 %</i>	1	
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	1	
<i>fluocinonide external cream 0.05 %</i>	1	
<i>fluocinonide external gel 0.05 %</i>	1	
<i>fluocinonide external ointment 0.05 %</i>	1	
<i>fluocinonide external solution 0.05 %</i>	1	
<i>fluticasone propionate external cream 0.05 %</i>	1	
<i>fluticasone propionate external ointment 0.005 %</i>	1	
<i>halobetasol propionate external cream 0.05 %</i>	1	
<i>hydrocortisone butyrate external cream 0.1 %</i>	1	
<i>hydrocortisone butyrate external ointment 0.1 %</i>	1	
<i>hydrocortisone butyrate external solution 0.1 %</i>	1	
<i>hydrocortisone external cream 1 %, 2.5 %</i>	1	
<i>hydrocortisone external lotion 2.5 %</i>	1	
<i>hydrocortisone external ointment 0.5 %, 1 %, 2.5 %</i>	1	
<i>hydrocortisone valerate external cream 0.2 %</i>	1	
LANACORT 10 EXTERNAL CREAM 1 %	1	

Drug Name	Tier	Notes
MEDPURA HYDROCORTISONE EXTERNAL CREAM 1 %	1	
<i>mometasone furoate external cream 0.1 %</i>	1	
<i>mometasone furoate external ointment 0.1 %</i>	1	
<i>mometasone furoate external solution 0.1 %</i>	1	
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	1	
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	1	
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	1	
*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL***		
<i>clotrimazole anti-fungal external cream 1 %</i>	1	
<i>clotrimazole external solution 1 %</i>	1	
<i>econazole nitrate external cream 1 %</i>	1	
<i>ketoconazole external cream 2 %</i>	1	
<i>ketoconazole external shampoo 2 %</i>	1	
*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL***		
<i>imiquimod external cream 5 %</i>	3	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (12 gm per 28 days)</p>
*KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS***		
<i>podofilox external solution 0.5 %</i>	1	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>

Drug Name	Tier	Notes
*LOCAL ANESTHETICS - TOPICAL***		
<i>lidocaine external ointment 5 %</i>	3	QL (500 GM per 30 days)
<i>lidocaine external patch 5 %</i>	3	QL (30 EA per 30 days)
<i>lidocaine hcl external cream 3 %</i>	1	
<i>lidocaine hcl external solution 4 %</i>	1	
*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL***		
<i>pimecrolimus external cream 1 %</i>	3	Continuous long-term use is not recommended. The length of treatment will be limited to 60 days. *; QL (120 GM per 365 days); AL (Min 2 Years)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	3	Continuous long-term use of Protopic is not recommended by the FDA. The length of treatment will be limited to 60 days. *; AL (Min 2 Years)
*PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL***		
EUCRISA EXTERNAL OINTMENT 2 %	4	PA; QL (60 EA per 30 days)
*PHOTODYNAMIC THERAPY AGENTS - TOPICAL***		
AMELUZ EXTERNAL GEL 10 %	MB	
*ROSACEA AGENTS***		
<i>azelaic acid external gel 15 %</i>	3	
FINACEA EXTERNAL FOAM 15 %	2	
<i>metronidazole external cream 0.75 %</i>	1	
<i>metronidazole external gel 0.75 %</i>	1	
<i>metronidazole external lotion 0.75 %</i>	1	
*SCABICIDES & PEDICULICIDES***		
<i>ivermectin external lotion 0.5 %</i>	3	ST; Approval length if criteria met: 1 month
LINDANE EXTERNAL SHAMPOO 1 %	2	
<i>permethrin external cream 5 %</i>	1	
*TOPICAL ANESTHETIC COMBINATIONS***		
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	1	
*WOUND CARE - GROWTH FACTOR AGENTS***		
REGRANEX EXTERNAL GEL 0.01 %	3	
DIAGNOSTIC PRODUCTS		

Drug Name	Tier	Notes
*DIAGNOSTIC DRUGS***		
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG	MB	
<i>dipyridamole intravenous solution 5 mg/ml</i>	MB	
THYROGEN INTRAMUSCULAR SOLUTION RECONSTITUTED 0.9 MG	MB	QL (1 Course per 1 Lifetime); SP
*DIAGNOSTIC TESTS***		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK GUIDE IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK GUIDE TEST IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK SMARTVIEW IN VITRO STRIP	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
KETOSTIX IN VITRO STRIP	2	
*MULTIPLE URINE TESTS***		
CHEMSTRIP UGK IN VITRO STRIP	2	
DIGESTIVE AIDS		
*DIGESTIVE ENZYMES***		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	2	
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800- 56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT	2	
DIURETICS		
*CARBONIC ANHYDRASE INHIBITORS***		

Drug Name	Tier	Notes
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	
<i>acetazolamide sodium injection solution reconstituted 500 mg</i>	MB	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	1	
*DIURETIC COMBINATIONS***		
ALDACTAZIDE ORAL TABLET 50-50 MG	2	
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	
*LOOP DIURETICS***		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>ethacrynic acid oral tablet 25 mg</i>	4	PA
<i>furosemide oral solution 10 mg/ml</i>	1	
FUROSEMIDE ORAL SOLUTION 8 MG/ML	2	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	
*POTASSIUM SPARING DIURETICS***		
<i>amiloride hcl oral tablet 5 mg</i>	1	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	3	
*THIAZIDES AND THIAZIDE-LIKE DIURETICS***		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
SODIUM DIURIL INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
ENDOCRINE AND METABOLIC AGENTS - MISC.		
*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS***		
<i>mifepristone oral tablet 200 mg</i>	\$0	

Drug Name	Tier	Notes
*BISPHOSPHONATES***		
<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	1	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT	3	
<i>ibandronate sodium oral tablet 150 mg</i>	3	ST; QL (1 EA per 28 days)
<i>risedronate sodium oral tablet 150 mg</i>	3	QL (1 EA per 30 days)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	3	QL (30 EA per 30 days)
<i>risedronate sodium oral tablet 35 mg</i>	3	QL (4 EA per 28 days)
<i>risedronate sodium oral tablet delayed release 35 mg</i>	3	QL (4 EA per 28 days)
*CALCIMIMETIC AGENTS***		
<i>cinacalcet hcl oral tablet 30 mg</i>	1	NDS
<i>cinacalcet hcl oral tablet 60 mg, 90 mg</i>	1	PA; NDS
*CALCITONINS***		
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	4	
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	1	
*DOPAMINE RECEPTOR AGONISTS***		
<i>cabergoline oral tablet 0.5 mg</i>	1	QL (56 EA per 28 days)
*GNRH/LHRH ANTAGONISTS***		
ORILISSA ORAL TABLET 150 MG	4	PA; QL (30 EA per 30 days); NDS; SP
ORILISSA ORAL TABLET 200 MG	4	PA; QL (60 EA per 30 days); NDS; SP
*GROWTH HORMONES***		
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	4	PA; NDS; SP
*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS***		
<i>calcitriol intravenous solution 1 mcg/ml</i>	MB	
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	1	
<i>doxercalciferol intravenous solution 4 mcg/2ml</i>	MB	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	3	
*HYPOPHOSPHATASIA (HPP) AGENTS***		
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML	4	PA; LA
*INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)***		
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	4	PA; NDS; SP
*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS***		

Drug Name	Tier	Notes
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG	MB	PA not required if billed with Dx codes F64.1 - F64.9.
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG	MB	PA not required if billed with Dx codes F64.1 - F64.9.
*NEUROKININ 3 (NK3) RECEPTOR ANTAGONISTS***		
VEOZAH ORAL TABLET 45 MG	3	PA; QL (2 EA per 1 day); AL (Min 18 Years)
*OVULATION STIMULANTS-GONADOTROPINS***		
NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	MB	PA
PREGNYL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT	MB	PA
*PARATHYROID HORMONE AND DERIVATIVES***		
<i>teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml, 600 mcg/2.4ml</i>	4	PA; NDS; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	4	PA; NDS; SP
*PHENYLKETONURIA TREATMENT - AGENTS***		
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML	4	PA; LA; QL (7 ML per 28 days); NDS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML	4	PA; LA; QL (3 ML per 35 days); NDS
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	PA; LA; QL (28 ML per 28 days); NDS
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	4	PA; LA; NDS
*RANK LIGAND (RANKL) INHIBITORS***		
JUBBONTI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	SP
WYOST SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	SP
*SCLEROSTIN INHIBITORS***		
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 105 MG/1.17ML	MB	PA; SP
*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)***		
<i>raloxifene hcl oral tablet 60 mg</i>	1	DX (Covered at a zero-dollar copay for the prevention of breast cancer per ACA)
*SOMATOSTATIC AGENTS***		

Drug Name	Tier	Notes
<i>octreotide acetate intramuscular kit 20 mg, 30 mg</i>	MB	
*VASOPRESSIN***		
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	1	
<i>desmopressin acetate injection solution 4 mcg/ml</i>	4	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	1	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	1	
*X-LINKED HYPOPHOSPHATEMIA (XLH) TREATMENT - AGENTS***		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML, 20 MG/ML, 30 MG/ML	MB	PA; NDS
ESTROGENS		
*ESTROGEN & PROGESTIN***		
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY	3	ST; QL (8 EA per 28 days)
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	1	
JINTELI ORAL TABLET 1-5 MG-MCG	1	
MIMVEY ORAL TABLET 1-0.5 MG	1	
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	1	
PREFEST ORAL TABLET 1/1-0.09 MG (15/15)	2	
PREMPHASE ORAL TABLET 0.625-5 MG	2	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	2	
*ESTROGEN-PROGESTIN-GNRH ANTAGONIST***		
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG	4	PA; QL (60 EA per 30 days)
*ESTROGENS***		
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	3	QL (8 EA per 28 days)
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML	MB	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML	MB	
DOTTI TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	1	QL (8 EA per 28 days)
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	
<i>estradiol transdermal gel 0.25 mg/0.25gm, 0.5 mg/0.5gm, 0.75 mg/0.75gm, 1 mg/gm, 1.25 mg/1.25gm</i>	1	

Drug Name	Tier	Notes
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	QL (8 EA per 28 days)
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	1	QL (4 EA per 28 days)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%)	3	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY	3	
LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR	1	QL (8 EA per 30 days)
PREMARIN INJECTION SOLUTION RECONSTITUTED 25 MG	MB	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	2	
FLUOROQUINOLONES		
*FLUOROQUINOLONES***		
CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%)	2	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
CIPROFLOXACIN HCL ORAL TABLET 100 MG	2	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>ciprofloxacin in d5w intravenous solution 200 mg/100ml</i>	MB	
<i>levofloxacin oral solution 25 mg/ml</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>moxifloxacin hcl oral tablet 400 mg</i>	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
GASTROINTESTINAL AGENTS - MISC.		
*GALLSTONE SOLUBILIZING AGENTS***		

Drug Name	Tier	Notes
<i>ursodiol oral capsule 300 mg</i>	1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	1	
*GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS***		
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	2	QL (60 EA per 30 days)
*GASTROINTESTINAL STIMULANTS***		
<i>metoclopramide hcl oral solution 5 mg/5ml</i>	1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	
*IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS***		
<i>alosetron hcl oral tablet 0.5 mg, 1 mg</i>	4	
*INFLAMMATORY BOWEL AGENTS***		
<i>balsalazide disodium oral capsule 750 mg</i>	1	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	3	QL (120 EA per 30 days)
<i>mesalamine oral capsule delayed release 400 mg</i>	3	
<i>mesalamine oral tablet delayed release 1.2 gm</i>	3	QL (120 EA per 30 days)
<i>mesalamine rectal enema 4 gm</i>	1	
<i>mesalamine rectal suppository 1000 mg</i>	4	QL (30 EA per 30 days)
<i>sulfasalazine oral tablet 500 mg</i>	1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	
*INTERLEUKIN ANTAGONISTS***		
IMULDOSA INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA; DX (Diagnosis Validation Required)
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	MB	PA; DX (Diagnosis Validation Required); QL (30 ML per 365 days); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	4	PA; DX (Diagnosis Validation Required); QL (1.2 ML per 56 days); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	4	PA; DX (Diagnosis Validation Required); QL (2.4 ML per 56 days); NDS; SP
STEQEYMA INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA; DX (Diagnosis Validation Required)
YESINTEK INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA; DX (Diagnosis Validation Required)
*INTESTINAL ACIDIFIERS***		
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	1	
*PHOSPHATE BINDER AGENTS***		
<i>calcium acetate (phos binder) oral tablet 667 mg</i>	1	

Drug Name	Tier	Notes
<i>ferric citrate oral tablet 1 gm 210 mg(fe)</i>	4	PA; QL (12 EA per 1 day)
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg</i>	4	PA; QL (3 EA per 1 day)
<i>lanthanum carbonate oral tablet chewable 750 mg</i>	4	PA; QL (6 EA per 1 day)
PHOSLYRA ORAL SOLUTION 667 MG/5ML	2	
<i>sevelamer carbonate oral tablet 800 mg</i>	4	
*TRYPTOPHAN HYDROXYLASE INHIBITORS***		
XERMELO ORAL TABLET 250 MG	4	PA; LA; QL (90 EA per 30 days); NDS
*TUMOR NECROSIS FACTOR ALPHA BLOCKERS***		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Diagnosis Validation Required)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 kit per 28 days); NDS; SP
CIMZIA PREFILLED SUBCUTANEOUS KIT 2 X 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 kit per 28 days); NDS; SP
CIMZIA PREFILLED SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 kit per 28 days); NDS; SP
CIMZIA STARTER KIT SUBCUTANEOUS KIT 6 X 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 kit per 28 days); NDS; SP
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (3 kits per 28 days); NDS; SP
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG, 2 X 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 kit per 28 days); NDS; SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (1 kit per 28 days); NDS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (3 kits per 28 days); NDS; SP
<i>infliximab solution reconstituted 100 mg intravenous</i>	MB	PA; SP
GENITOURINARY AGENTS - MISCELLANEOUS		
*5-ALPHA REDUCTASE INHIBITORS***		
<i>dutasteride oral capsule 0.5 mg</i>	3	
<i>finasteride oral tablet 5 mg</i>	1	

Drug Name	Tier	Notes
*ALPHA 1-ADRENOCEPTOR ANTAGONISTS***		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	1	QL (30 EA per 30 days)
<i>tamsulosin hcl oral capsule 0.4 mg</i>	1	
*ANTI-INFECTIVE GENITOURINARY IRRIGANTS***		
<i>neomycin-polymyxin b gu irrigation solution 40-200000</i>	1	
*CITRATES***		
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 5 meq (540 mg)</i>	1	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (1620 MG)	2	
*INTERSTITIAL CYSTITIS AGENTS***		
ELMIRON ORAL CAPSULE 100 MG	3	PA; QL (90 EA per 30 days)
*URINARY ANALGESICS***		
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	1	
*URINARY STONE AGENTS***		
<i>tiopronin oral tablet 100 mg</i>	3	PA; LA; QL (300 EA per 30 days); NDS
GOUT AGENTS		
*GOUT AGENT COMBINATIONS***		
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	
*GOUT AGENTS***		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	
<i>colchicine oral tablet 0.6 mg</i>	1	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	3	QL (30 EA per 30 days)
*URICOSURICS***		
<i>probenecid oral tablet 500 mg</i>	1	
HEMATOLOGICAL AGENTS - MISC.		
*ANTIHEMOPHILIC PRODUCTS***		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	NDS
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT	MB	NDS
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	NDS
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT	MB	NDS

Drug Name	Tier	Notes
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT	MB	NDS
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT	MB	NDS
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT	MB	NDS
KCENTRA INTRAVENOUS KIT 1000 UNIT, 500 UNIT	MB	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT	MB	NDS
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT	MB	NDS
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	NDS
MONONINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT	MB	NDS
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	NDS
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG	MB	NDS
NUWIQ INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	NDS
NUWIQ INTRAVENOUS KIT 1500 UNIT	MB	
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	NDS
<i>obizur intravenous solution reconstituted 500 unit</i>	MB	NDS
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	NDS
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED	MB	NDS
<i>rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit</i>	MB	NDS
TRETEN INTRAVENOUS SOLUTION RECONSTITUTED 2000-3125 UNIT	MB	NDS
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500- 500 UNIT	MB	NDS
*BRADYKININ B2 RECEPTOR ANTAGONISTS***		
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	4	PA; QL (18 ML per 28 days); NDS; SP
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML	4	PA; QL (18 ML per 28 days); NDS; SP

Drug Name	Tier	Notes
*C1 ESTERASE INHIBITORS***		
BERINERT INTRAVENOUS KIT 500 UNIT	4	PA; NDS; SP
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	4	PA; NDS; SP
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	MB	PA; NDS; SP
*COMPLEMENT C5 INHIBITORS***		
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA; DX (Diagnosis Validation Required); NDS
ULTOMIRIS INTRAVENOUS SOLUTION 1100 MG/11ML, 300 MG/3ML	MB	PA; DX (Diagnosis Validation Required); NDS
ULTOMIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA; DX (Diagnosis Validation Required); NDS; SP
*DIRECT-ACTING P2Y12 INHIBITORS***		
KENGREAL INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA
<i>ticagrelor oral tablet 60 mg</i>	2	QL (60 EA per 30 days)
<i>ticagrelor oral tablet 90 mg</i>	2	Maximum of 730 tablets per lifetime.; QL (60 EA per 30 days)
*GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS***		
INTEGRILIN INTRAVENOUS SOLUTION 75 MG/100ML	MB	
*PHOSPHODIESTERASE III INHIBITORS***		
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	
*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES***		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML	4	PA; QL (2 Vials per 28 days); NDS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; QL (2 ML per 28 days); NDS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	4	PA; QL (4 ML per 28 days); NDS; SP
*PLATELET AGGREGATION INHIBITOR COMBINATIONS***		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	3	
*PLATELET AGGREGATION INHIBITORS***		
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	1	
*QUINAZOLINE AGENTS***		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	1	

Drug Name	Tier	Notes
*THIENOPYRIDINE DERIVATIVES***		
<i>clopidogrel bisulfate oral tablet 75 mg</i>	1	
<i>prasugrel hcl oral tablet 10 mg</i>	3	
<i>prasugrel hcl oral tablet 5 mg</i>	3	PA
HEMATOPOIETIC AGENTS		
*COBALAMINS***		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	1	
*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)***		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML	MB	PA; NDS
PROCRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply;; QL (12 ML per 28 days); NDS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 4000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 20000 UNIT/ML	MB	PA; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 3000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply;;; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply; QL (4 ML per 28 days)
*FOLIC ACID/FOLATES***		
<i>cvs folic acid oral tablet 800 mcg</i>	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
<i>folic acid oral tablet 1 mg</i>	1	
<i>folic acid oral tablet 400 mcg</i>	1	AL (Max 55 Years)
<i>folic acid oral tablet 800 mcg</i>	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
<i>gnp folic acid oral tablet 400 mcg</i>	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
<i>hm folic acid oral tablet 400 mcg</i>	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
<i>kp folic acid oral tablet 800 mcg</i>	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
<i>px folic acid oral tablet 400 mcg</i>	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)

Drug Name	Tier	Notes
ra folic acid oral tablet 400 mcg, 800 mcg	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
sm folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
yl folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)***		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; NDS; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML	MB	PA; NDS; SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
*IRON***		
ferumoxytol intravenous solution 510 mg/17ml	MB	
INJECTAFER INTRAVENOUS SOLUTION 100 MG/2ML	MB	
*THROMBOPOIETIN (TPO) RECEPTOR AGONISTS***		
MULPLETA ORAL TABLET 3 MG	4	PA; QL (7 EA per 7 days); NDS; SP
HEMOSTATICS		
*HEMOSTATICS - SYSTEMIC***		
aminocaproic acid oral solution 0.25 gm/ml	4	PA; AL (Max 12 Years)
aminocaproic acid oral tablet 1000 mg, 500 mg	4	
CYKLOKAPRON INTRAVENOUS SOLUTION 1000 MG/10ML	MB	
tranexamic acid intravenous solution 1000 mg/10ml	MB	
tranexamic acid oral tablet 650 mg	1	QL (30 EA per 30 days)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
*BARBITURATE HYPNOTICS***		
AMYTAL SODIUM INJECTION SOLUTION RECONSTITUTED 500 MG	MB	

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

Drug Name	Tier	Notes
<i>temazepam oral capsule 15 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>temazepam oral capsule 30 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS***		
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	3	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
*OREXIN RECEPTOR ANTAGONISTS***		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	3	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
DAYVIGO ORAL TABLET 10 MG, 5 MG	4	PA; QL (30 EA per 30 days)
*SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES***		
<i>dexmedetomidine hcl in nacl intravenous solution 200 mcg/50ml, 400 mcg/100ml</i>	MB	
*SELECTIVE MELATONIN RECEPTOR AGONISTS***		
<i>ramelteon oral tablet 8 mg</i>	3	PA; QL (30 EA per 30 days)
LAXATIVES		
*BOWEL EVACUANT COMBINATIONS***		
GaviLyte-C Oral Solution Reconstituted 240 GM	\$0	QL (8000 ML per 365 days); AL (Min 50 Years)
GaviLyte-G Oral Solution Reconstituted 236 GM	\$0	QL (8000 ML per 30 days); AL (Min 50 Years)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	\$0	\$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AL (Min 50 Years)

Drug Name	Tier	Notes
peg-3350/electrolytes oral solution reconstituted 236 gm	\$0	\$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AL (Min 50 Years)
*LAXATIVES - MISCELLANEOUS***		
<i>lactulose oral solution 10 gm/15ml</i>	1	
*SALINE LAXATIVES***		
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	1	
*LOCAL ANESTHETICS-PARENTERAL *		
*LOCAL ANESTHETICS - AMIDES***		
CARBOCAINE PRESERVATIVE-FREE INJECTION SOLUTION 1 %	MB	
EXPAREL INJECTION SUSPENSION 1.3 %	MB	
MACROLIDES		
*AZITHROMYCIN***		
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
*CLARITHROMYCIN***		
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	1	
*ERYTHROMYCINS***		

Drug Name	Tier	Notes
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML	4	<p>PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)</p>
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML	4	<p>PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)</p>
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML	4	<p>PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)</p>
ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG	4	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	

Drug Name	Tier	Notes
ERYTHROCIN STEARATE ORAL TABLET 250 MG	1	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	4	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	4	<p>STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)</p>
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml</i>	4	<p>PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)</p>

Drug Name	Tier	Notes
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*FIDAXOMICIN***		
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	4	PA; QL (10 ML per 1 day)
MEDICAL DEVICES AND SUPPLIES		
*CONDOMS - FEMALE***		
FC Female Condom	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
FC2 Female Condom	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
*CONDOMS - MALE***		
condoms	\$0	
*DIAPHRAGMS***		
Caya Vaginal Diaphragm	\$0	\$0 copay per PPACA guidelines.
Omniflex Diaphragm Vaginal Diaphragm	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 60 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 65 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 70 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 75 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 80 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 85 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 90 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 95 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.

Drug Name	Tier	Notes
*GLUCOSE MONITORING TEST SUPPLIES***		
ACCU-CHEK FASTCLIX LANCETS	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK MULTICLIX LANCETS	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK SOFTCLIX LANCETS	1	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
DEXCOM G6 RECEIVER DEVICE	2	PA; QL (1 EA per 365 days)
DEXCOM G6 SENSOR	2	PA; QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER	2	PA; QL (1 EA per 90 days)
DEXCOM G7 RECEIVER DEVICE	2	PA; QL (1 EA per 365 days)
DEXCOM G7 SENSOR	2	PA; QL (3 EA per 30 days)
FREESTYLE LIBRE 14 DAY READER DEVICE	2	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER DEVICE	2	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 2 SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 READER DEVICE	2	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 3 SENSOR	2	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE	2	ST; QL (1 EA per 365 days)
GUARDIAN 4 GLUCOSE SENSOR	2	PA; QL (5 EA per 30 days)
GUARDIAN 4 TRANSMITTER	2	PA; QL (1 EA per 365 days)
GUARDIAN LINK 3 TRANSMITTER	2	PA; QL (1 EA per 365 days)
GUARDIAN SENSOR (3)	2	PA; QL (5 EA per 30 days)
<i>guardian sensor 3</i>	2	PA; QL (5 EA per 30 days)
*INSULIN ADMINISTRATION SUPPLIES***		
OMNIPOD 5 LIBRE2 G6 INTRO G5 KIT	3	PA; QL (1 EA per 365 days); NDS
OMNIPOD 5 LIBRE2 PLUS G6 PODS	3	PA; QL (10 Pods per 30 days); NDS
OMNIPOD DASH INTRO (GEN 4) KIT	3	PA; QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	3	PA; QL (10 Pods per 30 days); NDS

Drug Name	Tier	Notes
*NEEDLES & SYRINGES***		
BD PEN NEEDLE MINI U/F 31G X 5 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE NANO U/F 32G X 4 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE SHORT U/F 31G X 8 MM	1	QL (100 EA per 30 days)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM	1	QL (100 EA per 30 days)
NOVOFINE 32G X 6 MM	1	QL (100 EA per 30 days)
NOVOFINE PEN NEEDLE 32G X 6 MM	1	QL (100 EA per 30 days)
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM	1	QL (100 EA per 30 days)
NOVOTWIST 32G X 5 MM	1	
*SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES***		
AEROCHAMBER PLUS FLO-VU	3	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
AEROCHAMBER PLUS FLOW VU	3	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
AEROCHAMBER Z-STAT PLUS	3	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
EASIVENT	3	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND	1	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-MD MASK	1	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-SM MASK	1	QL (2 EA per 180 days)
POCKET CHAMBER DEVICE	1	QL (2 EA per 180 days)
VORTEX VALVED HOLDING CHAMBER DEVICE	1	QL (2 EA per 180 days)
MIGRAINE PRODUCTS		
*CGRP RECEPTOR ANTAGONISTS - MONOCLONAL ANTIBODIES***		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	2	PA; QL (1 ML per 28 days); NDS
*ERGOT COMBINATIONS***		
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	3	QL (40 EA per 30 days)
*MIGRAINE PRODUCTS***		
D.H.E. 45 INJECTION SOLUTION 1 MG/ML	MB	
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	3	ST; QL (8 ML per 30 days)
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	4	ST; QL (8 ML per 30 days)

Drug Name	Tier	Notes
*SELECTIVE SEROTONIN AGONISTS 5-HT(1)***		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	3	ST; QL (18 EA per 30 days)
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	3	ST; QL (18 EA per 30 days)
<i>frovatriptan succinate oral tablet 2.5 mg</i>	3	ST; QL (18 EA per 30 days)
<i>naratriptan hcl oral tablet 1 mg</i>	3	QL (18 EA per 30 days)
<i>naratriptan hcl oral tablet 2.5 mg</i>	1	QL (18 EA per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	1	QL (18 EA per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	1	QL (18 EA per 30 days)
<i>sumatriptan nasal solution 20 mg/act</i>	1	QL (2 ML per 30 days)
<i>sumatriptan nasal solution 5 mg/act</i>	1	QL (6 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	1	QL (18 EA per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml</i>	1	
<i>sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml</i>	1	QL (2 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	1	QL (2 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	1	QL (2 ML per 30 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	1	ST; QL (18 EA per 30 days)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	3	ST; QL (18 EA per 30 days)
MINERALS & ELECTROLYTES		
*CALCIUM***		
<i>calcium gluconate intravenous solution 10 %</i>	MB	
*FLUORIDE***		
Flura-Drops Oral Solution 0.275 (0.125 F) MG/DROP, 0.55 (0.25 F) MG/DROP	\$0	\$0 Copay per PPACA Guidelines.; AL (Max 6 Years)
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	\$0	\$0 copay per PPACA guidelines.; AL (Max 6 Years)
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	\$0	\$0 Copay per PPACA guidelines.; AL (Max 6 Years)
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	\$0	\$0 Copay per PPACA guidelines.; AL (Max 6 Years)
*POTASSIUM***		
KLOR-CON 10 TABLET EXTENDED RELEASE 10 MEQ ORAL	1	Generic NDC: 00245-0836-13
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	1	

Drug Name	Tier	Notes
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	1	
KLOR-CON ORAL PACKET 20 MEQ	1	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	1	
KLOR-CON/EF ORAL TABLET EFFERVESCENT 25 MEQ	1	
K-PRIME ORAL TABLET EFFERVESCENT 25 MEQ	1	
<i>potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq</i>	1	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	1	
<i>potassium chloride er oral tablet extended release 10 meq, 8 meq</i>	1	
<i>potassium chloride oral packet 20 meq</i>	1	
*ZINC***		
<i>zinc sulfate intravenous solution 3 mg/ml</i>	MB	
MISCELLANEOUS THERAPEUTIC CLASSES		
*ANTILEPROTICS***		
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	4	PA; DX (Diagnosis Validation Required); NDS; SP
*B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS***		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	4	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
*CHELATING AGENTS***		
<i>penicillamine oral tablet 250 mg</i>	4	PA; QL (240 EA per 30 days)
*CYCLOSPORINE ANALOGS***		
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	1	
GENGRAF ORAL CAPSULE 100 MG, 25 MG	2	
GENGRAF ORAL SOLUTION 100 MG/ML	2	
SANDIMMUNE ORAL SOLUTION 100 MG/ML	2	
*ENZYMES***		

Drug Name	Tier	Notes
HYLENEX INJECTION SOLUTION 150 UNIT/ML	MB	PA
*IMMUNOMODULATORS FOR MYELOYDYSPLASTIC SYNDROMES***		
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	4	PA; LA; DX (Diagnosis Validation Required); NDS
<i>lenalidomide oral capsule 2.5 mg, 20 mg</i>	4	PA; DX (Diagnosis Validation Required); NDS; SP
*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS***		
<i>mycophenolate mofetil oral capsule 250 mg</i>	1	
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	4	PA; AL (Max 12 Years)
<i>mycophenolate mofetil oral tablet 500 mg</i>	1	
*MACROLIDE IMMUNOSUPPRESSANTS***		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG	3	PA; QL (30 EA per 30 days)
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG	4	PA; QL (120 EA per 30 days)
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG	4	PA; QL (90 EA per 30 days)
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg</i>	4	PA; NDS; SP
<i>everolimus oral tablet 1 mg</i>	4	PA
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	3	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	1	
*MONOCLONAL ANTIBODIES***		
SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG	MB	
*POTASSIUM REMOVING AGENTS***		
LOKELMA ORAL PACKET 10 GM	4	PA; QL (30 EA per 30 days)
LOKELMA ORAL PACKET 5 GM	4	PA; QL (90 EA per 30 days)
<i>sodium polystyrene sulfonate oral powder</i>	1	
VELTASSA ORAL PACKET 1 GM, 16.8 GM, 25.2 GM, 8.4 GM	4	PA; QL (30 EA per 30 days)
*PURINE ANALOGS***		
<i>azathioprine oral tablet 50 mg</i>	1	
*SCLEROSING AGENTS***		
ETHAMOLIN INTRAVENOUS SOLUTION 5 %	MB	
MOUTH/THROAT/DENTAL AGENTS		
*ANESTHETICS TOPICAL ORAL ***		

Drug Name	Tier	Notes
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	1	
<i>lidocaine viscous mouth/throat solution 2 %</i>	1	
*ANTI-INFECTIVES - THROAT***		
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	1	
*ANTISEPTICS - MOUTH/THROAT***		
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	
PERIOGARD MOUTH/THROAT SOLUTION 0.12 %	1	
*SALIVA STIMULANTS***		
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	1	QL (90 EA per 30 days)
*STEROIDS - MOUTH/THROAT/DENTAL ***		
ORALONE MOUTH/THROAT PASTE 0.1 %	1	QL (5 GM per 30 days)
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	1	QL (5 GM per 30 days)
MULTIVITAMINS		
*PEDIATRIC VITAMINS A & D W/ C***		
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	\$0	\$0 Copay per PPACA Guidelines.; AL (Max 6 Years)
*PRENATAL MV & MIN W/FE-FA***		
CO-NATAL FA ORAL TABLET	2	
INATAL GT ORAL TABLET	2	
<i>multi prenatal oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
NIVA-PLUS ORAL TABLET 27-1 MG	2	
OBSTETRIX EC (WITH DOCUSATE) ORAL TABLET 29-1 MG	2	
OBSTETRIX EC ORAL TABLET 29-1 MG	2	
OBTREX ORAL TABLET	2	
<i>pnv prenatal plus multivitamin oral tablet 27-1 mg</i>	2	
<i>pnv tabs 29-1 oral tablet 29-1 mg</i>	2	
PRENATABS RX ORAL TABLET 29-1 MG	2	
<i>prenatal 19 oral tablet chewable , 29-1 mg</i>	2	
<i>prenatal low iron oral tablet 27-0.8 mg</i>	2	AL (Max 55 Years)
<i>prenatal one daily oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
<i>prenatal oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
<i>prenatal oral tablet 27-1 mg</i>	2	
<i>prenatal plus iron oral tablet 29-1 mg</i>	2	
<i>prenatal plus oral tablet 27-1 mg</i>	2	

Drug Name	Tier	Notes
<i>prenatal plus/iron oral tablet 27-1 mg</i>	2	
<i>prenatal vitamin oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
PRENATAL/FOLIC ACID ORAL TABLET	2	
PRENATAL-U ORAL CAPSULE 106.5-1 MG	2	
<i>preplus oral tablet 27-1 mg</i>	2	
<i>pretab oral tablet 29-1 mg</i>	2	
<i>right step prenatal oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
<i>se-natal 19 oral tablet chewable 29-1 mg</i>	2	
THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG	2	
TRICARE ORAL TABLET	2	
MUSCULOSKELETAL THERAPY AGENTS		
*CENTRAL MUSCLE RELAXANTS***		
<i>baclofen oral tablet 10 mg, 20 mg</i>	1	
<i>chlorzoxazone oral tablet 500 mg</i>	1	
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	1	
LIORESAL INTRATHECAL SOLUTION 0.05 MG/ML	MB	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	1	
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	1	
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	1	
*DIRECT MUSCLE RELAXANTS***		
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	1	
*VISCOSUPPLEMENTS***		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE 60 MG/3ML	MB	PA; NDS
NASAL AGENTS - SYSTEMIC AND TOPICAL		
*NASAL ANTICHOLINERGICS***		
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	
*NASAL ANTIHISTAMINES***		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1	
*NASAL STEROIDS***		
BECONASE AQ NASAL SUSPENSION 42 MCG/SPRAY	3	ST; Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center

Drug Name	Tier	Notes
<i>budesonide nasal suspension 32 mcg/act</i>	3	ST; Benefit Exclusion for group A000001 PRES Employees.
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	2	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	1	BENEFIT EXCLUSION for group A0000001 Pres Emp
<i>mometasone furoate nasal suspension 50 mcg/act</i>	3	ST; BENEFIT EXCLUSION for group A000001 Pres Emp
NEUROMUSCULAR AGENTS		
*BENZATHIAZOLES***		
<i>riluzole oral tablet 50 mg</i>	4	
*DEPOLARIZING MUSCLE RELAXANTS***		
ANECTINE INJECTION SOLUTION 20 MG/ML	MB	
QUELICIN INJECTION SOLUTION 20 MG/ML	MB	
<i>succinylcholine chloride injection solution 20 mg/ml</i>	MB	
*NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS***		
BOTOX INJECTION SOLUTION RECONSTITUTED 200 UNIT	MB	PA
MYOBLOC INTRAMUSCULAR SOLUTION 10000 UNIT/2ML, 2500 UNIT/0.5ML, 5000 UNIT/ML	MB	PA
OPHTHALMIC AGENTS		
*ALPHA ADRENERGIC AGONIST & CARBONIC ANHYDRASE INHIB COMB***		
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	3	QL (8 ML per 30 days)
*BETA-BLOCKERS - OPHTHALMIC COMBINATIONS***		
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	3	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	1	
*BETA-BLOCKERS - OPHTHALMIC***		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	1	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 %	2	
<i>carteolol hcl ophthalmic solution 1 %</i>	1	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	3	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	
*CYCLOPLEGIC MYDRIATICS***		

Drug Name	Tier	Notes
ATROPINE SULFATE OPHTHALMIC OINTMENT 1 %	1	
ATROPINE SULFATE OPHTHALMIC SOLUTION 1 %	2	
CYCLOGYL OPHTHALMIC SOLUTION 0.5 %, 2 %	2	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	1	
HOMATROPAIRE OPHTHALMIC SOLUTION 5 %	1	
<i>phenylephrine hcl ophthalmic solution 10 %, 2.5 %</i>	1	
<i>tropicamide ophthalmic solution 0.5 %, 1 %</i>	1	
*MIOTICS - CHOLINESTERASE INHIBITORS***		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 %	2	
*MIOTICS - DIRECT ACTING***		
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	1	
*OPHTHALMIC ANTIALLERGIC***		
ALOCRIAL OPHTHALMIC SOLUTION 2 %	3	
ALOMIDE OPHTHALMIC SOLUTION 0.1 %	2	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	1	
*OPHTHALMIC ANTIBIOTICS***		
CILOXAN OPHTHALMIC OINTMENT 0.3 %	2	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	1	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	\$0	\$0 Copay for members 1 year of age or younger per PPACA guidelines; AL (Max 1 Years)
GENTAK OPHTHALMIC OINTMENT 0.3 %	1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	1	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	3	
<i>ofloxacin ophthalmic solution 0.3 %</i>	1	
<i>tobramycin ophthalmic solution 0.3 %</i>	1	
TOBREX OPHTHALMIC OINTMENT 0.3 %	2	
*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS***		
<i>ak-poly-bac ophthalmic ointment 500-10000 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	1	

Drug Name	Tier	Notes
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
*OPHTHALMIC ANTIVIRALS***		
trifluridine ophthalmic solution 1 %	1	
*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS***		
brinzolamide ophthalmic suspension 1 %	3	
dorzolamide hcl ophthalmic solution 2 %	1	
*OPHTHALMIC IMMUNOMODULATORS***		
cyclosporine ophthalmic emulsion 0.05 %	3	QL (60 EA per 30 days)
*OPHTHALMIC LOCAL ANESTHETICS***		
proparacaine hcl ophthalmic solution 0.5 %	1	
*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS***		
diclofenac sodium ophthalmic solution 0.1 %	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
*OPHTHALMIC RHO KINASE INHIBITORS***		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	2	ST
*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS***		
apraclonidine hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate ophthalmic solution 0.1 %	2	
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	1	
*OPHTHALMIC STEROID COMBINATIONS***		
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	1	
BLEPHAMIDE OPHTHALMIC SUSPENSION 10-0.2 %	2	
BLEPHAMIDE S.O.P. OPHTHALMIC OINTMENT 10-0.2 %	2	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	

Drug Name	Tier	Notes
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	1	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	3	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	1	
*OPHTHALMIC STEROIDS***		
ALREX OPHTHALMIC SUSPENSION 0.2 %	3	ST
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	1	
<i>fluorometholone ophthalmic suspension 0.1 %</i>	1	
FML FORTE OPHTHALMIC SUSPENSION 0.25 %	2	
FML OPHTHALMIC OINTMENT 0.1 %	2	
LOTEMAX SM OPHTHALMIC GEL 0.38 %	2	ST
<i>loteprednol etabonate ophthalmic gel 0.5 %</i>	3	ST
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	3	ST
MAXIDEX OPHTHALMIC SUSPENSION 0.1 %	2	
PRED MILD OPHTHALMIC SUSPENSION 0.12 %	2	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	1	
*OPHTHALMIC SULFONAMIDES***		
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	1	
*OPHTHALMIC SURGICAL AIDS - COMBINATIONS***		
OMIDRIA INTRAOCULAR SOLUTION 1-0.3 %	MB	
*PROSTAGLANDINS - OPHTHALMIC***		
<i>latanoprost ophthalmic solution 0.005 %</i>	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	2	
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	3	
*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS***		
EYLEA HD INTRAVITREAL SOLUTION 8 MG/0.07ML	MB	
PAVBLU INTRAVITREAL SOLUTION 2 MG/0.05ML	MB	
PAVBLU INTRAVITREAL SOLUTION PREFILLED SYRINGE 2 MG/0.05ML	MB	

Drug Name	Tier	Notes
OTIC AGENTS		
*OTIC AGENTS - MISCELLANEOUS***		
<i>acetic acid otic solution 2 %</i>	1	
*OTIC ANTI-INFECTIVES***		
<i>ofloxacin otic solution 0.3 %</i>	1	
*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS***		
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	3	ST; QL (7.5 ML per 30 days); AL (Max 12 Years)
<i>neomycin-polymyxin-hc otic solution 3.5-10000-1</i>	1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	1	
*OTIC STEROIDS***		
<i>fluocinolone acetonide otic oil 0.01 %</i>	1	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	1	
OXYTOCICS		
*ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS***		
<i>carboprost tromethamine intramuscular solution 250 mcg/ml</i>	MB	
PREPIDIL VAGINAL GEL 0.5 MG/3GM	3	
*OXYTOCICS***		
<i>methylergonovine maleate injection solution 0.2 mg/ml</i>	2	
<i>methylergonovine maleate oral tablet 0.2 mg</i>	2	
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
*ANTITOXINS-ANTIVENINS***		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
ANAVIP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED	MB	
*ANTIVIRAL MONOCLONAL ANTIBODIES***		
BEYFORTUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML	MB	
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML	MB	PA; NDS
*IMMUNE SERUMS***		

Drug Name	Tier	Notes
CYTOGAM INTRAVENOUS INJECTABLE 50 MG/ML	MB	PA
CYTOGAM INTRAVENOUS SOLUTION 50 MG/ML	MB	PA
PENICILLINS		
*AMINOPENICILLINS***		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	
AMOXICILLIN ORAL TABLET CHEWABLE 125 MG, 250 MG	2	
<i>ampicillin oral capsule 500 mg</i>	2	
<i>ampicillin sodium injection solution reconstituted 125 mg</i>	MB	
*NATURAL PENICILLINS***		
BICILLIN L-A INTRAMUSCULAR SUSPENSION 600000 UNIT/ML	MB	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 600000 UNIT/ML	MB	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	
*PENICILLIN COMBINATIONS***		
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	1	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	1	
AMOXICILLIN-POT CLAVULANATE ORAL TABLET CHEWABLE 200-28.5 MG, 400-57 MG	2	
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML	MB	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML	MB	
UNASYN INJECTION SOLUTION RECONSTITUTED 1.5 (1-0.5) GM	MB	
*PENICILLINASE-RESISTANT PENICILLINS***		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	1	
PROGESTINS		
*PROGESTINS***		
GALLIFREY ORAL TABLET 5 MG	1	

Drug Name	Tier	Notes
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
<i>megestrol acetate oral suspension 625 mg/5ml</i>	1	PA
<i>norethindrone acetate oral tablet 5 mg</i>	1	
<i>progesterone oral capsule 100 mg, 200 mg</i>	1	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
*ALCOHOL DETERRENTS***		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
<i>disulfiram oral tablet 250 mg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>disulfiram oral tablet 500 mg</i>	1	
*ANTI-CATAPLECTIC AGENTS***		
<i>sodium oxybate oral solution 500 mg/ml</i>	4	PA; LA; QL (540 ML per 30 days); AL (Min 7 Years); NDS
*BENZODIAZEPINES & TRICYCLIC AGENTS***		
CHLORDIAZEPOXIDE-AMITRIPTYLINE ORAL TABLET 10-25 MG, 5-12.5 MG	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*CHOLINOMIMETICS - ACHE INHIBITORS***		
<i>donepezil hcl oral tablet 10 mg</i>	1	QL (30 EA per 30 days)

Drug Name	Tier	Notes
<i>donepezil hcl oral tablet 5 mg</i>	1	QL (60 EA per 30 days)
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	1	PA; QL (30 EA per 30 days)
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	1	
GALANTAMINE HYDROBROMIDE ORAL SOLUTION 4 MG/ML	2	
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	1	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	3	
*MOVEMENT DISORDER DRUG THERAPY***		
AUSTEDO ORAL TABLET 12 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); NDS; SP
AUSTEDO ORAL TABLET 6 MG, 9 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); NDS; SP
<i>tetrabenazine oral tablet 12.5 mg</i>	4	PA; QL (90 EA per 30 days); NDS; SP
<i>tetrabenazine oral tablet 25 mg</i>	4	PA; QL (120 EA per 30 days); NDS; SP
*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS***		
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	1	QL (30 EA per 30 days)
*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES***		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (20 per per 326 days); NDS; SP
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (8 per per 326 days); NDS; SP

Drug Name	Tier	Notes
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (10 per per 326 days); NDS; SP
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (12 per per 326 days); NDS; SP
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (14 Per per 326 days); NDS; SP
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (16 per per 326 days); NDS; SP
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG	4	PA; DX (Diagnosis Validation Required); QL (18 Per per 326 days); NDS; SP
*MULTIPLE SCLEROSIS AGENTS - INTERFERONS***		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML	4	DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	4	DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
*MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES***		
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML	MB	PA; DX (Diagnosis Validation Required)
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML	MB	PA; DX (Diagnosis Validation Required); NDS; SP
*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS***		
<i>dimethyl fumarate oral capsule delayed release 120 mg, 240 mg</i>	1	DX (Diagnosis Validation Required); QL (60 EA per 30 days)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	1	DX (Diagnosis Validation Required); QL (60 EA per 30 days)
*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS***		
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	3	DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS
*MULTIPLE SCLEROSIS AGENTS***		
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	DX (Diagnosis Validation Required); QL (30 ML per 30 days); NDS; SP
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	4	DX (Diagnosis Validation Required); QL (12 ML per 28 days); NDS; SP
*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS***		

Drug Name	Tier	Notes
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	3	ST; QL (30 EA per 30 days)
<i>memantine hcl oral tablet 10 mg, 5 mg</i>	1	QL (60 EA per 30 days)
*PHENOTHIAZINES & TRICYCLIC AGENTS***		
PERPHENAZINE-AMITRIPTYLINE ORAL TABLET 2-10 MG, 2-25 MG, 4-10 MG, 4-25 MG, 4-50 MG	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*PSEUDOBULBAR AFFECT AGENT COMBINATIONS***		
NUEDEXTA ORAL CAPSULE 20-10 MG	4	PA; QL (60 EA per 30 days)
*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.***		
ERGOLOID MESYLATES ORAL TABLET 1 MG	2	
<i>pimozide oral tablet 1 mg, 2 mg</i>	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*SMOKING DETERRENTS***		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	\$0	\$0 Copay per PPACA guidelines. Limited to two 90 day courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (360 EA per 365 days)

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

Drug Name	Tier	Notes
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr	\$0	<p>\$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (182 EA per 365 days)</p>
nicotine transdermal patch 24 hour 7 mg/24hr	\$0	<p>\$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (182 EA per 365 days)</p>
Nicotrol Inhalation Inhaler 10 MG	\$0	<p>ST; \$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3024 EA per 365 days)</p>
Nicotrol NS Nasal Solution 10 MG/ML	\$0	<p>ST; \$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share.</p> <p>* High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (720 ML per 365 days)</p>

Drug Name	Tier	Notes
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	\$0	QL (106 EA per 365 days)
varenicline tartrate oral tablet 0.5 mg, 1 mg	\$0	QL (360 EA per 365 days)
varenicline tartrate(continue) oral tablet 1 mg	\$0	QL (360 EA per 365 days)
*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS***		
<i>fingolimod hcl oral capsule 0.5 mg</i>	3	
MAYZENT ORAL TABLET 0.25 MG	4	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
MAYZENT ORAL TABLET 1 MG, 2 MG	4	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG, 7 X 0.25 MG	4	PA; DX (Diagnosis Validation Required); QL (1 pack per 365 days); NDS; SP
*THIENBENZODIAZEPINES & OPIOID ANTAGONISTS***		
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
RESPIRATORY AGENTS - MISC.		
*CFTR POTENTIATORS***		
KALYDECO ORAL PACKET 13.4 MG	4	PA; QL (2 packets per 1 day); AL (Max 6 Years); NDS; SP
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG	4	PA; QL (60 EA per 30 days); AL (Max 6 Years); NDS; SP
KALYDECO ORAL TABLET 150 MG	4	PA; QL (60 EA per 30 days); AL (Min 6 Years); NDS; SP
*CYSTIC FIBROSIS AGENT - COMBINATIONS***		
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	4	PA; QL (120 EA per 30 days); NDS; SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG	4	PA; QL (60 EA per 30 days); NDS; SP
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG	4	PA; QL (60 EA per 30 days); AL (Min 6 Years and Max 12 Years); NDS; SP
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	4	PA; QL (90 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	4	PA; QL (2 packets per 1 day); NDS; SP
*HYDROLYTIC ENZYMES***		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	4	LA; NDS
*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS***		
OFEV ORAL CAPSULE 100 MG, 150 MG	4	PA; QL (60 EA per 30 days); NDS; SP
SULFONAMIDES		
*SULFONAMIDES***		
SULFADIAZINE ORAL TABLET 500 MG	1	
TETRACYCLINES		
*TETRACYCLINES***		
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	3	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>doxycycline hyclate oral tablet 100 mg</i>	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
<i>doxycycline hyclate oral tablet 20 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	
TETRACYCLINE HCL ORAL CAPSULE 250 MG, 500 MG	2	
VIBRAMYCIN ORAL SUSPENSION RECONSTITUTED 25 MG/5ML	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
THYROID AGENTS		
*ANTITHYROID AGENTS***		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	
<i>propylthiouracil oral tablet 50 mg</i>	1	
*THYROID HORMONES***		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG	2	
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	1	

Drug Name	Tier	Notes
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
NATURE-THROID ORAL TABLET 113.75 MG, 130 MG, 146.25 MG, 16.25 MG, 162.5 MG, 195 MG, 260 MG, 32.5 MG, 325 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG	2	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	1	
WESTHROID ORAL TABLET 130 MG, 195 MG, 32.5 MG, 65 MG, 97.5 MG	2	
TOXOIDS		
*TOXOID COMBINATIONS***		
Adacel Intramuscular Suspension 5-2-15.5 LF-MCG/0.5	\$0	\$0 Copay for Preventative Services.
Boostrix Intramuscular Suspension 5-2.5-18.5 LF-MCG/0.5	\$0	\$0 Copay per PPACA Guidelines.
Boostrix Intramuscular Suspension Prefilled Syringe 5-2.5-18.5 LF-MCG/0.5	\$0	\$0 Copay for Preventative Services.
tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml	\$0	\$0 Copay for Preventative Services.
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINE RGICS		
*ANTISPASMODICS***		
BENTYL INTRAMUSCULAR SOLUTION 10 MG/ML	MB	
<i>dicyclomine hcl intramuscular solution 10 mg/ml</i>	MB	
<i>dicyclomine hcl oral capsule 10 mg</i>	1	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	1	
<i>dicyclomine hcl oral tablet 20 mg</i>	1	
*BELLADONNA ALKALOIDS***		
<i>atropine sulfate injection solution 8 mg/20ml</i>	MB	

Drug Name	Tier	Notes
<i>atropine sulfate injection solution prefilled syringe 1 mg/10ml</i>	MB	
<i>hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg</i>	1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate oral solution 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	1	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	1	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	1	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG	1	
*H-2 ANTAGONISTS***		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	2	
*MISC. ANTI-ULCER***		
<i>sucralfate oral suspension 1 gm/10ml</i>	3	QL (1200 ML per 30 days); AL (Max 12 Years)
<i>sucralfate oral tablet 1 gm</i>	1	
*PROTON PUMP INHIBITORS***		
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</i>	1	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center; QL (30 EA per 30 days)
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	3	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center; QL (60 EA per 30 days)
<i>omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg</i>	1	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center; QL (60 EA per 30 days)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center; QL (60 EA per 30 days)
<i>pantoprazole sodium intravenous solution reconstituted 40 mg</i>	MB	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center

Drug Name	Tier	Notes
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center; QL (60 EA per 30 days)
PROTONIX INTRAVENOUS SOLUTION RECONSTITUTED 40 MG	MB	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	1	Benefit Exclusion for Pres Employees A0000001 and A000263 Farmers Family Center; QL (60 EA per 30 days)
*QUATERNARY ANTICHOLINERGICS***		
<i>glycopyrrolate injection solution 0.2 mg/ml, 0.4 mg/2ml, 1 mg/5ml, 4 mg/20ml</i>	1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	
*ULCER DRUGS - PROSTAGLANDINS***		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	1	
URINARY ANTISPASMODICS		
*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)***		
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	1	
<i>oxybutynin chloride oral syrup 5 mg/5ml</i>	1	
<i>oxybutynin chloride oral tablet 5 mg</i>	1	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	1	QL (30 EA per 30 days)
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	3	QL (30 EA per 30 days)
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	1	
<i>trospium chloride er oral capsule extended release 24 hour 60 mg</i>	3	ST; QL (30 EA per 30 days)
<i>trospium chloride oral tablet 20 mg</i>	3	
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS***		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	1	
*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS***		
<i>flavoxate hcl oral tablet 100 mg</i>	1	
VACCINES		
*BACTERIAL VACCINES***		
Capvaxive Intramuscular Solution Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 1 Lifetime)

Drug Name	Tier	Notes
Menactra Intramuscular Injectable	\$0	\$0 Copay for Preventative Services.
Menactra Intramuscular Solution	\$0	
MenQuadfi Intramuscular Solution 0.5 ML	\$0	
Menveo Intramuscular Solution	\$0	\$0 Copay for Preventative Services.
Menveo Intramuscular Solution Reconstituted	\$0	\$0 Copay for Preventative Services.
Penbraya Intramuscular Suspension Reconstituted	\$0	
Pneumovax 23 Injection Injectable 25 MCG/0.5ML	\$0	\$0 Copay for Preventative Services
Pneumovax 23 Injection Solution 25 MCG/0.5ML	\$0	\$0 Copay for Preventative Services
Pneumovax 23 Injection Solution Prefilled Syringe 25 MCG/0.5ML	\$0	\$0 Copay for Preventative Services
Prevnar 13 Intramuscular Suspension	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Prevnar 20 Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay Preventative Services; QL (0.5 ML per 1 Lifetime)
Trumenba Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	
Vaxneuvance Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay Preventative Services
*VIRAL VACCINE COMBINATIONS***		
M-M-R II Injection Solution Reconstituted	\$0	
M-M-R II Subcutaneous Injectable	\$0	
Twinrix Intramuscular Suspension Prefilled Syringe 720-20 ELU-MCG/ML	\$0	
*VIRAL VACCINES***		
Abrysvo Intramuscular Solution Reconstituted 120 MCG/0.5ML	\$0	AL (Min 60 Years)
Afluria Intramuscular Suspension	\$0	QL (0.5 ML per 180 days)
Afluria Preservative Free Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days)
Arexvy Intramuscular Suspension Reconstituted 120 MCG/0.5ML	\$0	AL (Min 60 Years)
astrazeneca covid-19 vaccine intramuscular suspension 0.5 ml	\$0	
Comirnaty Intramuscular Suspension 30 MCG/0.3ML	\$0	QL (0.3 ML per 21 days); AL (Min 12 Years)
Comirnaty Intramuscular Suspension Prefilled Syringe 30 MCG/0.3ML	\$0	AL (Min 12 Years)
Engerix-B Injection Suspension 10 MCG/0.5ML, 20 MCG/ML	\$0	\$0 Copay for Preventative Services.
Fluad Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days); AL (Min 65 Years)
Fluarix Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days)

Drug Name	Tier	Notes
Flucelvax Intramuscular Suspension	\$0	QL (0.5 ML per 180 days)
Flucelvax Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days)
Flulaval Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days)
Flulaval Quadrivalent Intramuscular Suspension	\$0	QL (0.5 ML per 180 days)
Flulaval Quadrivalent Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
FluMist Nasal Liquid	\$0	QL (0.5 mL per 180 days); AL (Min 2 Years and Max 49 Years)
FluMist Quadrivalent Nasal Suspension	\$0	QL (1 EA per 180 days); AL (Min 2 Years and Max 49 Years)
Fluzone High-Dose Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days); AL (Min 65 Years)
Fluzone Intramuscular Suspension	\$0	QL (0.5 ML per 180 days)
Fluzone Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	QL (0.5 ML per 180 days)
Gardasil 9 Intramuscular Suspension 0.5 ML	\$0	\$0 Copay PPACA Guidelines.; AL (Min 9 Years and Max 45 Years)
Gardasil 9 Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay PPACA Guidelines.; AL (Min 9 Years and Max 45 Years)
Havrix Intramuscular Suspension 1440 EL U/ML	\$0	\$0 Copay for Preventative Services.
Havrix Intramuscular Suspension 720 EL U/0.5ML	\$0	\$0 Copay for Preventative Services
Havrix Intramuscular Suspension Prefilled Syringe 720 EL U/0.5ML	\$0	\$0 Copay for Preventative Services
Heplisav-B Intramuscular Solution Prefilled Syringe 20 MCG/0.5ML	\$0	
Ipol Injection Injectable	\$0	
janssen covid-19 vaccine intramuscular suspension 0.5 ml	\$0	Max 2 doses in 365 days; QL (0.5 ML per 56 days); AL (Min 18 Years)
mNexspike Intramuscular Suspension Prefilled Syringe 10 MCG/0.2ML	\$0	AL (Min 12 Years)
moderna covid-19 bival 6m-5y intramuscular suspension 10 mcg/0.2ml	\$0	
moderna covid-19 bival booster intramuscular suspension 50 mcg/0.5ml	\$0	\$0 Copay Preventative; QL (0.5 ML per 365 days); AL (Min 18 Years)
moderna covid-19 bivalent intramuscular suspension 50 mcg/0.5ml	\$0	\$0 Copay Preventative; QL (0.5 ML per 365 days); AL (Min 18 Years)
moderna covid-19 vac (booster) intramuscular suspension 50 mcg/0.5ml, 50 mg/0.5ml	\$0	Max 3 doses in 365 days; QL (0.5 ML per 28 days); AL (Min 6 Years)
Moderna COVID-19 Vac 6m-11y Intramuscular Suspension 25 MCG/0.25ML	\$0	
moderna covid-19 vacc 6-11y intramuscular suspension 50 mcg/0.5ml	\$0	Max 3 doses in 365 days; QL (0.5 ML per 28 days); AL (Min 6 Years)
moderna covid-19 vacc 6m-5y intramuscular suspension 25 mcg/0.25ml	\$0	Max 3 doses in 365 days; QL (0.25 ML per 28 days); AL (Min 6 Years)

Drug Name	Tier	Notes
moderna covid-19 vaccine intramuscular suspension 100 mcg/0.5ml	\$0	QL (0.5 ML per 28 days); AL (Min 12 Years)
novavax covid-19 vaccine intramuscular suspension prefilled syringe 5 mcg/0.5ml	\$0	Max 2 doses in 365 days; QL (0.5 ML per 28 days); AL (Min 12 Years)
pfizer covid-19 vac bivalent intramuscular suspension 30 mcg/0.3ml	\$0	QL (0.3 ML per 365 days); AL (Min 12 Years)
pfizer covid-19 vac-tris 5-11y intramuscular suspension 10 mcg/0.2ml	\$0	Max 3 doses in 365 days; QL (0.2 ML per 21 days); AL (Min 5 Years)
Pfizer COVID-19 Vac-TriS 5-11y Intramuscular Suspension 10 MCG/0.3ML	\$0	AL (Min 3 Years and Max 11 Years)
pfizer covid-19 vac-tris 6m-4y intramuscular suspension 3 mcg/0.2ml	\$0	Max 3 doses in 365 days; QL (0.2 ML per 21 days); AL (Min 6 Years)
pfizer covid-19 vac-tris 6m-4y intramuscular suspension 3 mcg/0.3ml	\$0	
pfizer-biont covid-19 vac-tris intramuscular suspension 30 mcg/0.3ml	\$0	QL (0.3 ML per 21 days); AL (Min 12 Years)
pfizer-biontech covid-19 vacc intramuscular suspension 30 mcg/0.3ml	\$0	QL (0.3 ML per 21 days); AL (Min 12 Years)
Recombivax HB Injection Suspension 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	\$0	\$0 Copay for Preventative Services.
Shingrix Intramuscular Suspension Reconstituted 50 MCG/0.5ML	\$0	QL (2 vials per 1 Lifetime); AL (Min 50 Years)
Spikevax Intramuscular Suspension Prefilled Syringe 50 MCG/0.5ML	\$0	
Vaqtia Intramuscular Suspension 25 UNIT/0.5ML	\$0	\$0 Copay for Preventative Services
Vaqtia Intramuscular Suspension 50 UNIT/ML	\$0	\$0 Copay for Preventative Services.
Varivax Injection Suspension Reconstituted 1350 PFU/0.5ML	\$0	\$0 Copay for Preventative Services.
Varivax Subcutaneous Injectable 1350 PFU/0.5ML	\$0	\$0 Copay for Preventative Services.
VAGINAL AND RELATED PRODUCTS		
*IMIDAZOLE-RELATED ANTIFUNGALS***		
terconazole vaginal cream 0.4 %, 0.8 %	1	
terconazole vaginal suppository 80 mg	1	
*SPERMICIDES***		
Encare Vaginal Suppository 100 MG	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
Options Gynol II Contraceptive Vaginal Gel 3 %	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
Shur-Seal Contraceptive Vaginal Gel 2 %	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
Today Sponge Vaginal 1000 MG	\$0	
VCF Vaginal Contraceptive Vaginal Film 28 %	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)

Drug Name	Tier	Notes
VCF Vaginal Contraceptive Vaginal Foam 12.5 %	\$0	\$0 Copay per PPACA guidelines.; AL (Max 55 Years)
VCF Vaginal Contraceptive Vaginal Gel 4 %	\$0	\$0 copay per PPACA guidelines.; AL (Max 55 Years)
*VAGINAL ANTI-INFECTIVES***		
<i>clindamycin phosphate vaginal cream 2 %</i>	1	
<i>metronidazole vaginal gel 0.75 %</i>	1	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
*VAGINAL ESTROGENS***		
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
<i>estradiol vaginal tablet 10 mcg</i>	1	
ESTRING VAGINAL RING 7.5 MCG/24HR	3	QL (1 EA per 90 days)
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR	3	QL (1 EA per 90 days)
PREMARIN VAGINAL CREAM 0.625 MG/GM	2	
YUVAFEM VAGINAL TABLET 10 MCG	1	
*VAGINAL PROGESTINS***		
CRINONE VAGINAL GEL 8 %	3	PA
VASOPRESSORS		
*ANAPHYLAXIS THERAPY AGENTS***		
EPINEPHRINE INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML, 0.3 MG/0.3ML	1	
SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML	1	
*VASOPRESSORS***		
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	
VITAMINS		
*VITAMIN D***		
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)</i>	1	
*VITAMIN K***		
<i>phytonadione oral tablet 5 mg</i>	4	

Medical Benefit

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

Drug Name	Tier	Notes
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML	MB	PA; QL (6 ML per 180 days); NDS
FemCap Vaginal Device 22 MM, 26 MM, 30 MM	\$0	\$0 copay per PPACA guidelines.
FERRLECIT INTRAVENOUS SOLUTION 12.5 MG/ML	MB	
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 0.5 GM/10ML, 10 GM/100ML, 2.5 GM/50ML, 20 GM/200ML, 20 GM/400ML	MB	PA; NDS
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/200ML, 5 GM/100ML, 5 GM/50ML	MB	PA
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
<i>fosaprepitant dimeglumine intravenous solution reconstituted 150 mg</i>	MB	QL (4 EA per 30 days)
<i>fosphenytoin sodium injection solution 100 mg pe/2ml, 500 mg pe/10ml</i>	MB	
GAMIFANT INTRAVENOUS SOLUTION 10 MG/2ML, 50 MG/10ML	MB	PA; NDS
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	MB	PA; NDS
GAZYVA INTRAVENOUS SOLUTION 1000 MG/40ML	MB	PA; DX (Diagnosis Validation Required)
<i>heparin sod (porcine) in d5w intravenous solution 100 unit/ml</i>	MB	
<i>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</i>	MB	
INFED INJECTION SOLUTION 50 MG/ML	MB	
INJECTAFER INTRAVENOUS SOLUTION 750 MG/15ML	MB	

Drug Name	Tier	Notes
JELMYTO SOLUTION RECONSTITUTED 80 (2 X 40) MG	MB	PA; DX (Diagnosis Validation Required); QL (17 Doses per 1 Lifetime); NDS
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG	MB	PA; DX (Diagnosis Validation Required); NDS
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML	MB	PA; NDS
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA; DX (Diagnosis Validation Required); NDS
KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 10 MG, 30 MG, 60 MG	MB	PA; DX (Diagnosis Validation Required)
LIBTAYO INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; DX (Diagnosis Validation Required); NDS
LUCENTIS INTRAVITREAL SOLUTION 0.3 MG/0.05ML, 0.5 MG/0.05ML	MB	NDS
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.; DX (Diagnosis Validation Required)
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.; DX (Diagnosis Validation Required)
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.; DX (Diagnosis Validation Required)
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.; DX (Diagnosis Validation Required)
MARQIBO INTRAVENOUS SUSPENSION 5 MG/31ML	MB	PA; DX (Diagnosis Validation Required); NDS
<i>micafungin sodium intravenous solution reconstituted 50 mg</i>	MB	
Mirena (52 MG) Intrauterine Device 20 MCG/24HR, 20 MCG/DAY	\$0	\$0 Copay per PPACA guidelines; AL (Max 55 Years)
<i>na ferric gluc cplx in sucrose intravenous solution 12.5 mg/ml</i>	MB	
Nexplanon Subcutaneous Implant 68 MG	\$0	\$0 Copay per PPACA guidelines; QL (1 EA per 3 Yearss); AL (Max 55 Years)
ONPATTRO INTRAVENOUS SOLUTION 10 MG/5ML	MB	PA; NDS
OPDIVO INTRAVENOUS SOLUTION 100 MG/10ML, 40 MG/4ML	MB	PA; DX (Diagnosis Validation Required)
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	MB	PA; DX (Diagnosis Validation Required); NDS
<i>palonosetron hcl intravenous solution 0.25 mg/5ml</i>	MB	QL (5 ML per 5 days)
PERJETA INTRAVENOUS SOLUTION 420 MG/14ML	MB	PA; DX (Diagnosis Validation Required); NDS

Drug Name	Tier	Notes
<i>procainamide hcl injection solution 100 mg/ml, 500 mg/ml</i>	MB	
PROVENGE INTRAVENOUS SUSPENSION	MB	PA; DX (Diagnosis Validation Required)
<i>romidepsin intravenous solution 27.5 mg/5.5ml</i>	MB	PA; DX (Diagnosis Validation Required); NDS
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	MB	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG	MB	
Skyla Intrauterine Intrauterine Device 13.5 MG	\$0	\$0 Copay per PPACA guidelines.
TESTOPEL IMPLANT PELLETT 75 MG	MB	PA; QL (6 EA per 90 days)
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED 420 MG	MB	DX (Diagnosis Validation Required)
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED 180 MG	MB	PA; DX (Diagnosis Validation Required); NDS
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML	MB	PA; DX (Diagnosis Validation Required); SP
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; NDS; SP
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	MB	PA
VENOFER INTRAVENOUS SOLUTION 20 MG/ML	MB	
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	MB	PA; NDS; SP
YERVOY INTRAVENOUS SOLUTION 200 MG/40ML, 50 MG/10ML	MB	PA; DX (Diagnosis Validation Required); NDS
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA; DX (Diagnosis Validation Required)
ZALTRAP INTRAVENOUS SOLUTION 200 MG/8ML	MB	PA; DX (Diagnosis Validation Required); NDS
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	MB	PA; DX (Diagnosis Validation Required)
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG	MB	DX (Diagnosis Validation Required)
<i>zoledronic acid intravenous concentrate 4 mg/5ml</i>	MB	NDS
<i>zoledronic acid intravenous solution 4 mg/100ml, 5 mg/100ml</i>	MB	NDS