PRESBYTERIAN

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

Presbyterian Health Plan and Presbyterian Insurance Company Individual and Family Metal Plans/Employer Group Metal Plans Formulary, Therapeutic Class Listing

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

What Is A Formulary?

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

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

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

How Is the Formulary Managed?

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

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

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

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

Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your provider and pharmacist check that the medications are used appropriately and promote patient safety.

Presbyterian Health Plan 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=0324498195**.

You may obtain more information by calling our local Pharmacy Services team, Monday through Friday, 7 a.m. to 6 p.m. at:

Presbyterian Insurance Company Commercial: (505) 923 -6980 or 1-800-923-6980
Presbyterian Health Plan Commercial HMO: (505) 923-5678 or 1-800-356-2219

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

Some medications may be excluded as determined by benefit.

Definition of Status

Icon	Status	Definition
	Tier 1	Tier 1 Preferred Generic.
	Tier 2	Tier 2 Non-Preferred Generic.
	Tier 3	Tier 3 Preferred Brand.
	Tier 4	Tier 4 Non-Preferred Drug.
	Tier 5	Tier 5 Self-Administered Specialty Pharmaceutical.
	$0	Zero Dollar Copay
	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
	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 a medical 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 dosages.
	Behavioral Health	. Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.
	Sexually Transmitted Infections	Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.
	Diagnosis Code	Diagnosis Code.
	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.
	Insulin for Diabetes Cost Sharing Cap	The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total of $25.00* per 30-day supply.

Icon	Restriction	Definition
		* High Deductible Health Plan copays/coinsurances will be applied towards the deductible, ***but your copay*** will not exceed a total $25.00* per thirty-day supply.
	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 health care 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 health care service and, if it meets our requirements for coverage and medical necessity, it is authorized (approved) before those services are provided.
	Quantity Limit	Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your doctor and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian Health Plan 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 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 Day	Schedule II maximum of 30-day supply.
	Specialty Pharmacy	Most specialty pharmaceuticals require prior authorization and must be obtained through the Specialty Pharmacy network. Specialty pharmaceuticals are often high cost, typically greater than $600 for up to a 30-day supply. Specialty pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply. Certain specialty pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.
	Split Fill - New Starts	Certain specialty pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.

Icon	Restriction	Definition
	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. at:

Presbyterian Insurance Company Commercial: (505) 923 -6980 or 1-800-923-6980
Presbyterian Health Plan Commercial HMO: (505) 923-5678 or 1-800-356-2219

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

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

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

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

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

Drug Name	Tier	Notes
amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 3 Years)
amphetamine-dextroamphetamine oral tablet 30 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 3 Years)
AMPHETAMINES**		
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg	2	PA required for age 19 years and older.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 6 Years and Max 18 Years)

Drug Name	Tier	Notes
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	2	PA required for age 19 years and older.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years and Max 18 Years)
dextroamphetamine sulfate oral tablet 10 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 3 Years)
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg	4	QL (30 EA per 30 days); AL (Min 6 Years)
methamphetamine hcl oral tablet 5 mg	4	PA; PA required for age 19 years and older.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (150 EA per 30 days); AL (Min 6 Years and Max 18 Years)
ANALEPTICS**		
CAFCIT INTRAVENOUS SOLUTION 60 MG/3ML	MB	
caffeine citrate intravenous solution 60 mg/3ml	2	
caffeine citrate oral solution 20 mg/ml	2	
ANOREXIANTS NON-AMPHETAMINE**		
benzphetamine hcl oral tablet 25 mg, 50 mg	4	PA; QL (90 EA per 30 days)
diethylpropion hcl er oral tablet extended release 24 hour 75 mg	4	PA; QL (30 EA per 30 days)
diethylpropion hcl oral tablet 25 mg	4	PA; QL (90 EA per 30 days)

Drug Name	Tier	Notes
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	4	PA; QL (30 EA per 30 days)
phendimetrazine tartrate oral tablet 35 mg	4	PA; QL (180 EA per 30 days)
phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg	4	
ANTI-OBESITY AGENT COMBINATIONS*		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)**		
SUNOSI ORAL TABLET 150 MG, 75 MG	5	PA; QL (30 EA per 30 days); AL (Min 18 Years)
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS**		
WAKIX ORAL TABLET 17.8 MG	5	PA; LA; QL (60 EA per 30 days); AL (Min 6 Years)
WAKIX ORAL TABLET 4.45 MG	5	PA; LA; QL (14 EA per 7 days); AL (Min 6 Years)
STIMULANTS - MISC.**		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	2	PA; QL (30 EA per 30 days)
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	2	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg	2	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er (osm) oral tablet extended release 36 mg	2	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 10 mg	2	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 20 mg	2	QL (90 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg	2	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 24 hour 36 mg	2	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl oral solution 10 mg/5ml	2	PA; PA required for age 19 years and older.; QL (450 ML per 30 days); AL (Min 6 Years and Max 12 Years)
methylphenidate hcl oral solution 5 mg/5ml	2	PA; PA required for age 19 years and older.; QL (180 ML per 30 days); AL (Min 6 Years and Max 12 Years)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	2	QL (90 EA per 30 days); AL (Min 3 Years)
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	4	QL (90 EA per 30 days); AL (Min 3 Years)
modafinil oral tablet 100 mg, 200 mg	2	QL (30 EA per 30 days)
AMINOGLYCOSIDES		
AMINOGLYCOSIDES**		
amikacin sulfate injection solution 50 mg/ml	MB	
gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%	MB	
neomycin sulfate oral tablet 500 mg	2	
paromomycin sulfate oral capsule 250 mg	4	
tobramycin inhalation nebulization solution 300 mg/5ml	5	SP

Drug Name	Tier	Notes
tobramycin sulfate injection solution 1.2 gm/30ml, 10 mg/ml, 80 mg/2ml	MB	
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS**		
RINVOQ LQ ORAL SOLUTION 1 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (360 ML per 30 days); SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 365 days); SP
XELJANZ ORAL SOLUTION 1 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (300 ML per 30 days); AL (Min 2 Years and Max 12 Years); SP
XELJANZ ORAL TABLET 10 MG, 5 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 22 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (112 EA per 6 days); SP
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES**		
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	5	PA; Coverage applies to approved products only. Covered NDCs: 55513-0482-01 and 555130482-02; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1.6 ML per 28 days); SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML	5	PA; Coverage applies to approved products only. Covered NDCs: 72511-0400-01 and 72511-0400-02.; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3.2 EA per 28 days); SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML	5	PA; Coverage applies to approved products only. Covered NDCs: 55513-0481-01 and 55513-0481-02; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1.6 ML per 28 days); SP

Drug Name	Tier	Notes
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	5	PA; Coverage applies to approved products only. Covered NDCs: 55513-0479-01 and 55513-0479-02; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1.6 ML per 28 days); SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.4 ML per 28 days); SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.4 ML per 28 days); SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.4ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.8 EA per 28 days); SP
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 28 days); SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 28 days); SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 28 days); SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 28 days); SP
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 28 days); SP
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 28 days); SP
CYCLOOXYGENASE 2 (COX-2) INHIBITORS**		
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	2	QL (60 EA per 30 days)
GOLD COMPOUNDS**		
RIDAURA ORAL CAPSULE 3 MG	3	
INTERLEUKIN-6 RECEPTOR INHIBITORS**		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3.6 ML per 28 days); SP
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3.6 ML per 28 days); SP

Drug Name	Tier	Notes
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days); SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days); SP
NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS**		
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	4	
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)**		
diclofenac sodium er oral tablet extended release 24 hour 100 mg	2	
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	2	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	2	
etodolac oral capsule 200 mg, 300 mg	2	
etodolac oral tablet 400 mg, 500 mg	2	
fenoprofen calcium oral tablet 600 mg	3	
flurbiprofen oral tablet 100 mg, 50 mg	2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	2	
indomethacin er oral capsule extended release 75 mg	2	
indomethacin oral capsule 25 mg, 50 mg	2	
ketoprofen oral capsule 50 mg, 75 mg	2	
ketorolac tromethamine intramuscular solution 30 mg/ml	MB	
ketorolac tromethamine oral tablet 10 mg	2	QL (20 EA per 30 days)
meclofenamate sodium oral capsule 100 mg, 50 mg	3	
meloxicam oral tablet 15 mg, 7.5 mg	2	
nabumetone oral tablet 500 mg, 750 mg	2	
naproxen dr oral tablet delayed release 375 mg, 500 mg	2	
naproxen oral tablet 250 mg, 375 mg, 500 mg	2	
naproxen sodium oral tablet 275 mg, 550 mg	2	
oxaprozin oral tablet 600 mg	2	
piroxicam oral capsule 10 mg, 20 mg	2	
sulindac oral tablet 150 mg, 200 mg	2	
tolmetin sodium oral capsule 400 mg	3	
tolmetin sodium oral tablet 600 mg	3	

Drug Name	Tier	Notes
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**		
OTEZLA ORAL TABLET 30 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
PYRIMIDINE SYNTHESIS INHIBITORS**		
leflunomide oral tablet 10 mg, 20 mg	2	
SELECTIVE COSTIMULATION MODULATORS**		
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1.6 ML per 28 days); SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2.8 ML per 28 days); SP
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS**		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 ML per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 ML per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	5	DX (Non-ASO Plans: Diagnosis Validation Required)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
ANALGESICS - NONNARCOTIC		
ANALGESICS-SEDATIVES**		

Drug Name	Tier	Notes
butalbital-acetaminophen oral tablet 50-325 mg	2	QL (6 EA per 1 day)
butalbital-apap-caffeine oral tablet 50-325-40 mg	2	QL (6 EA per 1 day)
SALICYLATES**		
aspirin ec oral tablet delayed release 325 mg	$0	$0 Copay per PPACA guidelines; AL (Min 45 Years)
aspirin ec oral tablet delayed release 81 mg	$0	AL (Min 45 Years)
aspirin low dose oral tablet 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
aspirin low dose oral tablet delayed release 81 mg	$0	AL (Min 45 Years)
aspirin oral tablet 325 mg, 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
aspirin oral tablet delayed release 325 mg, 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
aspirtab oral tablet delayed release 324 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)
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
BAYER ASPIRIN REGIMEN ORAL TABLET DELAYED RELEASE 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)
cvs aspirin oral tablet delayed release 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
cvs childrens aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
diflunisal oral tablet 500 mg	2	
ec-81 aspirin oral tablet delayed release 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
eq aspirin low dose oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
eq aspirin oral tablet 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
eq aspirin oral tablet delayed release 325 mg, 500 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
eq childrens aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
eql aspirin oral tablet 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)

Drug Name	Tier	Notes
eql childrens aspirin oral tablet chewable 81 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)
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)
mm aspirin oral tablet 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
NORWICH 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	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
ra aspirin oral tablet 325 mg, 500 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
ra childrens aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
salsalate oral tablet 500 mg, 750 mg	2	
sb aspirin oral tablet 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
sb aspirin oral tablet delayed release 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
sb childrens aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
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)

Drug Name	Tier	Notes
ST JOSEPH ADULT ORAL TABLET CHEWABLE 75 MG	2	AL (Min 45 Years and Max 79 Years)
ST JOSEPH 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)
tgt aspirin oral tablet 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
tgt aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
tgt aspirin oral tablet delayed release 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
tgt childrens aspirin oral tablet chewable 81 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
th aspirin oral tablet 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
th enteric aspirin oral tablet delayed release 325 mg	$0	$0 Copay per PPACA guidelines.; AL (Min 45 Years)
ANALGESICS - OPIOID		
CODEINE COMBINATIONS**		
acetaminophen-codeine #2 oral tablet 300-15 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (13 EA per 1 day); AL (Min 12 Years)
acetaminophen-codeine #3 oral tablet 300-30 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (13 EA per 1 day); AL (Min 12 Years)
acetaminophen-codeine #4 oral tablet 300-60 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (13 EA per 1 day); AL (Min 12 Years)
acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (166 ML per 1 day); AL (Min 12 Years)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (13 EA per 1 day); AL (Min 12 Years)

Drug Name	Tier	Notes
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (6 EA per 1 day); AL (Min 12 Years)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for patients 12 to 18 years of age.; QL (6 EA per 1 day); AL (Min 12 Years)
HYDROCODONE COMBINATIONS**		
hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml	2	Schedule II medications are limited to a 34 day maximum.; QL (180 ML per 30 days)
hydrocodone-acetaminophen oral solution 5-217 mg/10ml, 7.5-325 mg/15ml	2	QL (180 ML per 1 day)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	2	QL (12 EA per 1 day)
hydrocodone-acetaminophen oral tablet 10-650 mg, 10-660 mg	2	QL (6 EA per 1 day)
hydrocodone-acetaminophen oral tablet 2.5-500 mg	2	QL (8 EA per 1 day)
OPIOID AGONISTS**		
codeine sulfate oral tablet 15 mg, 30 mg	2	PA; Not covered for members under 12 years of age. Prior authorization required for members 12 to 18 years of age.; QL (180 EA per 30 days); AL (Min 12 Years)
codeine sulfate oral tablet 60 mg	3	PA; Not covered for members under 12 years of age. Prior authorization required for members 12 to 18 years of age.; QL (180 EA per 30 days); AL (Min 12 Years)
fentanyl citrate (pf) injection solution 100 mcg/2ml, 1000 mcg/20ml, 250 mcg/5ml, 2500 mcg/50ml, 500 mcg/10ml	MB	
fentanyl citrate (pf) injection solution cartridge 100 mcg/2ml	MB	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	2	QL (10 EA per 30 days)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 30 mg, 40 mg, 60 mg	4	ST; QL (30 EA per 30 days)
hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 12 mg, 16 mg, 8 mg	4	ST; QL (30 EA per 30 days)
hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 8 mg	4	Schedule II medications are limited to a 34 day maximum.
hydromorphone hcl injection solution 1 mg/ml	MB	
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	2	QL (180 EA per 30 days)

Drug Name	Tier	Notes
KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 200 MG	4	ST; QL (30 EA per 30 days)
levorphanol tartrate oral tablet 2 mg	4	QL (180 EA per 30 days)
meperidine hcl injection solution 10 mg/ml	MB	
meperidine hcl oral solution 50 mg/5ml	3	QL (2000 ML per 30 days)
methadone hcl oral solution 10 mg/5ml, 5 mg/5ml	3	QL (900 ML per 30 days)
methadone hcl oral tablet 10 mg, 5 mg	2	QL (180 EA per 30 days)
morphine sulfate (concentrate) oral solution 20 mg/ml	2	QL (180 ML per 30 days)
morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	4	ST; QL (30 EA per 30 days)
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	4	ST; Schedule II medications are limited to a 34 day supply maximum; QL (60 EA per 30 days)
morphine sulfate er oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg	2	QL (180 EA per 30 days)
morphine sulfate intravenous solution 25 mg/ml	MB	
morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml	2	QL (1000 ML per 30 days)
morphine sulfate oral tablet 15 mg, 30 mg	2	QL (180 EA per 30 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG	4	PA; QL (60 EA per 30 days)
oxycodone hcl oral concentrate 100 mg/5ml	2	QL (180 ML per 30 days)
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	2	QL (180 EA per 30 days)
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg	4	ST; QL (60 EA per 30 days)
oxymorphone hcl oral tablet 10 mg	4	ST; QL (360 EA per 30 days)
oxymorphone hcl oral tablet 5 mg	4	ST; QL (180 EA per 30 days)
tramadol hcl er oral tablet extended release 24 hour 100 mg	4	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; QL (90 EA per 30 days); AL (Min 12 Years)
tramadol hcl er oral tablet extended release 24 hour 200 mg	4	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; QL (30 EA per 30 days); AL (Min 12 Years)
tramadol hcl oral tablet 50 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; QL (240 EA per 30 days); AL (Min 12 Years)
OPIOID COMBINATIONS**		

Drug Name	Tier	Notes
ENDOCET ORAL TABLET 2.5-325 MG	2	QL (12 EA per 1 day)
oxycodone-acetaminophen oral capsule 5-500 mg	2	QL (8 EA per 1 day)
oxycodone-acetaminophen oral solution 5-325 mg/5ml	2	QL (60 ML per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	2	QL (12 EA per 1 day)
oxycodone-acetaminophen oral tablet 10-650 mg	2	QL (6 EA per 1 day)
oxycodone-acetaminophen oral tablet 7.5-500 mg	2	QL (8 EA per 1 day)
oxycodone-aspirin oral tablet 4.8355-325 mg	2	QL (180 EA per 30 days)
ROXICET ORAL TABLET 5-325 MG	2	QL (12 EA per 1 day)
XARTEMIS XR ORAL TABLET EXTENDED RELEASE 7.5-325 MG	4	PA; QL (120 EA per 30 days)
OPIOID PARTIAL AGONISTS**		
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.28 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 24 MG/0.48ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.92 ML per 28 days)
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 32 MG/0.64ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.56 ML per 28 days)

Drug Name	Tier	Notes
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 8 MG/0.16ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.64 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.36 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 64 MG/0.18ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.18 ML per 28 days)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 96 MG/0.27ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.27 ML per 28 days)

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

Drug Name	Tier	Notes
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); AL (Min 16 Years)
butorphanol tartrate nasal solution 10 mg/ml	4	QL (10 ML per 30 days)
nalbuphine hcl injection solution 10 mg/ml	2	
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.5 ML per 30 days)
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/1.5ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.5 ML per 30 days)
TALWIN INJECTION SOLUTION 30 MG/ML	MB	
PENTAZOCINE COMBINATIONS**		
pentazocine-acetaminophen oral tablet 25-650 mg	2	QL (6 EA per 1 day)

Drug Name	Tier	Notes
TRAMADOL COMBINATIONS**		
tramadol-acetaminophen oral tablet 37.5-325 mg	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; QL (300 EA per 30 days); AL (Min 12 Years)
ANDROGENS-ANABOLIC		
ANDROGENS**		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR	4	PA; QL (60 EA per 30 days)
ANDROXY ORAL TABLET 10 MG	4	PA; QL (120 EA per 30 days)
danazol oral capsule 100 mg, 200 mg, 50 mg	2	
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	2	
testosterone enanthate intramuscular solution 200 mg/ml	3	
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%)	4	QL (150 GM per 30 days)
testosterone transdermal gel 10 mg/act (2%)	4	QL (120 GM per 30 days)
testosterone transdermal gel 12.5 mg/act (1%), 50 mg/5gm (1%)	2	QL (300 GM per 30 days)
testosterone transdermal gel 20.25 mg/1.25gm (1.62%)	4	QL (75 GM per 30 days)
testosterone transdermal gel 25 mg/2.5gm (1%)	2	QL (75 GM per 30 days)
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS**		
CORTIFOAM RECTAL FOAM 10 %	4	
hydrocortisone rectal enema 100 mg/60ml	2	
RECTAL ANESTHETIC/STEROIDS**		
hydrocortisone ace-pramoxine rectal cream 1-1 %	2	
lidocaine-hydrocort (perianal) external cream 3-0.5 %	2	
lidocaine-hydrocortisone ace rectal cream 3-0.5 %	2	
PROCTOFOAM HC EXTERNAL FOAM 1-1 %	3	
PROCTOFOAM HC RECTAL FOAM 1-1 %	3	
RECTAL LOCAL ANESTHETICS**		
pramoxine hcl rectal foam 1 %	2	
PROCTOFOAM EXTERNAL FOAM 1 %	4	
RECTAL STEROIDS**		
hydrocortisone (perianal) external cream 2.5 %	2	

Drug Name	Tier	Notes
hydrocortisone rectal cream 2.5 %	2	
PROCTOCARE-HC RECTAL CREAM 2.5 %	2	
PROCTO-MED HC EXTERNAL CREAM 2.5 %	2	
PROCTOSOL HC EXTERNAL CREAM 2.5 %	2	
PROCTOSOL HC RECTAL CREAM 2.5 %	2	
PROCTOZONE-HC EXTERNAL CREAM 2.5 %	2	
PROCTOZONE-HC RECTAL CREAM 2.5 %	2	
ANTHELMINTICS		
ANTHELMINTICS**		
albendazole oral tablet 200 mg	5	
BILTRICIDE ORAL TABLET 600 MG	4	
EMVERM ORAL TABLET CHEWABLE 100 MG	5	PA; QL (6 EA per 21 days)
ivermectin oral tablet 3 mg	4	QL (30 EA per 90 days)
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER**		
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	4	ST
NITRATES**		
DILATRATE-SR ORAL CAPSULE EXTENDED RELEASE 40 MG	3	
isosorbide dinitrate er oral tablet extended release 40 mg	3	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 5 mg	2	
isosorbide dinitrate oral tablet 30 mg	3	
isosorbide dinitrate sublingual tablet sublingual 2.5 mg	2	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	2	
isosorbide mononitrate oral tablet 10 mg, 20 mg	2	
MINITRAN TRANSDERMAL PATCH 24 HOUR 0.6 MG/HR	2	
NITRO-BID TRANSDERMAL OINTMENT 2 %	3	
nitroglycerin er oral capsule extended release 2.5 mg	3	
nitroglycerin er oral capsule extended release 6.5 mg, 9 mg	2	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg	2	
nitroglycerin sublingual tablet sublingual 0.6 mg	3	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	2	

Drug Name	Tier	Notes
ANTIANXIETY AGENTS		
ANTIANXIETY AGENTS - MISC.**		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
droperidol injection solution 2.5 mg/ml	MB	
hydroxyzine hcl intramuscular solution 25 mg/ml, 50 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
hydroxyzine hcl oral solution 10 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
hydroxyzine hcl oral syrup 10 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
meprobamate oral tablet 200 mg, 400 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
BENZODIAZEPINES**		
alprazolam er oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
alprazolam er oral tablet extended release 24 hour 3 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
alprazolam oral tablet 2 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (135 EA per 30 days)
alprazolam xr oral tablet extended release 24 hour 0.5 mg, 1 mg, 2 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
alprazolam xr oral tablet extended release 24 hour 3 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)

Drug Name	Tier	Notes
diazepam injection solution 5 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
diazepam oral tablet 10 mg, 2 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
lorazepam injection solution 2 mg/ml, 4 mg/ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.5 ML per 1 day)
lorazepam oral concentrate 2 mg/ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (150 ML per 30 days)

Drug Name	Tier	Notes
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
oxazepam oral capsule 10 mg, 15 mg, 30 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A**		
disopyramide phosphate oral capsule 100 mg, 150 mg	2	
quinidine gluconate er oral tablet extended release 324 mg	2	
quinidine sulfate oral tablet 200 mg, 300 mg	2	
ANTIARRHYTHMICS TYPE I-B**		
lidocaine in d5w intravenous solution 3-5 mg/ml-%, 4-5 mg/ml-%	MB	
mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg	2	
ANTIARRHYTHMICS TYPE I-C**		
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	2	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	2	
ANTIARRHYTHMICS TYPE III**		
amiodarone hcl intravenous solution 150 mg/3ml	2	
amiodarone hcl oral tablet 200 mg, 400 mg	2	
CORVERT INTRAVENOUS SOLUTION 1 MG/10ML	MB	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	4	
MULTAQ ORAL TABLET 400 MG	4	PA; QL (60 EA per 30 days)
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		

Drug Name	Tier	Notes
5-LIPOXYGENASE INHIBITORS**		
zileuton er oral tablet extended release 12 hour 600 mg	5	PA; QL (120 EA per 30 days); SP
ADRENERGIC COMBINATIONS**		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH	4	ST; QL (30 EA per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	4	QL (8 GM per 30 days)
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT, 50-5 MCG/ACT	4	ST; QL (13 GM per 30 days)
DUONEB INHALATION SOLUTION 0.5-2.5 (3) MG/3ML	MB	
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	4	QL (60 EA per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose	4	ST; QL (60 EA per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act	3	QL (1 EA per 30 days)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	2	
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	3	QL (4 GM per 30 days)
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT	3	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	3	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	4	QL (60 EA per 30 days)
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	4	ST; 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; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; SP
ANTI-INFLAMMATORY AGENTS**		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	2	

Drug Name	Tier	Notes
BETA ADRENERGICS**		
albuterol sulfate er oral tablet extended release 12 hour 4 mg, 8 mg	2	
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	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)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml	2	
albuterol sulfate oral syrup 2 mg/5ml	2	
albuterol sulfate oral tablet 2 mg, 4 mg	2	
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML	MB	
isoproterenol hcl injection solution 0.2 mg/ml	MB	
levalbuterol tartrate inhalation aerosol 45 mcg/act	4	QL (30 GM per 30 days)
metaproterenol sulfate oral syrup 10 mg/5ml	3	
metaproterenol sulfate oral tablet 10 mg, 20 mg	3	
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/DOSE	3	
terbutaline sulfate injection solution 1 mg/ml	2	
terbutaline sulfate oral tablet 2.5 mg, 5 mg	2	
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	3	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)
XOPENEX CONCENTRATE INHALATION NEBULIZATION SOLUTION 1.25 MG/0.5ML	MB	
BRONCHODILATORS - ANTICHOLINERGICS**		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	3	
ipratropium bromide inhalation solution 0.02 %	2	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	3	

Drug Name	Tier	Notes
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	3	
LEUKOTRIENE RECEPTOR ANTAGONISTS**		
montelukast sodium oral tablet 10 mg	2	QL (30 EA per 30 days)
montelukast sodium oral tablet chewable 4 mg, 5 mg	2	QL (30 EA per 30 days)
zafirlukast oral tablet 10 mg, 20 mg	2	
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**		
roflumilast oral tablet 500 mcg	3	PA; QL (30 EA per 30 days)
STEROID INHALANTS**		
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT	4	ST; QL (12.2 GM per 30 days)
ALVESCO INHALATION AEROSOL SOLUTION 80 MCG/ACT	4	ST; QL (6.1 GM per 30 days)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	QL (30 EA per 30 days)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	2	QL (120 ML per 30 days)
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act	3	
fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act	3	
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT	4	
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT	4	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT	4	QL (21.2 GM per 30 days)
XANTHINES**		
aminophylline intravenous solution 25 mg/ml	MB	
ELIXOPHYLLIN ORAL ELIXIR 80 MG/15ML	4	
THEOCHRON ORAL TABLET EXTENDED RELEASE 12 HOUR 200 MG	2	
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 450 mg	2	
theophylline er oral tablet extended release 12 hour 300 mg	3	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	2	

Drug Name	Tier	Notes
theophylline in d5w intravenous solution 0.8-5 mg/ml-%	MB	
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS**		
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	2	
DIRECT FACTOR XA INHIBITORS**		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	3	QL (74 EA per 365 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	3	QL (60 EA per 30 days)
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	3	QL (600 ML per 30 days)
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	QL (51 EA per 90 days)
HEPARINS AND HEPARINOID-LIKE AGENTS**		
BD HEPARIN POSIFLUSH INTRAVENOUS SOLUTION 10 UNIT/ML, 100 UNIT/ML	2	
heparin (porcine) in nacl injection solution 100-0.45 unit/ml-%, 50-0.45 unit/ml-%	MB	
heparin lock flush intravenous solution 100 unit/ml	2	
heparin na (pork) lock flsh pf intravenous solution 1 unit/ml, 10 unit/ml, 100 unit/ml	2	
heparin sod (pork) lock flush intravenous solution 1 unit/ml, 10 unit/ml, 100 unit/ml	2	
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 5000 unit/ml	2	
heparin sodium (porcine) injection solution 20000 unit/ml	4	
heparin sodium (porcine) intravenous solution prefilled syringe 10000 unit/10ml, 3000 unit/3ml, 5000 unit/5ml	2	
heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml	2	
heparin sodium lock flush intravenous solution 10 unit/ml	2	
LOW MOLECULAR WEIGHT HEPARINS**		
enoxaparin sodium injection solution 300 mg/3ml	2	PA
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	2	PA

Drug Name	Tier	Notes
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	2	PA
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 25000 UNIT/ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML	5	PA; QL (30 ML per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML	5	PA; QL (30 ML per 30 days)
SYNTHETIC HEPARINOID-LIKE AGENTS**		
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	5	PA
THROMBIN INHIBITORS - HIRUDIN TYPE**		
ANGIOMAX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	MB	
THROMBIN INHIBITORS - SELECTIVE DIRECT & REVERSIBLE**		
argatroban intravenous solution 250 mg/2.5ml	MB	
dabigatran etexilate mesylate oral capsule 110 mg	4	PA; QL (2 EA per 1 Day)
dabigatran etexilate mesylate oral capsule 150 mg	4	PA; QL (60 EA per 30 days)
dabigatran etexilate mesylate oral capsule 75 mg	4	PA; QL (30 EA per 30 days)
ANTICONVULSANTS		
ANTICONVULSANTS - BENZODIAZEPINES**		
clobazam oral suspension 2.5 mg/ml	4	ST; QL (8 ML per 1 day)
clobazam oral tablet 10 mg, 20 mg	4	ST; QL (2 EA per 1 day)
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	2	QL (90 EA per 30 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	2	QL (90 EA per 30 days)
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	3	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (5 EA per 30 days)

Drug Name	Tier	Notes
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	5	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (10 EA per 30 days)
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	5	ST; QL (10 EA per 30 days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML	5	ST; QL (5 packs per 30 Days)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML	5	PA; QL (5 packs per 30 Days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML	5	PA; QL (5 packs per 30 Days)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML	5	ST; QL (5 packs per 30 Days)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	5	ST; QL (10 EA per 30 days)
ANTICONVULSANTS - MISC.**		
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
carbamazepine oral suspension 100 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
carbamazepine oral tablet 200 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
carbamazepine oral tablet chewable 100 mg, 200 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
gabapentin oral capsule 100 mg, 300 mg, 400 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
gabapentin oral solution 250 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
gabapentin oral tablet 600 mg, 800 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lacosamide oral solution 10 mg/ml	5	ST; QL (1200 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	2	QL (60 EA per 30 days)
lamotrigine er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
lamotrigine er oral tablet extended release 24 hour 200 mg, 250 mg, 300 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lamotrigine oral tablet chewable 25 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	4	QL (120 EA per 30 days)
levetiracetam intravenous solution 500 mg/5ml	MB	
levetiracetam oral solution 100 mg/ml	2	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	2	
oxcarbazepine oral suspension 300 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
POTIGA ORAL TABLET 200 MG, 300 MG, 400 MG, 50 MG	4	PA; QL (90 EA per 30 days)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 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 cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
pregabalin oral capsule 225 mg, 300 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
primidone oral tablet 250 mg, 50 mg	2	
ROWEEPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG	4	QL (120 EA per 30 days)
topiramate oral capsule sprinkle 15 mg, 25 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
zonisamide oral capsule 100 mg, 25 mg, 50 mg	2	
CARBAMATES**		

Drug Name	Tier	Notes
felbamate oral suspension 600 mg/5ml	4	QL (900 ML per 30 days)
felbamate oral tablet 400 mg	4	QL (90 EA per 30 days)
felbamate oral tablet 600 mg	5	QL (180 EA per 30 days)
GABA MODULATORS**		
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	4	
HYDANTOINS**		
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG	4	
DILANTIN ORAL CAPSULE 30 MG	4	
fosphenytoin sodium injection solution 100 mg pe/2ml, 500 mg pe/10ml	MB	
phenytoin oral suspension 125 mg/5ml	2	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	2	
phenytoin sodium injection solution 50 mg/ml	MB	
SUCCINIMIDES**		
ethosuximide oral capsule 250 mg	2	
ethosuximide oral solution 250 mg/5ml	2	
VALPROIC ACID**		
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
divalproex sodium oral capsule sprinkle 125 mg	2	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
valproic acid oral capsule 250 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
valproic acid oral syrup 250 mg/5ml	2	
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)**		
mirtazapine oral tablet 15 mg, 30 mg, 45 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDEPRESSANTS - MISC.**		
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
bupropion hcl oral tablet 100 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 cost 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	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
MONOAMINE OXIDASE INHIBITORS (MAOIS)**		

Drug Name	Tier	Notes
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
phenelzine sulfate oral tablet 15 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
tranylcypromine sulfate oral tablet 10 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS**		
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	MB	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	MB	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**		
citalopram hydrobromide oral solution 10 mg/5ml, 20 mg/10ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (600 ML per 30 days)
citalopram hydrobromide oral tablet 10 mg, 20 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
citalopram hydrobromide oral tablet 40 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

Drug Name	Tier	Notes
escitalopram oxalate oral solution 5 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (600 ML per 30 days)
escitalopram oxalate oral tablet 10 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
fluoxetine hcl oral solution 20 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
paroxetine hcl oral suspension 10 mg/5ml	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 (900 ML per 30 days)

Drug Name	Tier	Notes
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
paroxetine hcl oral tablet 40 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
sertraline hcl oral concentrate 20 mg/ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
sertraline hcl oral tablet 100 mg, 25 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

Drug Name	Tier	Notes
sertraline hcl oral tablet 50 mg	1	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (45 EA per 30 days)
SEROTONIN MODULATORS**		
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)**		

Drug Name	Tier	Notes
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 75 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days)
venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 37.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 EA per 1 Day)

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

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

Drug Name	Tier	Notes
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
nortriptyline hcl oral capsule 10 mg, 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 cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS**		
acarbose oral tablet 100 mg, 25 mg, 50 mg	1	
ANTIDIABETIC - AMYLIN ANALOGS**		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML	4	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML	4	PA
BIGUANIDES**		
metformin hcl er oral tablet extended release 24 hour 500 mg	1	
metformin hcl er oral tablet extended release 24 hour 750 mg	2	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	
DIABETIC OTHER**		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE	3	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE	3	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	3	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML	3	

Drug Name	Tier	Notes
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML	3	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML	3	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS**		
alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg	3	ST; QL (30 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	ST; QL (30 EA per 30 days)
saxagliptin hcl oral tablet 2.5 mg, 5 mg	4	PA; QL (30 EA per 30 days)
DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS**		
alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg	3	ST; QL (60 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	ST; QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	3	ST; QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	3	ST; QL (60 EA per 30 days)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg	4	PA; QL (60 EA per 30 days)
saxagliptin-metformin er oral tablet extended release 24 hour 5-1000 mg, 5-500 mg	4	PA; QL (30 EA per 30 days)
DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS**		
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	3	ST; QL (30 EA per 30 days)
OSENI ORAL TABLET 25-45 MG	3	ST; QL (30 EA per 30 days)
HUMAN INSULIN**		
APIDRA INJECTION SOLUTION 100 UNIT/ML	4	ST; QL (50 ML per 30 days)
HUMALOG INJECTION SOLUTION 100 UNIT/ML	3	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
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	ST; 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 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	4	ST; QL (45 ML per 30 days)
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML	4	ST; QL (50 ML per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	3	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 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	3	ST; 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	3	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 PEN-INJECTOR (75-25) 100 UNIT/ML	3	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	3	ST; 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
HUMALOG PEN SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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	3	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 SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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 SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	4	ST; QL (50 ML per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	4	ST; QL (45 ML per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	4	ST; QL (50 ML per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	4	ST; QL (45 ML per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	4	QL (50 ML per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	4	ST; QL (50 ML per 30 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	4	PA; QL (20 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	4	PA; QL (18 ML per 30 days)

Drug Name	Tier	Notes
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin aspart injection solution 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
insulin aspart penfill subcutaneous solution cartridge 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)

Drug Name	Tier	Notes
insulin aspart subcutaneous solution 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
insulin glargine-yfgn subcutaneous solution 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
insulin lispro injection solution 100 unit/ml	3	ST; CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
insulin lispro subcutaneous solution 100 unit/ml	4	ST; QL (50 EA per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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 SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	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	3	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
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	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	3	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	3	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 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	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	3	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 70/30 PENFILL SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	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	3	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	3	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	3	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 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	3	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 PENFILL SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	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	3	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	3	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	3	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	3	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	3	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 PENFILL INJECTION SOLUTION 100 UNIT/ML	3	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 RELION INJECTION SOLUTION 100 UNIT/ML	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. * High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (45 ML per 30 days)

Drug Name	Tier	Notes
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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	3	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	3	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	3	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	3	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	3	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 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	CB (The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. The copay amount for a preferred Formulary prescription insulin covered at an amount not to exceed a total $25.00* per thirty-day supply. *High Deductible Health Plan copays/coinsurances are subject to deductible first.); QL (50 ML per 30 days)
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	3	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 SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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	3	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)
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	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	3	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
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	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	3	PA; QL (2 ML per 28 days)
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	3	PA; QL (2 ML per 28 days)
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	3	PA; QL (2 ML per 28 days)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	3	PA; QL (2 ML per 28 days)
MEGLITINIDE ANALOGUES**		
nateglinide oral tablet 120 mg, 60 mg	1	
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	4	
MEGLITINIDE-BIGUANIDE COMBINATIONS**		
repaglinide-metformin hcl oral tablet 1-500 mg, 2-500 mg	4	
SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS**		
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG	3	ST; QL (30 EA per 30 days)
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS**		
FARXIGA ORAL TABLET 10 MG, 5 MG	3	ST; QL (30 EA per 30 days)
STEGLATRO ORAL TABLET 15 MG, 5 MG	3	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	3	ST; QL (60 EA per 30 days)

Drug Name	Tier	Notes
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG	3	ST; QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	3	ST; QL (60 EA per 30 days)
SULFONYLUREA-BIGUANIDE COMBINATIONS**		
glipizide-metformin hcl oral tablet 2.5-250 mg	2	
glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg	1	
glyburide-metformin oral tablet 1.25-250 mg, 5-500 mg	1	
glyburide-metformin oral tablet 2.5-500 mg	2	
SULFONYLUREAS**		
chlorpropamide oral tablet 100 mg, 250 mg	3	
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
glipizide oral tablet 10 mg, 5 mg	1	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	1	
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	1	
tolazamide oral tablet 250 mg, 500 mg	3	
tolbutamide oral tablet 500 mg	3	
SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS**		
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	2	ST
THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS**		
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	2	ST
THIAZOLIDINEDIONES**		
AVANDIA ORAL TABLET 2 MG, 4 MG, 8 MG	4	ST
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	2	QL (30 EA per 30 days)
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS**		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	3	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	2	
ANTIDOTES AND SPECIFIC ANTAGONISTS		

Drug Name	Tier	Notes
ANTIDOTES AND SPECIFIC ANTAGONISTS**		
ACETADOTE INTRAVENOUS SOLUTION 200 MG/ML	MB	
ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 200 MG	MB	
calcium disodium versenate injection solution 1 gm/5ml	MB	
DESFERAL INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
fomepizole intravenous solution 1.5 gm/1.5ml	MB	
PROTOPAM CHLORIDE INTRAVENOUS SOLUTION RECONSTITUTED 1 GM	MB	
OPIOID ANTAGONISTS**		
naloxone hcl injection solution 0.4 mg/ml	2	Naloxone injectable used with nasal atomizer is covered.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 ML per 30 days)
naloxone hcl injection solution 1 mg/ml	2	Naloxone injectable used with nasal atomizer is covered.; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (4 ML per 30 days)
naloxone hcl injection solution prefilled syringe 2 mg/2ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
naloxone hcl nasal liquid 4 mg/0.1ml	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
naltrexone hcl oral tablet 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS**		
ANZEMET ORAL TABLET 100 MG, 50 MG	4	PA; QL (4 EA per 30 days)
granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml	MB	
granisetron hcl oral tablet 1 mg	2	ST; QL (20 EA per 30 days)
ondansetron hcl injection solution 4 mg/2ml, 40 mg/20ml	MB	
ondansetron hcl injection solution prefilled syringe 4 mg/2ml	MB	
ondansetron hcl oral solution 4 mg/5ml	2	AL (Max 4 Years)
ondansetron hcl oral tablet 4 mg, 8 mg	2	QL (90 EA per 30 days)
ondansetron oral tablet dispersible 4 mg, 8 mg	2	QL (90 EA per 30 days)
palonosetron hcl intravenous solution 0.25 mg/2ml	MB	QL (2 ML per 5 days)
palonosetron hcl intravenous solution 0.25 mg/5ml	MB	QL (5 ML per 5 days)
ANTIEMETICS - ANTICHOLINERGIC**		
meclizine hcl oral tablet 25 mg	2	
scopolamine transdermal patch 72 hour 1 mg/3days	4	
TIGAN INTRAMUSCULAR SOLUTION 100 MG/ML	MB	
trimethobenzamide hcl oral capsule 300 mg	2	
ANTIEMETICS - MISCELLANEOUS**		
CESAMET ORAL CAPSULE 1 MG	MB	

Drug Name	Tier	Notes
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS**		
aprepitant oral capsule 125 mg, 40 mg	4	PA; Quantity is limited to 40mg and 125mg=1 per fill, 80/125 Pack=3(1 package)per fill, 80 mg=3 per fill; QL (1 EA per 30 days)
aprepitant oral capsule 80 & 125 mg, 80 mg	4	PA; Quantity is limited to 40mg and 125mg=1 per fill, 80/125 Pack=3(1 package)per fill, 80 mg=3 per fill; QL (3 EA per 30 days)
CINVANTI INTRAVENOUS EMULSION 130 MG/18ML	MB	PA
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML	5	PA; QL (6 EA per 28 days)
fosaprepitant dimeglumine intravenous solution reconstituted 150 mg	MB	QL (4 EA per 30 days)
ANTIFUNGALS		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)**		
caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg	MB	
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG	MB	
micafungin sodium intravenous solution reconstituted 50 mg	MB	
ANTIFUNGALS**		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	MB	
AMPHOTEC INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG, 50 MG	MB	
amphotericin b injection solution reconstituted 50 mg	MB	
bio-statin oral capsule 500000 unit	3	
griseofulvin microsize oral suspension 125 mg/5ml	2	
griseofulvin ultramicrosize oral tablet 125 mg	4	
GRIS-PEG ORAL TABLET 250 MG	4	
nystatin oral tablet 500000 unit	2	
terbinafine hcl oral tablet 250 mg	2	QL (90 EA per 365 days)
IMIDAZOLES**		
ketoconazole oral tablet 200 mg	2	
TRIAZOLES**		
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%	MB	

Drug Name	Tier	Notes
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	2	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 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.)
itraconazole oral capsule 100 mg	4	ST; QL (168 EA per 365 days)
VFEND IV INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	
voriconazole intravenous solution reconstituted 200 mg	MB	
voriconazole oral suspension reconstituted 40 mg/ml	4	PA; QL (150 ML per 14 days)
voriconazole oral tablet 200 mg	4	PA; QL (60 EA per 30 days)
voriconazole oral tablet 50 mg	2	PA; QL (60 EA per 30 days)
ANTIHISTAMINES		
ANTIHISTAMINES - ETHANOLAMINES**		
carbinoxamine maleate oral tablet 4 mg	4	
diphenhydramine hcl injection solution 50 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
diphenhydramine hcl oral elixir 12.5 mg/5ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIHISTAMINES - NON-SEDATING**		

Drug Name	Tier	Notes
desloratadine oral tablet 5 mg	4	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	4	
levocetirizine dihydrochloride oral tablet 5 mg	4	
ANTIHISTAMINES - PHENOTHIAZINES**		
promethazine hcl injection solution 25 mg/ml, 50 mg/ml	2	
promethazine hcl oral solution 6.25 mg/5ml	2	
promethazine hcl oral syrup 6.25 mg/5ml	2	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	2	
promethazine hcl rectal suppository 12.5 mg, 25 mg	2	
ANTIHISTAMINES - PIPERIDINES**		
cyproheptadine hcl oral syrup 2 mg/5ml	2	
cyproheptadine hcl oral tablet 4 mg	2	
ANTIHYPERLIPIDEMICS		
ANTIHYPERLIPIDEMICS - MISC.**		
omega-3-acid ethyl esters oral capsule 1 gm	4	QL (120 EA per 30 days)
BILE ACID SEQUESTRANTS**		
cholestyramine light oral packet 4 gm	2	
cholestyramine light oral powder 4 gm/dose	2	
cholestyramine oral packet 4 gm	1	
cholestyramine oral powder 4 gm/dose	2	
colesevelam hcl oral packet 3.75 gm	5	QL (30 EA per 30 days)
colesevelam hcl oral tablet 625 mg	2	
colestipol hcl oral tablet 1 gm	4	
PREVALITE ORAL PACKET 4 GM	2	
PREVALITE ORAL POWDER 4 GM/DOSE	2	
FIBRIC ACID DERIVATIVES**		
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg	2	
fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg	2	
gemfibrozil oral tablet 600 mg	2	
HMG COA REDUCTASE INHIBITORS**		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	$0	QL (30 EA per 30 days)
fluvastatin sodium oral capsule 20 mg, 40 mg	4	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	$0	$0 Copay per PPACA guidelines.
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	4	ST

Drug Name	Tier	Notes
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	2	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	$0	$0 Copay per PPACA guidelines.
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	4	
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS**		
ezetimibe oral tablet 10 mg	2	
NICOTINIC ACID DERIVATIVES**		
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	2	
PCSK9 INHIBITORS**		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML	3	PA; QL (3.5 ML per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	3	PA; QL (2 ML per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA; QL (2 ML per 28 days)
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	2	
ACE INHIBITORS & THIAZIDE/THIAZIDE-LIKE**		
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	2	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	3	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	2	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	2	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	2	
moexipril-hydrochlorothiazide oral tablet 15-12.5 mg, 15-25 mg, 7.5-12.5 mg	2	

Drug Name	Tier	Notes
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	2	
ACE INHIBITORS**		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	1	
enalapril maleate oral solution 1 mg/ml	4	PA; AL (Max 12 Years)
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	2	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
moexipril hcl oral tablet 15 mg, 7.5 mg	2	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	4	
QBRELIS ORAL SOLUTION 1 MG/ML	5	PA
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	2	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	2	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	2	
AGENTS FOR PHEOCHROMOCYTOMA**		
phenoxybenzamine hcl oral capsule 10 mg	4	
phentolamine mesylate injection solution reconstituted 5 mg	MB	
ANGIOTENSIN II RECEPTOR ANTAG & THIAZIDE/THIAZIDE-LIKE**		
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	4	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	2	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	2	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	4	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	2	
ANGIOTENSIN II RECEPTOR ANTAGONISTS**		
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	4	
eprosartan mesylate oral tablet 600 mg	4	ST
irbesartan oral tablet 150 mg, 300 mg, 75 mg	2	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	2	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	4	QL (30 EA per 30 days)

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

Drug Name	Tier	Notes
TENORETIC 100 ORAL TABLET 100-25 MG	2	
TENORETIC 50 ORAL TABLET 50-25 MG	2	
DIRECT RENIN INHIBITORS & THIAZIDE/THIAZIDE-LIKE COMB**		
TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG	4	PA; QL (30 EA per 30 days)
DIRECT RENIN INHIBITORS**		
aliskiren fumarate oral tablet 150 mg	4	PA; QL (30 EA per 30 days)
TEKTURNA ORAL TABLET 150 MG, 300 MG	4	PA; QL (30 EA per 30 days)
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)**		
eplerenone oral tablet 25 mg, 50 mg	4	
VASODILATORS**		
hydralazine hcl injection solution 20 mg/ml	MB	
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	
minoxidil oral tablet 10 mg, 2.5 mg	2	
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.**		
baciim intramuscular solution reconstituted 50000 unit	4	
metronidazole oral tablet 250 mg, 500 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.)
PENTAM INJECTION SOLUTION RECONSTITUTED 300 MG	4	
pentamidine isethionate inhalation solution reconstituted 300 mg	4	QL (1 EA per 28 days)
trimethoprim oral tablet 100 mg	2	
vancomycin hcl intravenous solution reconstituted 5000 mg	2	
XIFAXAN ORAL TABLET 200 MG	5	PA; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; QL (60 EA per 30 days)

Drug Name	Tier	Notes
ANTI-INFECTIVE MISC. - COMBINATIONS**		
erythromycin-sulfisoxazole oral suspension reconstituted 200-600 mg/5ml	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.)
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	2	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	2	
ANTIPROTOZOAL AGENTS**		
atovaquone oral suspension 750 mg/5ml	2	
CARBAPENEM COMBINATIONS**		
PRIMAXIN IV INTRAVENOUS SOLUTION RECONSTITUTED 250-250 MG	MB	
CARBAPENEMS**		
INVANZ INJECTION SOLUTION RECONSTITUTED 1 GM	MB	
MERREM INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
CHLORAMPHENICALS**		
chloramphenicol sod succinate intravenous solution reconstituted 1 gm	MB	
GLYCOPEPTIDES**		
vancomycin hcl in dextrose intravenous solution 1-5 gm/200ml-%, 500-5 mg/100ml-%	MB	
vancomycin hcl in nacl intravenous solution 1-0.9 gm/200ml-%, 500-0.9 mg/100ml-%, 750-0.9 mg/150ml-%	MB	
vancomycin hcl intravenous solution reconstituted 1000 mg	2	
vancomycin hcl intravenous solution reconstituted 500 mg	5	
vancomycin hcl oral capsule 125 mg	4	QL (56 EA per 14 days)
vancomycin hcl oral capsule 250 mg	4	PA; QL (80 EA per 30 days)
vancomycin hcl oral solution reconstituted 25 mg/ml, 50 mg/ml	3	QL (300 ML per 14 days)

Drug Name	Tier	Notes
VIBATIV INTRAVENOUS SOLUTION RECONSTITUTED 750 MG	MB	
LEPROSTATICS**		
dapsone oral tablet 100 mg, 25 mg	3	
LINCOSAMIDES**		
clindamycin hcl oral capsule 150 mg, 300 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.)
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	2	
lincomycin hcl injection solution 300 mg/ml	MB	
MONOBACTAMS**		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5	PA; QL (84 ML per 56 days); SP
OXAZOLIDINONES**		
linezolid intravenous solution 2 mg/ml	MB	PA
linezolid oral suspension reconstituted 100 mg/5ml	4	PA
linezolid oral tablet 600 mg	4	PA
POLYMYXINS**		
colistimethate sodium (cba) injection solution reconstituted 150 mg	MB	
STREPTOGRAMIN COMBINATIONS**		
SYNERCID INTRAVENOUS SOLUTION RECONSTITUTED 150-350 MG	MB	
URINARY ANTI-INFECTIVES**		
fosfomycin tromethamine oral packet 3 gm	4	
methenamine hippurate oral tablet 1 gm	2	
methenamine mandelate oral tablet 0.5 gm	3	
methenamine mandelate oral tablet 1 gm	2	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	2	
nitrofurantoin monohyd macro oral capsule 100 mg	2	
nitrofurantoin oral suspension 25 mg/5ml	4	QL (560 ML per 7 days); AL (Max 12 Years)

Drug Name	Tier	Notes
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS**		
atovaquone-proguanil hcl oral tablet 62.5-25 mg	4	
ANTIMALARIALS**		
chloroquine phosphate oral tablet 250 mg, 500 mg	2	
hydroxychloroquine sulfate oral tablet 200 mg	2	
primaquine phosphate oral tablet 26.3 (15 base) mg, 26.3 mg	3	
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS**		
FIRDAPSE ORAL TABLET 10 MG	5	PA; LA; QL (240 EA per 30 days); SP
MESTINON ORAL SYRUP 60 MG/5ML	4	
neostigmine methylsulfate intravenous solution 5 mg/10ml	MB	
pyridostigmine bromide oral solution 60 mg/5ml	4	
pyridostigmine bromide oral tablet 60 mg	2	
ANTIMYCOBACTERIAL AGENTS		
ANTI TB COMBINATIONS**		
RIFAMATE ORAL CAPSULE 150-300 MG	5	
ANTIMYCOBACTERIAL AGENTS**		
ethambutol hcl oral tablet 100 mg, 400 mg	2	
isoniazid oral syrup 50 mg/5ml	3	
isoniazid oral tablet 100 mg	2	
isoniazid oral tablet 300 mg	3	
PASER ORAL PACKET 4 GM	2	
PRIFTIN ORAL TABLET 150 MG	4	
pyrazinamide oral tablet 500 mg	3	
rifabutin oral capsule 150 mg	5	
rifampin oral capsule 150 mg, 300 mg	2	
TRECATOR ORAL TABLET 250 MG	4	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS**		
busulfan intravenous solution 6 mg/ml	MB	

Drug Name	Tier	Notes
carboplatin intravenous solution 50 mg/5ml	MB	
cisplatin intravenous solution 100 mg/100ml, 50 mg/50ml	MB	
HEXALEN ORAL CAPSULE 50 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
MYLERAN ORAL TABLET 2 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
oxaliplatin intravenous solution 50 mg/10ml	MB	
thiotepa injection solution reconstituted 15 mg	MB	
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED 4 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANDROGEN BIOSYNTHESIS INHIBITORS**		
abiraterone acetate oral tablet 250 mg	4	QL (120 EA per 30 days)
ANTIADRENALS**		
LYSODREN ORAL TABLET 500 MG	5	
ANTIANDROGENS**		
bicalutamide oral tablet 50 mg	2	
ERLEADA ORAL TABLET 240 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 1 day); SP
ERLEADA ORAL TABLET 60 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
flutamide oral capsule 125 mg	2	
NUBEQA ORAL TABLET 300 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
XTANDI ORAL CAPSULE 40 MG	5	PA; QL (120 EA per 30 days); SP
XTANDI ORAL TABLET 40 MG	5	PA; QL (120 EA per 30 days); SP
XTANDI ORAL TABLET 80 MG	5	PA; QL (60 EA per 30 days); SP
ANTIESTROGENS**		
tamoxifen citrate oral tablet 10 mg, 20 mg	2	$0 ($0 cost share when prescribed with the diagnosis code of Z15.01, Z80.3, Z80.9, Z85.3, Z85.9: Genetic susceptibility or family/personal history of neoplasm of breast.); DX (Diagnosis Code at Point of Sale is accepted.)
ANTIMETABOLITES**		
ADRUCIL INTRAVENOUS SOLUTION 500 MG/10ML	MB	
capecitabine oral tablet 150 mg, 500 mg	4	

Drug Name	Tier	Notes
cytarabine (pf) injection solution 100 mg/ml	MB	
DEPOCYT INTRATHECAL SUSPENSION 50 MG/5ML	MB	
fludarabine phosphate intravenous solution 50 mg/2ml	MB	
FUDR INJECTION SOLUTION RECONSTITUTED 0.5 GM	MB	
GEMZAR INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	
LEUSTATIN INTRAVENOUS SOLUTION 1 MG/ML	MB	
mercaptopurine oral tablet 50 mg	2	
methotrexate oral tablet 2.5 mg	2	
methotrexate sodium (pf) injection solution 1 gm/40ml, 100 mg/4ml, 25 mg/ml, 250 mg/10ml, 50 mg/2ml	2	
methotrexate sodium injection solution 25 mg/ml, 250 mg/10ml, 50 mg/2ml	2	
methotrexate sodium injection solution reconstituted 1 gm	2	
methotrexate sodium oral tablet 2.5 mg	2	
nelarabine intravenous solution 5 mg/ml	MB	
TABLOID ORAL TABLET 40 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	3	
XATMEP ORAL SOLUTION 2.5 MG/ML	5	PA
ANTINEOPLASTIC - ALK INHIBITORS**		
ALECENSA ORAL CAPSULE 150 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (240 EA per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
ALUNBRIG ORAL TABLET 30 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days)
LORBRENA ORAL TABLET 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
LORBRENA ORAL TABLET 25 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP

Drug Name	Tier	Notes
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ZYKADIA ORAL CAPSULE 150 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (150 EA per 30 days); SP
ANTINEOPLASTIC - ANTI-BCMA ANTIBODY-DRUG COMPLEX**		
BLENREP INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES**		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES**		
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX**		
BESPONSA INTRAVENOUS SOLUTION RECONSTITUTED 0.9 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD30 ANTIBODY-DRUG COMPLEX**		
ADCETRIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX**		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED 4.5 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES**		
DARZALEX INTRAVENOUS SOLUTION 100 MG/5ML, 400 MG/20ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
SARCLISA INTRAVENOUS SOLUTION 100 MG/5ML, 500 MG/25ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX**		
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 140 MG, 30 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-HER2 AGENTS**		

Drug Name	Tier	Notes
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	MB	
TUKYSA ORAL TABLET 150 MG, 50 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
ANTINEOPLASTIC - ANTI-NECTIN-4 ANTIBODY-DRUG COMPLEX**		
PADCEV INTRAVENOUS SOLUTION RECONSTITUTED 20 MG, 30 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES**		
LIBTAYO INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
OPDIVO INTRAVENOUS SOLUTION 120 MG/12ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES**		
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES**		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED 300 MG, 400 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - BCL-2 INHIBITORS**		
VENCLEXTA ORAL TABLET 10 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 28 days)
ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS**		
BOSULIF ORAL CAPSULE 100 MG	5	PA; QL (3 EA per 1 day); SP
BOSULIF ORAL TABLET 100 MG	5	PA; QL (90 EA per 30 days); SP
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PA; QL (30 EA per 30 days); SP
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg	5	PA; QL (30 EA per 30 days); SP

Drug Name	Tier	Notes
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	5	PA; LA; QL (30 EA per 30 days); SP
imatinib mesylate oral tablet 100 mg, 400 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ANTINEOPLASTIC - BRAF KINASE INHIBITORS**		
BRAFTOVI ORAL CAPSULE 50 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (180 EA per 30 days); SP
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
ZELBORAF ORAL TABLET 240 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (240 EA per 30 days); SP
ANTINEOPLASTIC - BTK INHIBITORS**		
BRUKINSA ORAL CAPSULE 80 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
CALQUENCE ORAL CAPSULE 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
CALQUENCE ORAL TABLET 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	5	PA; LA; QL (1 EA per 1 day)
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA; LA; QL (6 ML per 1 day)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PA; LA; QL (28 EA per 28 days)
JAYPIRCA ORAL TABLET 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
JAYPIRCA ORAL TABLET 50 MG	5	PA; DX (Non-ASO Plans: 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 (Non-ASO Plans: Diagnosis Validation Required)
erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP

Drug Name	Tier	Notes
gefitinib oral tablet 250 mg	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days)
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days)
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
ANTINEOPLASTIC - FGFR KINASE INHIBITORS**		
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (14 EA per 21 days)
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS**		
DAURISMO ORAL TABLET 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
DAURISMO ORAL TABLET 25 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ERIVEDGE ORAL CAPSULE 150 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
ODOMZO ORAL CAPSULE 200 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS**		
FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (6 EA per 21 days)
ZOLINZA ORAL CAPSULE 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
ANTINEOPLASTIC - IMMUNOMODULATORS**		
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (21 EA per 28 days); SP

Drug Name	Tier	Notes
ANTINEOPLASTIC - KRAS INHIBITORS**		
KRAZATI ORAL TABLET 200 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (180 EA per 30 days)
LUMAKRAS ORAL TABLET 120 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (8 EA per 1 day); SP
LUMAKRAS ORAL TABLET 320 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3 EA per 1 day); SP
ANTINEOPLASTIC - MEK INHIBITORS**		
MEKINIST ORAL TABLET 0.5 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP
MEKINIST ORAL TABLET 2 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
MEKTOVI ORAL TABLET 15 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (180 EA per 30 days)
ANTINEOPLASTIC - MET INHIBITORS**		
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS**		
TAZVERIK ORAL TABLET 200 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (240 EA per 30 days)
ANTINEOPLASTIC - MTOR KINASE INHIBITORS**		
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
TORISEL INTRAVENOUS SOLUTION 25 MG/ML	MB	
ANTINEOPLASTIC - MULTIKINASE INHIBITORS**		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA; QL (30 EA per 30 days); SP
CAPRELSA ORAL TABLET 100 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days)

Drug Name	Tier	Notes
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required)
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required)
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required)
lapatinib ditosylate oral tablet 250 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (180 EA per 30 days); SP
NERLYNX ORAL TABLET 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (180 EA per 30 days); SP
pazopanib hcl oral tablet 200 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
QINLOCK ORAL TABLET 50 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days)
RYDAPT ORAL CAPSULE 25 MG	5	PA; QL for AML = 120/30QL for ASM, SM-AHN,and MCL= 240/30.; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
sorafenib tosylate oral tablet 200 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
STIVARGA ORAL TABLET 40 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
UKONIQ ORAL TABLET 200 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days)
XOSPATA ORAL TABLET 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days)
ANTINEOPLASTIC - MULTIPLE RECEPTOR ANTIBODIES**		
RYBREVANT INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS**		
AYVAKIT ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP

Drug Name	Tier	Notes
ANTINEOPLASTIC - PROTEASOME INHIBITORS**		
bortezomib intravenous solution reconstituted 3.5 mg	MB	
ANTINEOPLASTIC - RET INHIBITORS**		
RETEVMO ORAL CAPSULE 40 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (180 EA per 30 days); SP
RETEVMO ORAL CAPSULE 80 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 1 day)
RETEVMO ORAL TABLET 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3 EA per 1 day)
ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS**		
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
ANTINEOPLASTIC - TYROSINE KINASE INHIBITORS**		
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 1 X 80 & 1 X 20 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 1 X 80 & 3 X 20 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC - XPO1 INHIBITORS**		
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (8 EA per 28 days)
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (8 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 60 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)

Drug Name	Tier	Notes
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required)
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 EA per 28 days)
ANTINEOPLASTIC ANTIBIOTICS**		
bleomycin sulfate injection solution reconstituted 15 unit	MB	
CERUBIDINE INTRAVENOUS SOLUTION RECONSTITUTED 20 MG	MB	
COSMEGEN INTRAVENOUS SOLUTION RECONSTITUTED 0.5 MG	MB	
DAUNOXOME INTRAVENOUS INJECTABLE 2 MG/ML	MB	
ELLENCE INTRAVENOUS SOLUTION 200 MG/100ML	MB	
IDAMYCIN PFS INTRAVENOUS SOLUTION 5 MG/5ML	MB	
mitomycin intravenous solution reconstituted 5 mg	MB	
mitoxantrone hcl intravenous concentrate 25 mg/12.5ml	MB	
valrubicin intravesical solution 40 mg/ml	MB	
ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES**		
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTIC COMBINATIONS**		
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1800-30000 MG-UT/15ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
INQOVI ORAL TABLET 35-100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (5 EA per 28 days); SP
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA; LA; QL (49 EA per 28 days)
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA; LA; QL (70 EA per 28 days)

Drug Name	Tier	Notes
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA; LA; QL (91 EA per 28 days)
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (40 EA per 28 days); SP
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 600-10000 MG-UT/5ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
TECENTRIQ HYBREZA SUBCUTANEOUS SOLUTION 1875-30000 MG-UT/15ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
VYXEOS INTRAVENOUS SUSPENSION RECONSTITUTED 44-100 MG	MB	PA
ANTINEOPLASTIC ENZYMES**		
ONCASPAR INJECTION SOLUTION 750 UNIT/ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ANTINEOPLASTICS - PHOTOACTIVATED AGENTS**		
PHOTOFRIN INTRAVENOUS SOLUTION RECONSTITUTED 75 MG	MB	
ANTINEOPLASTICS MISC.**		
ALFERON N INJECTION SOLUTION 5000000 UNIT/ML	MB	
dacarbazine intravenous solution reconstituted 100 mg	MB	
hydroxyurea oral capsule 500 mg	2	
INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML	5	SP
INTRON-A SUBCUTANEOUS KIT 10000000 UNIT/0.2ML	5	
MATULANE ORAL CAPSULE 50 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
NIPENT INTRAVENOUS SOLUTION RECONSTITUTED 10 MG	MB	
ONTAK INTRAVENOUS SOLUTION 150 MCG/ML	MB	
SYLATRON SUBCUTANEOUS KIT 4 X 200 MCG, 4 X 300 MCG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
SYLATRON SUBCUTANEOUS KIT 600 MCG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML	MB	
AROMATASE INHIBITORS**		

Drug Name	Tier	Notes
anastrozole oral tablet 1 mg	2	$0 ($0 cost share when prescribed with the diagnosis code of Z15.01, Z80.3, Z80.9, Z85.3, Z85.9: Genetic susceptibility or family/personal history of neoplasm of breast); DX (Diagnosis Code at Point of Sale is accepted.)
exemestane oral tablet 25 mg	4	$0 ($0 cost share when prescribed with the diagnosis code of Z15.01, Z80.3, Z80.9, Z85.3, Z85.9: Genetic susceptibility or family/personal history of neoplasm of breast); DX (Diagnosis Code at Point of Sale is accepted.)
letrozole oral tablet 2.5 mg	2	$0 ($0 cost share when prescribed with the diagnosis code of Z15.01, Z80.3, Z80.9, Z85.3, Z85.9: Genetic susceptibility or family/personal history of neoplasm of breast); DX (Diagnosis Code at Point of Sale is accepted.)
CARDIAC PROTECTIVE AGENTS**		
dexrazoxane intravenous solution reconstituted 250 mg	MB	
CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS**		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (21 EA per 28 days); SP
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (21 EA per 28 days); SP
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (21 EA per 28 days)
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (42 EA per 28 days)
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (63 EA per 28 days)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ESTROGEN RECEPTOR ANTAGONIST**		
fulvestrant intramuscular solution 250 mg/5ml	MB	
ESTROGENS-ANTINEOPLASTIC**		

Drug Name	Tier	Notes
EMCYT ORAL CAPSULE 140 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
FOLIC ACID ANTAGONISTS RESCUE AGENTS**		
leucovorin calcium injection solution reconstituted 50 mg	MB	
leucovorin calcium oral tablet 10 mg, 15 mg	3	
leucovorin calcium oral tablet 25 mg, 5 mg	2	
GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS**		
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG	MB	
IMIDAZOTETRAZINES**		
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	4	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS**		
TIBSOVO ORAL TABLET 250 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
JANUS ASSOCIATED KINASE (JAK) INHIBITORS**		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
LHRH ANALOGS**		
leuprolide acetate injection kit 1 mg/0.2ml	MB	PA not required if billed with Dx codes F64.1 - F64.9.
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 7.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
VANTAS SUBCUTANEOUS KIT 50 MG	MB	
MITOTIC INHIBITORS**		
docetaxel intravenous concentrate 160 mg/8ml, 20 mg/ml, 200 mg/10ml, 80 mg/4ml	MB	
ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	

Drug Name	Tier	Notes
etoposide oral capsule 50 mg	4	
IXEMPRA KIT INTRAVENOUS SOLUTION RECONSTITUTED 15 MG, 45 MG	MB	
NAVELBINE INTRAVENOUS SOLUTION 10 MG/ML	MB	
ONXOL INTRAVENOUS CONCENTRATE 150 MG/25ML	MB	
TOPOSAR INTRAVENOUS SOLUTION 100 MG/5ML	MB	
vinblastine sulfate intravenous solution 1 mg/ml	MB	
VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML	MB	
NITROGEN MUSTARDS AND RELATED ANALOGUES**		
ALKERAN INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	
ALKERAN ORAL TABLET 2 MG	MB	
cyclophosphamide injection solution reconstituted 1 gm	MB	
cyclophosphamide oral capsule 25 mg, 50 mg	4	
IFEX INTRAVENOUS SOLUTION RECONSTITUTED 1 GM	MB	
LEUKERAN ORAL TABLET 2 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
melphalan oral tablet 2 mg	2	
MUSTARGEN INJECTION SOLUTION RECONSTITUTED 10 MG	MB	
NITROSOUREAS**		
carmustine intravenous solution reconstituted 300 mg, 50 mg	MB	
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	4	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ZANOSAR INTRAVENOUS SOLUTION RECONSTITUTED 1 GM	MB	
PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS**		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
ITOVEBI ORAL TABLET 3 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2 EA per 1 day); SP
ITOVEBI ORAL TABLET 9 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 1 day); SP

Drug Name	Tier	Notes
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS**		
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
ZEJULA ORAL CAPSULE 100 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
PROGESTINS-ANTINEOPLASTIC**		
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml	2	
megestrol acetate oral tablet 20 mg, 40 mg	2	
SELECTIVE ESTROGEN RECEPTOR DEGRADERS**		
ORSERDU ORAL TABLET 345 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
ORSERDU ORAL TABLET 86 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP
SELECTIVE RETINOID X RECEPTOR AGONISTS**		

Drug Name	Tier	Notes
bexarotene oral capsule 75 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
TOPOISOMERASE I INHIBITORS**		
CAMPTOSAR INTRAVENOUS SOLUTION 40 MG/2ML	MB	
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
URINARY TRACT PROTECTIVE AGENTS**		
MESNEX INTRAVENOUS SOLUTION 100 MG/ML	MB	
MESNEX ORAL TABLET 400 MG	5	
VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS**		
INLYTA ORAL TABLET 1 MG, 5 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (120 EA per 30 days); SP
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (90 EA per 30 days); SP
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 EA per 30 days); SP
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS**		

Drug Name	Tier	Notes
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
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 cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
trihexyphenidyl hcl oral elixir 0.4 mg/ml	2	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIPARKINSON DOPAMINERGICS**		
amantadine hcl oral capsule 100 mg	2	
amantadine hcl oral syrup 50 mg/5ml	2	
amantadine hcl oral tablet 100 mg	2	
bromocriptine mesylate oral capsule 5 mg	2	
bromocriptine mesylate oral tablet 2.5 mg	2	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS**		
rasagiline mesylate oral tablet 0.5 mg, 1 mg	4	ST

Drug Name	Tier	Notes
selegiline hcl oral capsule 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
selegiline hcl oral tablet 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
CENTRAL/PERIPHERAL COMT INHIBITORS**		
tolcapone oral tablet 100 mg	4	
LEVODOPA COMBINATIONS**		
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	2	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	2	
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	2	
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	4	
NONERGOLINE DOPAMINE RECEPTOR AGONISTS**		
APOKYN SUBCUTANEOUS SOLUTION 10 MG/ML	5	PA; LA
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA; LA; QL (150 EA per 30 days)
KYNMOBI TITRATION KIT SUBLINGUAL KIT 10&15&20&25&30 MG	5	PA; LA; QL (1 EA per 180 days)

Drug Name	Tier	Notes
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	2	
PERIPHERAL COMT INHIBITORS**		
entacapone oral tablet 200 mg	2	
ONGENTYS ORAL CAPSULE 50 MG	5	PA; QL (30 EA per 30 days); SP
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS**		
lithium carbonate er oral tablet extended release 300 mg, 450 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
lithium carbonate oral tablet 300 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lithium oral solution 8 meq/5ml	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTIPSYCHOTICS - MISC.**		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5	PA; QL (30 EA per 30 days); AL (Min 18 Years)
lurasidone hcl oral tablet 120 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 13 Years)
lurasidone hcl oral tablet 20 mg, 40 mg, 60 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 10 Years)

Drug Name	Tier	Notes
lurasidone hcl oral tablet 80 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 10 Years)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 1 day); AL (Min 18 Years)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 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 (7 EA per 365 days); AL (Min 18 Years)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
BENZISOXAZOLES**		

Drug Name	Tier	Notes
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	5	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 (60 EA per 30 days); AL (Min 18 Years)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 365 days); AL (Min 18 Years)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.75 ML per 28 days); AL (Min 18 Years)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 ML per 28 days); AL (Min 18 Years)

Drug Name	Tier	Notes
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.5 ML per 28 days); AL (Min 18 Years)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.25 ML per 28 days); AL (Min 18 Years)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.5 ML per 28 days); AL (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.88 ML per 84 days); AL (Min 18 Years)

Drug Name	Tier	Notes
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (0.88 ML per 84 days); AL (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.315ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.32 ML per 84 days); AL (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.32 ML per 84 days); AL (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.75 ML per 84 days); AL (Min 18 Years)

Drug Name	Tier	Notes
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.625ML	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.63 ML per 84 days); AL (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML	5	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 (2.63 ML per 84 days); AL (Min 18 Years)
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 12 Years)
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2 vials per 28 days); AL (Min 18 Years)

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

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

Drug Name	Tier	Notes
haloperidol lactate injection solution 5 mg/ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Min 18 Years)
haloperidol lactate oral concentrate 2 mg/ml	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Min 3 Years)
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Min 3 Years)
DIBENZODIAZEPINES**		
clozapine oral tablet 100 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (270 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
clozapine oral tablet 200 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (135 EA per 30 days); AL (Min 6 Years)
clozapine oral tablet 25 mg, 50 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days); AL (Min 6 Years)
DIBENZO-OXEPINO PYRROLES**		
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (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	5	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.)
DIBENZOTHIAZEPINES**		

Drug Name	Tier	Notes
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
quetiapine fumarate er oral tablet extended release 24 hour 400 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 400 mg, 50 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (90 EA per 30 days); AL (Min 6 Years)
quetiapine fumarate oral tablet 150 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

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

Drug Name	Tier	Notes
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
COMPRO RECTAL SUPPOSITORY 25 MG	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluphenazine decanoate injection solution 25 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluphenazine hcl oral concentrate 5 mg/ml	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
fluphenazine hcl oral elixir 2.5 mg/5ml	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
fluphenazine hcl oral tablet 5 mg	2	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
prochlorperazine edisylate injection solution 10 mg/2ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

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

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

Drug Name	Tier	Notes
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
aripiprazole oral tablet dispersible 10 mg, 15 mg	5	PA; Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.4 ML per 30 days); AL (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3.9 ML per 56 days); AL (Min 18 Years)

Drug Name	Tier	Notes
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1.6 ML per 28 days); AL (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (2.4 ML per 28 days); AL (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (3.2 ML per 28 days); AL (Min 18 Years)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 13 Years)
THIENBENZODIAZEPINES**		

Drug Name	Tier	Notes
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	2	Prior Authorization required for patients under 6 years of age; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); AL (Min 6 Years)
THIOXANTHENES**		
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTISEPTICS & DISINFECTANTS		
CHLORINE ANTISEPTICS**		
chlorhexidine gluconate solution 20 %	2	
ANTIVIRALS		
ANTIRETROVIRAL COMBINATIONS**		

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

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

Drug Name	Tier	Notes
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
emtricitabine-tenofovir df oral tablet 167-250 mg, 200-300 mg	$0	DX (Covered at a zero-dollar copay for the diagnosis of Pre-exposure prophylaxis (PrEP) per ACA); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
EVOTAZ ORAL TABLET 300-150 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
GENVOYA ORAL TABLET 150-150-200-10 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

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

Drug Name	Tier	Notes
ODEFSEY ORAL TABLET 200-25-25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
PREZCOBIX ORAL TABLET 800-150 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)

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

Drug Name	Tier	Notes
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)
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 KIT 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)

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

Drug Name	Tier	Notes
ISENTRESS ORAL PACKET 100 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ISENTRESS ORAL TABLET 400 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)

Drug Name	Tier	Notes
TIVICAY ORAL TABLET 10 MG, 25 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)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	$0	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days); AL (Max 12 Years)
VITEKTA ORAL TABLET 150 MG, 85 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 - PROTEASE INHIBITORS**		
APTIVUS ORAL CAPSULE 250 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)

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

Drug Name	Tier	Notes
darunavir oral tablet 800 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
fosamprenavir calcium oral tablet 700 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
INVIRASE 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 (120 EA per 30 days)
INVIRASE ORAL TABLET 500 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
LEXIVA ORAL SUSPENSION 50 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.)
NORVIR ORAL CAPSULE 100 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (360 EA per 30 days)
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 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)

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

Drug Name	Tier	Notes
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)
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)
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)

Drug Name	Tier	Notes
nevirapine oral suspension 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.); QL (1200 ML 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 (30 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)
RESCRIPTOR 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 (180 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)
didanosine oral capsule delayed release 125 mg, 200 mg, 250 mg, 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)
VIDEX ORAL SOLUTION RECONSTITUTED 2 GM, 4 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 (1200 ML per 30 days)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES**		

Drug Name	Tier	Notes
emtricitabine oral capsule 200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lamivudine oral solution 10 mg/ml	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
lamivudine oral tablet 150 mg	$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 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)
ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES**		
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML	$0	
stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 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)
stavudine oral solution reconstituted 1 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 (2400 EA per 30 days)
zidovudine oral capsule 100 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)

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.); QL (1800 ML per 30 days)
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)
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)

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)
ANTIRETROVIRALS ADJUVANTS**		
TYBOST ORAL TABLET 150 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
ANTIVIRAL COMBINATIONS**		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	4	QL (40 EA per 365 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	4	QL (60 EA per 365 days)
PAXLOVID ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	4	QL (40 EA per 365 days)
PAXLOVID ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	4	QL (60 EA per 365 days)
CMV AGENTS**		
CYTOVENE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
foscarnet sodium intravenous solution 24 mg/ml	MB	
valganciclovir hcl oral solution reconstituted 50 mg/ml	5	PA; QL (900 ML per 30 days)
valganciclovir hcl oral tablet 450 mg	4	PA; QL (60 EA per 30 days)
VISTIDE INTRAVENOUS SOLUTION 75 MG/ML	MB	
HEPATITIS B AGENTS**		
entecavir oral tablet 0.5 mg, 1 mg	5	PA; QL (30 EA per 30 days); SP
EPIVIR HBV ORAL SOLUTION 5 MG/ML	3	QL (900 ML per 30 days)
lamivudine oral tablet 100 mg	2	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	5	QL (30 EA per 30 days); SP

Drug Name	Tier	Notes
HEPATITIS C AGENT - COMBINATIONS**		
MAVYRET ORAL PACKET 50-20 MG	5	PA; QL (150 EA per 30 days); SP
MAVYRET ORAL TABLET 100-40 MG	5	PA; QL (3 EA per 1 day); SP
sofosbuvir-velpatasvir oral tablet 400-100 mg	5	PA; QL (84 EA per 365 days); SP
TECHNIVIE ORAL TABLET 12.5-75-50 MG	5	PA; SP
VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG	5	PA; QL (112 EA per 28 days); AL (Min 18 Years); SP
VIEKIRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 200-8.33-50- 33.33 MG	5	PA; QL (90 EA per 30 days); SP
HEPATITIS C AGENTS**		
PEGASYS PROCLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 180 MCG/0.5ML	5	PA; QL (2 ML per 28 days); SP
PEGASYS SUBCUTANEOUS KIT 180 MCG/0.5ML	5	PA
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA; SP
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML	5	PA; QL (2 ML per 28 days); SP
ribavirin oral capsule 200 mg	4	PA
ribavirin oral tablet 200 mg	4	PA
HERPES AGENTS - PURINE ANALOGUES**		
acyclovir oral capsule 200 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.)
acyclovir oral suspension 200 mg/5ml	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
acyclovir oral tablet 400 mg, 800 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.)
acyclovir sodium intravenous solution 50 mg/ml	MB	
valacyclovir hcl oral tablet 1 gm, 500 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.)
HERPES AGENTS - THYMIDINE ANALOGUES**		
famciclovir oral tablet 125 mg, 250 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
INFLUENZA AGENTS**		
rimantadine hcl oral tablet 100 mg	3	
MISC. ANTIVIRALS**		
LAGEVRIO ORAL CAPSULE 200 MG	4	QL (80 EA per 365 days)
VEKLURY INTRAVENOUS SOLUTION 100 MG/20ML	MB	
VEKLURY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	
NEURAMINIDASE INHIBITORS**		

Drug Name	Tier	Notes
oseltamivir phosphate oral capsule 30 mg	4	QL (20 EA per 180 days)
oseltamivir phosphate oral capsule 45 mg, 75 mg	4	QL (10 EA per 180 days)
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	4	QL (180 ML per 180 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/BLISTER	4	QL (20 EA per 126 days)
BETA BLOCKERS		
ALPHA-BETA BLOCKERS**		
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
labetalol hcl intravenous solution 5 mg/ml	2	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
BETA BLOCKERS CARDIO-SELECTIVE**		
acebutolol hcl oral capsule 200 mg, 400 mg	2	
atenolol oral tablet 100 mg, 25 mg, 50 mg	2	
betaxolol hcl oral tablet 10 mg, 20 mg	2	
bisoprolol fumarate oral tablet 10 mg, 5 mg	2	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	4	
BETA BLOCKERS NON-SELECTIVE**		
LEVATOL ORAL TABLET 20 MG	4	
nadolol oral tablet 20 mg, 40 mg, 80 mg	1	
pindolol oral tablet 10 mg, 5 mg	2	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	2	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	3	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	3	
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKERS**		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
CARDENE SR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 30 MG, 60 MG	4	

Drug Name	Tier	Notes
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	2	
dilt-cd oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	2	
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	2	
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	2	
diltiazem hcl intravenous solution 50 mg/10ml	MB	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	2	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	2	
isradipine oral capsule 2.5 mg, 5 mg	2	
KATERZIA ORAL SUSPENSION 1 MG/ML	4	AL (Max 12 Years)
nicardipine hcl in nacl intravenous solution 20-0.9 mg/200ml-%, 40-0.9 mg/200ml-%	MB	
nicardipine hcl oral capsule 20 mg, 30 mg	2	
NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HOUR 90 MG	2	
NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG	2	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine oral capsule 10 mg, 20 mg	2	
nimodipine oral capsule 30 mg	4	PA
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	4	ST; QL (30 EA per 30 days)
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 360 MG	2	
TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg	3	
verapamil hcl er oral capsule extended release 24 hour 120 mg, 240 mg	2	

Drug Name	Tier	Notes
verapamil hcl er oral capsule extended release 24 hour 180 mg	2	QL (60 EA per 30 days)
verapamil hcl er oral tablet extended release 180 mg, 240 mg	2	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
CARDIOTONICS		
CARDIAC GLYCOSIDES**		
digoxin oral tablet 125 mcg, 250 mcg	2	
LANOXIN INJECTION SOLUTION 0.25 MG/ML	MB	
INOTROPES**		
dobutamine hcl intravenous solution 250 mg/20ml	MB	
dopamine hcl intravenous solution 40 mg/ml	MB	
milrinone lactate intravenous solution 20 mg/20ml	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	4	QL (30 EA per 30 days)
NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB**		
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG	4	PA; QL (60 EA per 30 Days)
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	4	PA; QL (60 EA per 30 days)
PERIPHERAL VASODILATORS**		
papaverine hcl injection solution 30 mg/ml	4	PA
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS**		
ambrisentan oral tablet 10 mg, 5 mg	5	PA; QL (30 EA per 30 days); SP
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS**		
sildenafil citrate oral tablet 20 mg	4	PA; QL (90 EA per 30 days)
VASOACTIVE NATRIURETIC PEPTIDES**		
NATRECOR INTRAVENOUS SOLUTION RECONSTITUTED 1.5 MG	MB	
CEPHALOSPORINS		
CEPHALOSPORIN COMBINATIONS**		

Drug Name	Tier	Notes
AVYCAZ INTRAVENOUS SOLUTION RECONSTITUTED 2.5 (2-0.5) GM	MB	
CEPHALOSPORINS - 1ST GENERATION**		
cefadroxil oral capsule 500 mg	2	
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	2	
cefadroxil oral tablet 1 gm	2	
cefazolin sodium-dextrose intravenous solution 1-4 gm/50ml-%	MB	
cephalexin oral capsule 250 mg, 500 mg	2	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
CEPHALOSPORINS - 2ND GENERATION**		
cefaclor oral capsule 250 mg, 500 mg	2	
cefoxitin sodium intravenous solution reconstituted 1 gm	MB	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cefprozil oral tablet 250 mg, 500 mg	2	
cefuroxime axetil oral suspension reconstituted 125 mg/5ml	2	
cefuroxime axetil oral tablet 250 mg, 500 mg	2	
ZINACEF INTRAVENOUS SOLUTION RECONSTITUTED 750 MG	MB	
CEPHALOSPORINS - 3RD GENERATION**		
cefdinir oral capsule 300 mg	2	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	2	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	2	
cefpodoxime proxetil oral tablet 100 mg, 200 mg	2	

Drug Name	Tier	Notes
ceftriaxone sodium injection solution reconstituted 1 gm	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.)
ceftriaxone sodium injection solution reconstituted 100 gm, 2 gm, 250 mg, 500 mg	2	
FORTAZ INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
ROCEPHIN INJECTION SOLUTION RECONSTITUTED 250 MG	MB	
SUPRAX ORAL TABLET 400 MG	3	
CEPHALOSPORINS - 4TH GENERATION**		
MAXIPIME INJECTION SOLUTION RECONSTITUTED 1 GM	MB	
CONTRACEPTIVES		
BIPHASIC CONTRACEPTIVES - ORAL**		
AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
BEKYREE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	2	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
KIMIDESS ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG	4	PA
NECON 10/11 (28) ORAL TABLET 35 MCG	3	
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	2	
VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	2	
COMBINATION CONTRACEPTIVES - ORAL**		
AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	$0	
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	2	

Drug Name	Tier	Notes
alyacen 1/35 oral tablet 1-35 mg-mcg	$0	$0 Copay per PPACA guidelines
APRI ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
AUBRA ORAL TABLET 0.1-20 MG-MCG	$0	
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG	2	
AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 copay Per PPACA Guidelines
AUROVELA FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	$0 copay Per PPACA Guidelines
AVIANE ORAL TABLET 0.1-20 MG-MCG	$0	
AYUNA ORAL TABLET 0.15-30 MG-MCG	2	
BALZIVA ORAL TABLET 0.4-35 MG-MCG	2	
BLISOVI 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	$0 Copay per PPACA guidelines.
briellyn oral tablet 0.4-35 mg-mcg	2	
CHATEAL ORAL TABLET 0.15-30 MG-MCG	2	
CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
CYCLAFEM 1/35 ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines
CYRED ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines
DELYLA ORAL TABLET 0.1-20 MG-MCG	$0	
desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg	$0	$0 Copay per PPACA guidelines.
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg	4	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	2	
ELINEST ORAL TABLET 0.3-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
EMOQUETTE ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg	$0	
ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg	2	
FALMINA ORAL TABLET 0.1-20 MG-MCG	$0	
FEMYNOR ORAL TABLET 0.25-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
GIANVI ORAL TABLET 3-0.02 MG	2	
GILDAGIA ORAL TABLET 0.4-35 MG-MCG	2	$0 Copay per PPACA guidelines.

Drug Name	Tier	Notes
GILDESS 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	$0 copay for the following NDCs: 00603-7606-15, 00603-7606-48. Preventative services.
GILDESS 1/20 ORAL TABLET 1-20 MG-MCG	2	$0 copay for the following NDCs: 00603-7607-15, 00603-7607-48. Preventative care.
GILDESS 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
GILDESS FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
GILDESS FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	$0 Copay per PPACA guidelines.
HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 copay Per PPACA Guidelines
HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
JASMIEL ORAL TABLET 3-0.02 MG	2	
JULEBER ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	2	
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	$0 Copay per PPACA guidelines.
JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)	2	
KAITLIB FE ORAL TABLET CHEWABLE 0.8-25 MG-MCG	2	
KALLIGA ORAL TABLET 0.15-30 MG-MCG	$0	
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	2	
KURVELO ORAL TABLET 0.15-30 MG-MCG	2	
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	2	
LARIN 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	$0 Copay per PPACA guidelines.
LARISSIA ORAL TABLET 0.1-20 MG-MCG	$0	
LAYOLIS FE ORAL TABLET CHEWABLE 0.8-25 MG-MCG	2	
LESSINA ORAL TABLET 0.1-20 MG-MCG	$0	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	$0	
levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg	2	

Drug Name	Tier	Notes
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	2	
LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	2	
LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	2	
LOESTRIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 copay Per PPACA Guidelines
LOMEDIA 24 FE ORAL TABLET 1-20 MG-MCG(24)	2	
LORYNA ORAL TABLET 3-0.02 MG	2	
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
LO-ZUMANDIMINE ORAL TABLET 3-0.02 MG	2	
LUTERA ORAL TABLET 0.1-20 MG-MCG	$0	
marlissa oral tablet 0.15-30 mg-mcg	2	
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	2	
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	2	
MICROGESTIN 24 FE ORAL TABLET 1-20 MG-MCG	2	
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	$0 Copay per PPACA guidelines.
MILI ORAL TABLET 0.25-35 MG-MCG	$0	$0 copay Per PPACA Guidelines
MONO-LINYAH ORAL TABLET 0.25-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
MONONESSA ORAL TABLET 0.25-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
NECON 1/35 (28) ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines
NECON 1/50 (28) ORAL TABLET 1-50 MG-MCG	3	
NIKKI ORAL TABLET 3-0.02 MG	2	
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	$0	$0 copay Per PPACA Guidelines
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg	$0	$0 Copay per PPACA guidelines.
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg(24)	2	
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	2	
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg	2	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	$0	$0 Copay per PPACA guidelines.
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines

Drug Name	Tier	Notes
NYMYO ORAL TABLET 0.25-35 MG-MCG	$0	$0 copay Per PPACA Guidelines
OCELLA ORAL TABLET 3-0.03 MG	2	
OGESTREL ORAL TABLET 0.5-50 MG-MCG	3	
ORSYTHIA ORAL TABLET 0.1-20 MG-MCG	$0	
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	
PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	2	
PREVIFEM ORAL TABLET 0.25-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
RAJANI ORAL TABLET 3-0.02-0.451 MG	4	
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
SOLIA ORAL TABLET 0.15-30 MG-MCG	$0	$0 Copay per PPACA guidelines.
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
SRONYX ORAL TABLET 0.1-20 MG-MCG	$0	
SYEDA ORAL TABLET 3-0.03 MG	2	
TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)	$0	
VESTURA ORAL TABLET 3-0.02 MG	2	
VIENVA ORAL TABLET 0.1-20 MG-MCG	$0	
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	2	
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	$0	$0 copay Per PPACA Guidelines
WERA ORAL TABLET 0.5-35 MG-MCG	2	
WYMZYA FE ORAL TABLET CHEWABLE 0.4-35 MG-MCG	2	
ZARAH ORAL TABLET 3-0.03 MG	2	
ZENCHENT FE ORAL TABLET CHEWABLE 0.4-35 MG-MCG	2	
ZENCHENT ORAL TABLET 0.4-35 MG-MCG	2	
ZOVIA 1/35E (28) ORAL TABLET 1-35 MG-MCG	$0	$0 Copay per PPACA guidelines.
ZUMANDIMINE ORAL TABLET 3-0.03 MG	2	
COMBINATION CONTRACEPTIVES - TRANSDERMAL**		
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR	$0	$0 Copay per PPACA guidelines; QL (3 EA per 28 days); AL (Max 55 Years)
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
COMBINATION CONTRACEPTIVES - VAGINAL**		
ELURYNG VAGINAL RING 0.12-0.015 MG/24HR	$0	QL (1 EA per 28 days); AL (Max 55 Years)

Drug Name	Tier	Notes
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	$0	QL (1 EA per 28 days); AL (Max 55 Years)
CONTINUOUS CONTRACEPTIVES - ORAL**		
AMETHYST ORAL TABLET 90-20 MCG	2	
levonorgestrel-ethinyl estrad oral tablet 90-20 mcg	2	
COPPER CONTRACEPTIVES - IUD**		
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE	$0	$0 Copay per PPACA guidelines; QL (1 EA per 10 Years); AL (Max 55 Years)
EMERGENCY CONTRACEPTIVES**		
AFTERA ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines
ECONTRA EZ ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines
ELLA ORAL TABLET 30 MG	$0	$0 Copay per PPACA guidelines
FALLBACK SOLO ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines
levonorgestrel oral tablet 0.75 mg	$0	$0 Copay per PPACA guidelines.
levonorgestrel oral tablet 1.5 mg	$0	$0 Copay per PPACA guidelines
MY WAY ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines
NEXT CHOICE ONE DOSE ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines; QL (3 EA per 365 days)
NEXT CHOICE ORAL TABLET 0.75 MG	$0	$0 Copay per PPACA guidelines
OPCICON ONE-STEP ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines
TAKE ACTION ORAL TABLET 1.5 MG	$0	$0 Copay per PPACA guidelines
EXTENDED-CYCLE CONTRACEPTIVES - ORAL**		
AMETHIA LO ORAL TABLET 0.1-0.02 & 0.01 MG	$0	$0 Copay per PPACA guidelines
AMETHIA ORAL TABLET 0.15-0.03 &0.01 MG	$0	$0 Copay per PPACA guidelines.
ASHLYNA ORAL TABLET 0.15-0.03 &0.01 MG	$0	$0 Copay per PPACA guidelines.
CAMRESE LO ORAL TABLET 0.1-0.02 & 0.01 MG	$0	$0 Copay per PPACA guidelines
CAMRESE ORAL TABLET 0.15-0.03 &0.01 MG	$0	$0 Copay per PPACA guidelines.
DAYSEE ORAL TABLET 0.15-0.03 &0.01 MG	$0	$0 Copay per PPACA guidelines.
ICLEVIA ORAL TABLET 0.15-0.03 MG	$0	$0 copay Per PPACA Guidelines
INTROVALE ORAL TABLET 0.15-0.03 MG	$0	$0 Copay per PPACA guidelines
JAIMIESS ORAL TABLET 0.15-0.03 &0.01 MG	$0	$0 Copay per PPACA guidelines
JOLESSA ORAL TABLET 0.15-0.03 MG	$0	$0 Copay per PPACA guidelines
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
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 &0.01 mg	$0	$0 Copay per PPACA guidelines.
LOJAIMIESS ORAL TABLET 0.1-0.02 & 0.01 MG	$0	$0 Copay per PPACA guidelines
QUASENSE ORAL TABLET 0.15-0.03 MG	$0	$0 Copay per PPACA guidelines

Drug Name	Tier	Notes
SETLAKIN ORAL TABLET 0.15-0.03 MG	$0	$0 Copay per PPACA guidelines.
SIMPESSE ORAL TABLET 0.15-0.03 &0.01 MG	$0	
PROGESTIN CONTRACEPTIVES - IMPLANTS**		
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG	$0	$0 Copay per PPACA guidelines; QL (1 EA per 3 Yearss); AL (Max 55 Years)
PROGESTIN CONTRACEPTIVES - INJECTABLE**		
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML	$0	
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	$0	
PROGESTIN CONTRACEPTIVES - IUD**		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG	$0	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/24HR, 20 MCG/DAY	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
PROGESTIN CONTRACEPTIVES - ORAL**		
CAMILA ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
DEBLITANE ORAL TABLET 0.35 MG	$0	$0 Copay Per PPACA Guidelines
ERRIN ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
HEATHER ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
JENCYCLA ORAL TABLET 0.35 MG	$0	$0 Copay Per PPACA Guidelines
JOLIVETTE ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
LYLEQ ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
LYZA ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
NORA-BE ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
norethindrone oral tablet 0.35 mg	$0	$0 Copay per PPACA guidelines.
NORLYDA ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
NORLYROC ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
OPILL ORAL TABLET 0.075 MG	$0	
SHAROBEL ORAL TABLET 0.35 MG	$0	$0 Copay per PPACA guidelines.
TRIPHASIC CONTRACEPTIVES - ORAL**		
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	2	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	

Drug Name	Tier	Notes
CAZIANT ORAL TABLET 0.1/0.125/0.15 -0.025 MG	$0	$0 Copay per PPACA guidelines.
CESIA ORAL TABLET 0.1/0.125/0.15 -0.025 MG	$0	$0 Copay per PPACA guidelines.
CYCLAFEM 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
DASETTA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
ENPRESSE-28 ORAL TABLET 50-30/75-40/ 125-30 MCG	$0	$0 Copay per PPACA guidelines.
LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG	2	
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	$0	$0 Copay per PPACA guidelines.
levonorg-eth estrad triphasic oral tablet	$0	$0 Copay Per PPACA Guidelines
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	$0	$0 copay Per PPACA Guidelines
MYZILRA ORAL TABLET 50-30/75-40/ 125-30 MCG	$0	$0 Copay per PPACA guidelines.
NECON 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	2	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	$0	$0 Copay per PPACA guidelines.
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
PIRMELLA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	2	
TILIA FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	2	
TRI FEMYNOR ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 Copay per PPACA guidelines.
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 Copay per PPACA guidelines.
TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	2	
TRI-LINYAH ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 Copay per PPACA guidelines.
TRI-LO-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-LO-MARZIA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-LO-MILI ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 copay Per PPACA Guidelines

Drug Name	Tier	Notes
TRINESSA (28) ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 Copay per PPACA guidelines.
TRINESSA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-NYMYO ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 copay Per PPACA Guidelines
TRI-PREVIFEM ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 Copay per PPACA guidelines.
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 Copay per PPACA guidelines.
TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG	$0	$0 Copay per PPACA guidelines.
TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	2	
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	$0 copay Per PPACA Guidelines
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	$0	$0 Copay per PPACA guidelines.
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS**		
A-HYDROCORT INJECTION SOLUTION RECONSTITUTED 100 MG	4	
ARISTOSPAN INTRA-ARTICULAR INJECTION SUSPENSION 20 MG/ML	MB	
budesonide er oral capsule extended release 24 hour 3 mg	4	
budesonide oral capsule delayed release particles 3 mg	4	QL (448 EA per 365 days)
cortisone acetate oral tablet 25 mg	3	
DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML, 40 MG/ML, 80 MG/ML	MB	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML	3	
dexamethasone oral elixir 0.5 mg/5ml	2	
dexamethasone oral solution 0.5 mg/5ml	2	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	2	
dexamethasone sodium phosphate injection solution 4 mg/ml	MB	
dexamethasone sodium phosphate injection solution prefilled syringe 4 mg/ml	MB	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	2	
KENALOG INJECTION SUSPENSION 40 MG/ML	MB	
KENALOG-40 INJECTION SUSPENSION 40 MG/ML	MB	

Drug Name	Tier	Notes
methylprednisolone (pak) oral tablet 4 mg	2	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	2	
methylprednisolone oral tablet therapy pack 4 mg	2	
methylprednisolone sodium succ injection solution reconstituted 1000 mg, 125 mg, 40 mg	MB	
prednisolone oral solution 15 mg/5ml	2	
prednisolone sodium phosphate oral solution 15 mg/5ml, 5 mg/5ml	2	
prednisone oral solution 5 mg/5ml	2	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	2	
SOLU-CORTEF INJECTION SOLUTION RECONSTITUTED 100 MG	MB	
SOLU-MEDROL (PF) INJECTION SOLUTION RECONSTITUTED 1000 MG, 125 MG, 40 MG, 500 MG	MB	
SOLU-MEDROL INJECTION SOLUTION RECONSTITUTED 1000 MG, 125 MG, 2 GM, 40 MG, 500 MG	MB	
MINERALOCORTICOIDS**		
fludrocortisone acetate oral tablet 0.1 mg	2	
STEROID COMBINATIONS**		
betamethasone sod phos & acet injection suspension 6 (3-3) mg/ml	MB	
CELESTONE SOLUSPAN INJECTION SUSPENSION 6 (3-3) MG/ML	MB	
COUGH/COLD/ALLERGY		
ANTITUSSIVE - NONNARCOTIC**		
benzonatate oral capsule 100 mg, 200 mg	2	
ANTITUSSIVE-EXPECTORANT**		
cheratussin ac oral syrup 100-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)
dex-tuss oral liquid 300-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)
FLOWTUSS ORAL SOLUTION 2.5-200 MG/5ML	4	QL (473 ML per 30 days)
guaiatussin ac oral syrup 100-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)

Drug Name	Tier	Notes
guaifenesin ac oral syrup 100-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)
guaifenesin-codeine oral solution 100-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)
guaifenesin-codeine oral syrup 100-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)
MISC. RESPIRATORY INHALANTS**		
sodium chloride inhalation nebulization solution 0.9 %, 7 %	2	
MUCOLYTICS**		
acetylcysteine inhalation solution 10 %, 20 %	2	
OPIOID ANTITUSSIVE-ANTIHISTAMINE**		
promethazine-codeine oral syrup 6.25-10 mg/5ml	2	PA; Not covered for members less than 12 years of age. Prior authorization required for members 12 to 18 years of age.; AL (Min 12 Years)
DERMATOLOGICALS		
ACNE ANTIBIOTICS**		
AKNE-MYCIN EXTERNAL OINTMENT 2 %	3	QL (25 GM per 30 days)
clindamycin phos (once-daily) external gel 1 %	2	QL (60 GM per 30 days)
clindamycin phos (twice-daily) external gel 1 %	2	QL (60 GM per 30 days)
clindamycin phosphate external gel 1 %	2	QL (60 GM per 30 days)
clindamycin phosphate external lotion 1 %	2	QL (60 ML per 30 days)
clindamycin phosphate external solution 1 %	2	
clindamycin phosphate external swab 1 %	2	
dapsone external gel 5 %, 7.5 %	4	
erythromycin external gel 2 %	2	
erythromycin external solution 2 %	2	
sulfacetamide sodium (acne) external lotion 10 %	4	
ACNE COMBINATIONS**		
BENZAMYCINPAK EXTERNAL PACKET 5-3 %	3	
benzoyl peroxide-erythromycin external gel 5-3 %	2	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-5 %	4	
ROSULA EXTERNAL PAD 10-5 %	4	QL (30 EA per 30 days)

Drug Name	Tier	Notes
sulfacetamide sodium-sulfur external cream 10-5 %	2	
sulfacetamide sodium-sulfur external emulsion 10-5 %	2	
sulfacetamide sodium-sulfur external lotion 10-5 %	2	
sulfacetamide sodium-sulfur external suspension 10-5 %	3	
ACNE PRODUCTS**		
adapalene external cream 0.1 %	2	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. **Approval length if criteria is met: 1 year; AL (Max 40 Years)
adapalene external gel 0.1 %	2	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. **Approval length if criteria is met: 1 year; AL (Max 40 Years)
AMNESTEEM ORAL CAPSULE 10 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.
AMNESTEEM ORAL CAPSULE 20 MG, 40 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.; AL (Max 40 Years)
AZELEX EXTERNAL CREAM 20 %	4	
benzoyl peroxide wash external liquid 10 %	2	OTC products are not covered.
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.; QL (60 EA per 30 days)
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	4	Length of therapy is limited to 24 weeks. Prior authorization is required for treatment beyond this.; QL (60 EA per 30 days); AL (Min 12 Years)
isotretinoin oral capsule 25 mg, 35 mg	4	QL (60 EA per 30 days); AL (Min 12 Years)
MYORISAN ORAL CAPSULE 10 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.; QL (60 EA per 30 days)

Drug Name	Tier	Notes
MYORISAN ORAL CAPSULE 20 MG, 30 MG, 40 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.; QL (60 EA per 30 days); AL (Max 40 Years)
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	2	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. **Approval length if criteria is met: 1 year; AL (Max 40 Years)
tretinoin external gel 0.01 %, 0.025 %	2	The following Prior authorization criteria applies to patients greater than 40 years of age: The patient must have a diagnosis of actinic keratosis OR adult acne. **Approval length if criteria is met: 1 year; AL (Max 40 Years)
ZENATANE ORAL CAPSULE 10 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.; QL (60 EA per 30 days)
ZENATANE ORAL CAPSULE 20 MG, 30 MG, 40 MG	4	Length of therapy is limited to 24 weeks per 365 days. Prior authorization is required for amounts exceeding this treatment length.; QL (60 EA per 30 days); AL (Max 40 Years)
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS**		
VEREGEN EXTERNAL OINTMENT 15 %	4	PA; Coverage duration is limited to 16 weeks total.; QL (15 GM per 30 days)
ANTIBIOTIC STEROID COMBINATIONS - TOPICAL**		
CORTISPORIN EXTERNAL CREAM 3.5-10000-0.5	4	
ANTIBIOTICS - TOPICAL**		
ALTABAX EXTERNAL OINTMENT 1 %	4	ST
gentamicin sulfate external cream 0.1 %	2	
gentamicin sulfate external ointment 0.1 %	3	
mupirocin external ointment 2 %	2	
ANTIFUNGALS - TOPICAL COMBINATIONS**		
clotrimazole-betamethasone external cream 1-0.05 %	2	

Drug Name	Tier	Notes
clotrimazole-betamethasone external lotion 1-0.05 %	2	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
ANTIFUNGALS - TOPICAL**		
ciclopirox external gel 0.77 %	2	
ciclopirox external shampoo 1 %	2	
ciclopirox external solution 8 %	2	QL (19.8 ML per 365 days)
ciclopirox olamine external cream 0.77 %	2	
ciclopirox olamine external suspension 0.77 %	2	
nystatin external cream 100000 unit/gm	2	
nystatin external ointment 100000 unit/gm	2	
nystatin external powder 100000 unit/gm	2	
NYSTOP EXTERNAL POWDER 100000 UNIT/GM	2	
pedi-dri external powder 100000 unit/gm	2	
ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL**		
fluorouracil external cream 5 %	2	
fluorouracil external solution 2 %	3	
ANTIPSORIATICS - SYSTEMIC**		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	5	PA; QL (60 EA per 30 days); SP
SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT 75 MG/0.83ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 kit per 12 weeks); SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 kit per 12 weeks); SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 kit per 12 weeks); SP
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 ML per 56 days); SP

Drug Name	Tier	Notes
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 ML per 28 days); SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.25 ML per 28 days); SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.5ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (0.5 ML per 28 days); SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 ML per 28 days); SP
ANTIPSORIATICS**		
calcipotriene external cream 0.005 %	4	
calcipotriene external ointment 0.005 %	4	
calcipotriene external solution 0.005 %	4	
CALCITRENE EXTERNAL OINTMENT 0.005 %	4	
calcitriol external ointment 3 mcg/gm	4	ST
tazarotene external cream 0.05 %	4	ST; QL (60 GM per 30 Days)
tazarotene external cream 0.1 %	4	ST; QL (60 GM per 30 days)
tazarotene external gel 0.05 %, 0.1 %	4	ST; QL (100 GM per 30 days)
TAZORAC EXTERNAL CREAM 0.05 %	4	ST; QL (60 GM per 30 days)
ANTISEBORRHEIC PRODUCTS**		
selenium sulfide external lotion 2.5 %	2	
ANTIVIRALS - TOPICAL**		
penciclovir external cream 1 %	3	QL (5 GM per 30 days)
ATOPIC DERMATITIS - MONOCLONAL ANTIBODIES**		
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days); SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	5	PA; QL (4 ML per 28 days); SP
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days); SP
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML	5	PA; QL (4 ML per 28 days); SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	5	PA; QL (1.34 ML per 28 days); SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days); SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	5	PA; QL (4 ML per 28 days); SP
BURN PRODUCTS**		

Drug Name	Tier	Notes
mafenide acetate external packet 5 %	4	PA
silver sulfadiazine external cream 1 %	2	
CORTICOSTEROIDS - TOPICAL**		
alclometasone dipropionate external cream 0.05 %	2	
alclometasone dipropionate external ointment 0.05 %	2	
amcinonide external ointment 0.1 %	4	
betamethasone dipropionate aug external cream 0.05 %	2	
betamethasone dipropionate aug external gel 0.05 %	2	
betamethasone dipropionate aug external lotion 0.05 %	2	
betamethasone dipropionate aug external ointment 0.05 %	2	
betamethasone dipropionate external cream 0.05 %	2	
betamethasone dipropionate external lotion 0.05 %	2	
betamethasone dipropionate external ointment 0.05 %	2	
betamethasone valerate external cream 0.1 %	2	
betamethasone valerate external lotion 0.1 %	2	
betamethasone valerate external ointment 0.1 %	2	
clobetasol propionate emollient cream 0.05 % external	2	
clobetasol propionate external cream 0.05 %	2	QL (60 GM per 30 days)
clobetasol propionate external gel 0.05 %	2	
clobetasol propionate external ointment 0.05 %	2	
clobetasol propionate external solution 0.05 %	2	
clocortolone pivalate external cream 0.1 %	4	ST; QL (45 GM per 30 days)
CORMAX SCALP APPLICATION EXTERNAL SOLUTION 0.05 %	4	
desoximetasone external cream 0.25 %	2	
diflorasone diacetate external ointment 0.05 %	4	
fluocinolone acetonide body external oil 0.01 %	2	
fluocinolone acetonide external cream 0.01 %, 0.025 %	2	
fluocinolone acetonide external ointment 0.025 %	2	
fluocinolone acetonide external solution 0.01 %	2	
fluocinolone acetonide scalp external oil 0.01 %	2	
fluocinonide external cream 0.05 %	2	
fluocinonide external gel 0.05 %	2	
fluocinonide external ointment 0.05 %	2	

Drug Name	Tier	Notes
fluocinonide external solution 0.05 %	2	
fluticasone propionate external cream 0.05 %	2	
fluticasone propionate external ointment 0.005 %	2	
halcinonide external cream 0.1 %	4	ST; QL (60 GM per 30 days)
halobetasol propionate external cream 0.05 %	2	
hydrocortisone butyrate external cream 0.1 %	2	
hydrocortisone butyrate external ointment 0.1 %	2	
hydrocortisone butyrate external solution 0.1 %	2	
hydrocortisone external cream 2.5 %	2	
hydrocortisone external lotion 2.5 %	2	
hydrocortisone external ointment 2.5 %	2	
hydrocortisone valerate external cream 0.2 %	2	
LANACORT 10 EXTERNAL CREAM 1 %	2	
mometasone furoate external cream 0.1 %	2	
mometasone furoate external ointment 0.1 %	2	
mometasone furoate external solution 0.1 %	2	
prednicarbate external ointment 0.1 %	4	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	2	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	2	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	2	
IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL**		
clotrimazole external cream 1 %	2	
econazole nitrate external cream 1 %	2	
EXELDERM EXTERNAL CREAM 1 %	4	PA
EXELDERM EXTERNAL SOLUTION 1 %	4	PA
ketoconazole external cream 2 %	2	
ketoconazole external shampoo 2 %	2	
IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL**		

Drug Name	Tier	Notes
imiquimod external cream 5 %	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.); QL (12 EA per 30 days)
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS**		
podofilox external solution 0.5 %	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.)
LOCAL ANESTHETICS - TOPICAL**		
lidocaine external ointment 5 %	4	QL (500 GM per 30 days)
lidocaine external patch 5 %	4	QL (30 EA per 30 days)
lidocaine hcl external cream 3 %	2	
lidocaine hcl external gel 2 %	2	
lidocaine hcl external solution 4 %	2	
MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL**		
pimecrolimus external cream 1 %	4	**Approval length if criteria is met: 2 months; QL (120 GM per 365 days); AL (Min 2 Years)
tacrolimus external ointment 0.03 %, 0.1 %	4	**Approval length if criteria is met: 2 months; AL (Min 2 Years)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL**		
EUCRISA EXTERNAL OINTMENT 2 %	5	PA; QL (60 GM per 30 days)
PHOTODYNAMIC THERAPY AGENTS - TOPICAL**		
AMELUZ EXTERNAL GEL 10 %	MB	

Drug Name	Tier	Notes
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 %	MB	
PIGMENTING AGENTS**		
OXSORALEN EXTERNAL LOTION 1 %	4	PA; QL (29.57 ML per 30 days)
ROSACEA AGENTS**		
azelaic acid external gel 15 %	4	
FINACEA EXTERNAL FOAM 15 %	3	
metronidazole external cream 0.75 %	2	
metronidazole external gel 0.75 %	2	
metronidazole external lotion 0.75 %	2	
ROSADAN EXTERNAL GEL 0.75 %	2	
SCABICIDES & PEDICULICIDES**		
EURAX EXTERNAL CREAM 10 %	3	
EURAX EXTERNAL LOTION 10 %	3	
ivermectin external lotion 0.5 %	4	ST; Approval length if criteria met: 1 month
lindane external shampoo 1 %	3	
malathion external lotion 0.5 %	4	ST; QL (60 ML per 90 days)
permethrin external cream 5 %	2	
ULESFIA EXTERNAL LOTION 5 %	4	PA; QL (227 GM per 30 days)
TOPICAL ANESTHETIC COMBINATIONS**		
ANECREAM EXTERNAL KIT 4 %	4	
lidocaine-prilocaine external cream 2.5-2.5 %	4	
lidocaine-transparent dressing external kit 4 %	4	
LIDOCREAM EXTERNAL KIT 4 %	4	
TOPICAL STEROID COMBINATIONS**		
calcipotriene-betameth diprop external ointment 0.005-0.064 %	4	
WOUND CARE - GROWTH FACTOR AGENTS**		
REGRANEX EXTERNAL GEL 0.01 %	4	
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS**		
ACTHREL INTRAVENOUS SOLUTION RECONSTITUTED 100 MCG	MB	
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG	MB	

Drug Name	Tier	Notes
dipyridamole intravenous solution 5 mg/ml	MB	
KINEVAC INJECTION SOLUTION RECONSTITUTED 5 MCG	MB	
PROVOCHOLINE INHALATION SOLUTION RECONSTITUTED 100 MG	MB	
THYROGEN INTRAMUSCULAR SOLUTION RECONSTITUTED 0.9 MG, 1.1 MG	MB	QL (1 Course per 1 Lifetime); SP
DIAGNOSTIC TESTS**		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP	2	100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days)
ACCU-CHEK GUIDE IN VITRO STRIP	2	100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days)
ACCU-CHEK GUIDE TEST IN VITRO STRIP	2	100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days)

Drug Name	Tier	Notes
ACCU-CHEK SMARTVIEW IN VITRO STRIP	2	100 test strips per 30 days or 300 test strips for 90 days are covered for members who are not on insulin. 200 test strips per 30 days or 600 test strips per 90 days are covered for members who are receiving insulin. 50 test strips per 30 days or 150 test strips per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days)
KETOSTIX IN VITRO STRIP	3	
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	3	
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 10500-35500 UNIT, 16800-56800 UNIT, 21000-54700 UNIT, 2600-8800 UNIT, 37000-97300 UNIT, 4200-14200 UNIT	3	
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS**		
acetazolamide er oral capsule extended release 12 hour 500 mg	2	
acetazolamide oral tablet 125 mg, 250 mg	2	
acetazolamide sodium injection solution reconstituted 500 mg	MB	
methazolamide oral tablet 25 mg, 50 mg	2	
DIURETIC COMBINATIONS**		
ALDACTAZIDE ORAL TABLET 50-50 MG	3	
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
spironolactone-hctz oral tablet 25-25 mg	1	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
LOOP DIURETICS**		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
ethacrynic acid oral tablet 25 mg	5	PA; QL (480 EA per 30 days)
furosemide injection solution 10 mg/ml	MB	
furosemide oral solution 10 mg/ml	2	
furosemide oral solution 8 mg/ml	3	

Drug Name	Tier	Notes
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	2	
OSMOTIC DIURETICS**		
mannitol intravenous solution 25 %	MB	
POTASSIUM SPARING DIURETICS**		
amiloride hcl oral tablet 5 mg	1	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
triamterene oral capsule 100 mg, 50 mg	4	
THIAZIDES AND THIAZIDE-LIKE DIURETICS**		
chlorothiazide sodium intravenous solution reconstituted 500 mg	MB	
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
methyclothiazide oral tablet 5 mg	3	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS**		
mifepristone oral tablet 200 mg	$0	
BISPHOSPHONATES**		
alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg	2	
alendronate sodium oral tablet 40 mg	3	
etidronate disodium oral tablet 200 mg, 400 mg	3	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT	4	
ibandronate sodium oral tablet 150 mg	4	ST; QL (1 EA per 28 days)
risedronate sodium oral tablet 150 mg	4	QL (1 EA per 28 days)
risedronate sodium oral tablet 30 mg, 5 mg	4	QL (30 EA per 30 days)
risedronate sodium oral tablet 35 mg	4	QL (4 EA per 28 days)
risedronate sodium oral tablet delayed release 35 mg	4	QL (30 EA per 30 days)
zoledronic acid intravenous solution 4 mg/100ml	MB	
CALCIMIMETIC AGENTS**		

Drug Name	Tier	Notes
cinacalcet hcl oral tablet 30 mg	2	
cinacalcet hcl oral tablet 60 mg, 90 mg	2	PA
CALCITONINS**		
calcitonin (salmon) injection solution 200 unit/ml	5	
calcitonin (salmon) nasal solution 200 unit/act	2	
CALCIUM REGULATORS - MISC.**		
GANITE INTRAVENOUS SOLUTION 25 MG/ML	MB	
CARNITINE REPLENISHER - AGENTS**		
levocarnitine intravenous solution 200 mg/ml	MB	
DOPAMINE RECEPTOR AGONISTS**		
cabergoline oral tablet 0.5 mg	2	QL (56 EA per 28 days)
GNRH/LHRH ANTAGONISTS**		
ORILISSA ORAL TABLET 150 MG	5	PA; QL (30 EA per 30 days); SP
ORILISSA ORAL TABLET 200 MG	5	PA; QL (60 EA per 30 days); SP
GROWTH HORMONES**		
OMNITROPE SUBCUTANEOUS SOLUTION 10 MG/1.5ML, 5 MG/1.5ML	5	PA; SP
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	5	PA; SP
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS**		
calcitriol oral capsule 0.25 mcg, 0.5 mcg	2	
doxercalciferol intravenous solution 4 mcg/2ml	MB	
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	4	
ZEMPLAR INTRAVENOUS SOLUTION 5 MCG/ML	MB	
HYPOPHOSPHATASIA (HPP) AGENTS**		
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45ML, 28 MG/0.7ML, 40 MG/ML, 80 MG/0.8ML	5	PA; LA
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)**		
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	5	PA; SP
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS**		
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 30 MG	MB	PA not required if billed with Dx codes F64.1 - F64.9.
SUPPRELIN LA SUBCUTANEOUS KIT 50 MG	MB	
NEUROKININ 3 (NK3) RECEPTOR ANTAGONISTS**		

Drug Name	Tier	Notes
VEOZAH ORAL TABLET 45 MG	4	PA; QL (2 EA per 1 day); AL (Min 18 Years)
PARATHYROID HORMONE AND DERIVATIVES**		
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML, 600 MCG/2.4ML, 620 MCG/2.48ML	5	PA; SP
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml, 600 mcg/2.4ml	5	PA; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5	PA; SP
PHENYLKETONURIA TREATMENT - AGENTS**		
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML	5	PA; LA; QL (7 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2.5 MG/0.5ML	5	PA; LA; QL (3 ML per 35 days)
PALYNZIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	5	PA; LA; QL (28 ML per 28 days)
sapropterin dihydrochloride oral packet 100 mg, 500 mg	5	PA; LA
sapropterin dihydrochloride oral tablet 100 mg	5	PA
sapropterin dihydrochloride oral tablet soluble 100 mg	5	PA
RANK LIGAND (RANKL) INHIBITORS**		
PROLIA SUBCUTANEOUS SOLUTION 60 MG/ML	MB	
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)**		
raloxifene hcl oral tablet 60 mg	2	DX (Covered at a zero-dollar copay for the prevention of breast cancer per ACA)
SOMATOSTATIC AGENTS**		
octreotide acetate injection solution 1000 mcg/ml	MB	PA
octreotide acetate intramuscular kit 20 mg, 30 mg	MB	
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	MB	
SANDOSTATIN INJECTION SOLUTION 1000 MCG/ML	MB	PA
VASOPRESSIN**		
DDAVP INJECTION SOLUTION 4 MCG/ML	MB	
desmopressin ace rhinal tube nasal solution 0.01 %	2	

Drug Name	Tier	Notes
desmopressin ace spray refrig nasal solution 0.01 %	2	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	2	
desmopressin acetate spray nasal solution 0.01 %	2	
X-LINKED HYPOPHOSPHATEMIA (XLH) TREATMENT - AGENTS**		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML, 20 MG/ML, 30 MG/ML	MB	PA
ESTROGENS		
ESTROGEN & ANDROGEN**		
methyltest-est estrogens oral tablet 2.5-1.25 mg	2	
ESTROGEN & PROGESTIN**		
COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY 0.05-0.14 MG/DAY, 0.05-0.25 MG/DAY	4	ST; QL (8 EA per 28 days)
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	2	
JINTELI ORAL TABLET 1-5 MG-MCG	2	
norethindrone-eth estradiol oral tablet 1-5 mg-mcg	2	
PREFEST ORAL TABLET 1/1-0.09 MG (15/15)	3	
PREMPHASE ORAL TABLET 0.625-5 MG	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	
ESTROGEN-PROGESTIN-GNRH ANTAGONIST**		
ORIAHNN ORAL CAPSULE THERAPY PACK 300-1-0.5 & 300 MG	5	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	4	QL (8 EA per 28 days)
CENESTIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	4	
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	2	QL (8 EA per 28 days)
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	2	
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	2	

Drug Name	Tier	Notes
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	2	QL (8 EA per 28 days)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	QL (4 EA per 28 days)
ESTRASORB TRANSDERMAL EMULSION 4.35 MG/1.74GM	4	
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%)	4	
estropipate oral tablet 0.75 mg, 1.5 mg, 3 mg	2	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY	4	
LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.1 MG/24HR	2	QL (8 EA per 30 days)
LYLLANA TRANSDERMAL PATCH TWICE WEEKLY 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR	2	
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	3	
FLUOROQUINOLONES		
FLUOROQUINOLONES**		
AVELOX INTRAVENOUS SOLUTION 400 MG/250ML	MB	
AVELOX ORAL TABLET 400 MG	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%)	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.)
ciprofloxacin hcl oral tablet 100 mg	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 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.)
ciprofloxacin in d5w intravenous solution 400 mg/200ml	MB	
ciprofloxacin oral suspension reconstituted 250 mg/5ml (5%)	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.)
FACTIVE ORAL TABLET 320 MG	4	
levofloxacin in d5w intravenous solution 250 mg/50ml	MB	

Drug Name	Tier	Notes
levofloxacin oral solution 25 mg/ml	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.)
levofloxacin oral tablet 250 mg, 500 mg, 750 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.)
moxifloxacin hcl oral tablet 400 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
NOROXIN ORAL TABLET 400 MG	4	
GASTROINTESTINAL AGENTS - MISC.		
GALLSTONE SOLUBILIZING AGENTS**		
ursodiol oral capsule 300 mg	2	
ursodiol oral tablet 250 mg, 500 mg	2	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS**		
lubiprostone oral capsule 24 mcg, 8 mcg	3	QL (60 EA per 30 days)
GASTROINTESTINAL STIMULANTS**		
metoclopramide hcl injection solution 5 mg/ml	MB	
metoclopramide hcl oral solution 5 mg/5ml	2	

Drug Name	Tier	Notes
metoclopramide hcl oral tablet 10 mg, 5 mg	2	
IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS**		
alosetron hcl oral tablet 0.5 mg, 1 mg	5	
INFLAMMATORY BOWEL AGENTS**		
balsalazide disodium oral capsule 750 mg	2	
mesalamine er oral capsule extended release 24 hour 0.375 gm	4	QL (120 EA per 30 days)
mesalamine oral capsule delayed release 400 mg	4	
mesalamine oral tablet delayed release 1.2 gm	4	QL (120 EA per 30 days)
mesalamine rectal enema 4 gm	2	QL (1682 ML per 28 days)
mesalamine rectal suppository 1000 mg	5	QL (30 EA per 30 days)
sulfasalazine oral tablet 500 mg	2	
sulfasalazine oral tablet delayed release 500 mg	2	
INTERLEUKIN ANTAGONISTS**		
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 ML per 365 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1.2 ML per 56 days); SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (2.4 ML per 8 weeks); SP
INTESTINAL ACIDIFIERS**		
generlac oral solution 10 gm/15ml	2	
lactulose encephalopathy oral solution 10 gm/15ml	2	
PHOSPHATE BINDER AGENTS**		
AURYXIA ORAL TABLET 1 GM 210 MG(FE)	5	PA; QL (12 EA per 1 day)
calcium acetate (phos binder) oral capsule 667 mg	2	
calcium acetate (phos binder) oral tablet 667 mg	2	
calcium acetate oral capsule 667 mg	2	
lanthanum carbonate oral tablet chewable 1000 mg, 500 mg	5	PA; QL (3 EA per 1 day)
lanthanum carbonate oral tablet chewable 750 mg	5	PA; QL (6 EA per 1 day)
PHOSLYRA ORAL SOLUTION 667 MG/5ML	3	
sevelamer carbonate oral tablet 800 mg	5	
sevelamer hcl oral tablet 400 mg	3	

Drug Name	Tier	Notes
TRYPTOPHAN HYDROXYLASE INHIBITORS**		
XERMELO ORAL TABLET 250 MG	5	PA; LA; QL (90 EA per 30 days)
TUMOR NECROSIS FACTOR ALPHA BLOCKERS**		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 28 days); SP
CIMZIA PREFILLED SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 kit per 28 days); SP
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3 kits per 28 days); SP
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 28 days); SP
CIMZIA SUBCUTANEOUS PREFILLED SYRINGE KIT 2 X 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 kit per 28 days); SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (3 EA per 28 days); SP
GENITOURINARY AGENTS - MISCELLANEOUS		
5-ALPHA REDUCTASE INHIBITORS**		
dutasteride oral capsule 0.5 mg	4	
finasteride oral tablet 5 mg	2	
ALPHA 1-ADRENOCEPTOR ANTAGONISTS**		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	2	QL (30 EA per 30 days)
silodosin oral capsule 4 mg, 8 mg	4	ST; QL (30 EA per 30 days)
tamsulosin hcl oral capsule 0.4 mg	2	
ANTI-INFECTIVE GENITOURINARY IRRIGANTS**		
neomycin-polymyxin b gu irrigation solution 40-200000	2	
CITRATES**		
citric acid-sodium citrate oral solution 334-500 mg/5ml	2	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	2	

Drug Name	Tier	Notes
sod citrate-citric acid oral solution 500-334 mg/5ml	2	
INTERSTITIAL CYSTITIS AGENTS**		
ELMIRON ORAL CAPSULE 100 MG	4	PA; QL (90 EA per 30 days)
URINARY ANALGESICS**		
phenazopyridine hcl oral tablet 100 mg, 200 mg	2	
URINARY STONE AGENTS**		
tiopronin oral tablet 100 mg	4	PA; LA; QL (300 EA per 30 days)
GOUT AGENTS		
GOUT AGENT COMBINATIONS**		
colchicine-probenecid oral tablet 0.5-500 mg	2	
GOUT AGENTS**		
allopurinol oral tablet 100 mg, 300 mg	2	
colchicine oral tablet 0.6 mg	2	
febuxostat oral tablet 40 mg, 80 mg	4	QL (30 EA per 30 days)
URICOSURICS**		
probenecid oral tablet 500 mg	2	
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS**		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT	MB	
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	MB	
ALPHANATE/VWF COMPLEX/HUMAN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	MB	
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT	MB	
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED	MB	

Drug Name	Tier	Notes
FIBRYGA INTRAVENOUS SOLUTION RECONSTITUTED	MB	
HELIXATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT	MB	
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT	MB	
KCENTRA INTRAVENOUS KIT 1000 UNIT, 500 UNIT	MB	
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT	MB	
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	
MONOCLATE-P INTRAVENOUS KIT 1000 UNIT	MB	
MONONINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT	MB	
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG	MB	
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	
obizur intravenous solution reconstituted 500 unit	MB	
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	
PROFILNINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT	MB	
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit	MB	

Drug Name	Tier	Notes
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2000-3125 UNIT	MB	
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT	MB	
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	MB	
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT	MB	
BRADYKININ B2 RECEPTOR ANTAGONISTS**		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	5	PA; QL (18 ML per 28 days); SP
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML	5	PA; QL (18 ML per 28 Days); SP
C1 ESTERASE INHIBITORS**		
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	MB	PA; SP
COMPLEMENT C5 INHIBITORS**		
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ULTOMIRIS INTRAVENOUS SOLUTION 1100 MG/11ML, 300 MG/3ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ULTOMIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
DIRECT-ACTING P2Y12 INHIBITORS**		
ticagrelor oral tablet 60 mg, 90 mg	3	Maximum of 730 tablets per lifetime; QL (60 EA per 30 days)
GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS**		
AGGRASTAT INTRAVENOUS CONCENTRATE 3.75 MG/15ML	MB	
AGGRASTAT INTRAVENOUS SOLUTION 5-0.9 MG/100ML-%	MB	
REOPRO INTRAVENOUS SOLUTION 2 MG/ML	MB	
HEMATORHEOLOGIC AGENTS**		
pentoxifylline er oral tablet extended release 400 mg	4	
HUMAN PROTEIN C**		
CEPROTIN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 500 UNIT	MB	
PHOSPHODIESTERASE III INHIBITORS**		
cilostazol oral tablet 100 mg, 50 mg	2	
PLASMA EXPANDERS**		

Drug Name	Tier	Notes
LMD IN D5W INTRAVENOUS SOLUTION 10-5 %	MB	
LMD IN NACL INTRAVENOUS SOLUTION 10-0.9 %	MB	
PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES**		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML	5	PA; QL (2 ML per 28 days); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (2 ML per 28 days); SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	5	PA; QL (4 ML per 28 days); SP
PLATELET AGGREGATION INHIBITOR COMBINATIONS**		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	4	
PLATELET AGGREGATION INHIBITORS**		
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	2	
PROTAMINE**		
protamine sulfate intravenous solution 10 mg/ml	MB	
QUINAZOLINE AGENTS**		
anagrelide hcl oral capsule 0.5 mg, 1 mg	2	
THIENOPYRIDINE DERIVATIVES**		
clopidogrel bisulfate oral tablet 75 mg	2	
prasugrel hcl oral tablet 10 mg	4	
prasugrel hcl oral tablet 5 mg	4	PA
ticlopidine hcl oral tablet 250 mg	4	PA; QL (60 EA per 30 days)
TISSUE PLASMINOGEN ACTIVATORS**		
ACTIVASE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG	MB	
CATHFLO ACTIVASE INJECTION SOLUTION RECONSTITUTED 2 MG	MB	
HEMATOPOIETIC AGENTS		
COBALAMINS**		
cyanocobalamin injection solution 1000 mcg/ml	2	
ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)**		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	MB	PA

Drug Name	Tier	Notes
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
RETACRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply;; QL (12 ML per 28 days); SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 3000 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 40000 UNIT/ML	MB	PA; If billed through medical benefit, the medical coinsurance will apply;; QL (4 ML per 28 days)
FOLIC ACID/FOLATES**		
cvs folic acid oral tablet 800 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
eql folic acid oral tablet 400 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
FA-8 ORAL TABLET 800 MCG	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
folic acid oral tablet 1 mg	2	
folic acid oral tablet 400 mcg, 800 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
gnp folic acid oral tablet 400 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
hm folic acid oral tablet 400 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
kp folic acid oral tablet 800 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
px folic acid oral tablet 400 mcg	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
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)
th 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; SP

Drug Name	Tier	Notes
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; SP
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML	MB	PA; 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; SP
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; SP
INTERLEUKINS**		
NEUMEGA SUBCUTANEOUS SOLUTION RECONSTITUTED 5 MG	MB	PA
IRON**		
ferretts ips oral solution 40 mg/15ml	$0	$0 Copay per PPACA guidelines; AL (Max 12 Years)
FERRIMIN 150 ORAL TABLET 150 MG	$0	$0 Copay Preventative Services; AL (Max 12 Years)
ferronate oral tablet 325 mg	$0	$0 Copay per PPACA guidelines
FERRO-SEQUELS ORAL TABLET EXTENDED RELEASE 50 MG	3	$0 Copay Per PPACA Guidelines; AL (Max 12 Years)
ferumoxytol intravenous solution 510 mg/17ml	MB	
INJECTAFER INTRAVENOUS SOLUTION 100 MG/2ML	MB	
iron oral tablet 246 (28 fe) mg, 90 (18 fe) mg	3	$0 Copay per PPACA guidelines; AL (Max 12 Years)
NOVAFERRUM PEDIATRIC DROPS ORAL LIQUID 15 MG/ML	$0	$0 Copay per PPACA guidelines; AL (Max 12 Years)
slow release iron oral tablet extended release 140 (45 fe) mg	3	$0 Copay per PPACA guidelines; AL (Max 12 Years)
THROMBOPOIETIN (TPO) RECEPTOR AGONISTS**		
MULPLETA ORAL TABLET 3 MG	5	PA; QL (7 EA per 7 days); SP
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC**		
aminocaproic acid oral solution 0.25 gm/ml	5	PA; AL (Max 12 Years)
aminocaproic acid oral tablet 1000 mg, 500 mg	5	
CYKLOKAPRON INTRAVENOUS SOLUTION 1000 MG/10ML	MB	
tranexamic acid intravenous solution 1000 mg/10ml	MB	

Drug Name	Tier	Notes
tranexamic acid oral tablet 650 mg	2	QL (30 EA per 30 days)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS**		
AMYTAL SODIUM INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
LUMINAL INJECTION SOLUTION 130 MG/ML	MB	
pentobarbital sodium injection solution 50 mg/ml	MB	
phenobarbital oral elixir 20 mg/5ml, 30 mg/7.5ml, 60 mg/15ml	2	
phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg	3	
phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg	2	
BENZODIAZEPINE HYPNOTICS**		
flurazepam hcl oral capsule 15 mg, 30 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
midazolam hcl (pf) injection solution 10 mg/2ml, 2 mg/2ml, 5 mg/ml	2	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
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	2	ST; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

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

Drug Name	Tier	Notes
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
zaleplon oral capsule 10 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
zolpidem tartrate oral tablet 10 mg, 5 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
OREXIN RECEPTOR ANTAGONISTS**		

Drug Name	Tier	Notes
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	4	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
DAYVIGO ORAL TABLET 10 MG, 5 MG	5	PA; QL (30 EA per 30 days)
SELECTIVE MELATONIN RECEPTOR AGONISTS**		
ramelteon oral tablet 8 mg	4	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 365 days); AL (Min 50 Years)
HALFLYTELY WITH FLAVOR PACKS ORAL KIT 5-210 MG-GM	4	
peg 3350/electrolytes oral solution reconstituted 240 gm	2	QL (8000 ML per 30 days)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	$0	$0 Copay per PPACA guidelines
peg-3350/electrolytes oral solution reconstituted 236 gm	2	QL (8000 ML per 30 days)
PEG-PREP ORAL KIT 5-210 MG-GM	4	
PREPOPIK ORAL PACKET 10-3.5-12 MG-GM-GM	4	PA
LAXATIVES - MISCELLANEOUS**		
lactulose oral solution 10 gm/15ml	2	
peg 3350 oral powder 17 gm/scoop	2	
polyethylene glycol 3350 oral powder 17 gm/scoop	2	
SALINE LAXATIVES**		
magnesium citrate oral solution 1.745 gm/30ml	2	
LOCAL ANESTHETICS-PARENTERAL		
LOCAL ANESTHETICS - AMIDES**		
EXPAREL INJECTION SUSPENSION 1.3 %	MB	
NAROPIN INJECTION SOLUTION 2 MG/ML	MB	

Drug Name	Tier	Notes
ropivacaine hcl injection solution 10 mg/ml, 2 mg/ml, 5 mg/ml, 7.5 mg/ml	MB	
ropivacaine hcl-nacl injection solution 0.2-0.9 %	MB	
LOCAL ANESTHETICS - ESTERS**		
chloroprocaine hcl (pf) injection solution 2 %	MB	
MACROLIDES		
AZITHROMYCIN**		
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	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.)
azithromycin oral tablet 250 mg, 500 mg, 600 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.)
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
CLARITHROMYCIN**		
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	2	
ERYTHROMYCINS**		

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

Drug Name	Tier	Notes
erythromycin base oral tablet 250 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	4	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)
erythromycin ethylsuccinate oral tablet 400 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
erythromycin stearate oral tablet 250 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.)
FIDAXOMICIN**		
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	5	PA; QL (10 ML per 1 day)
MEDICAL DEVICES AND SUPPLIES		
CERVICAL CAPS**		
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
PRENTIF CAVITY-RIM CERV CAP VAGINAL DEVICE 22 MM, 25 MM, 28 MM, 31 MM	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
PRENTIF FITTING SET VAGINAL	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
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.; AL (Max 55 Years)
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)

Drug Name	Tier	Notes
ORTHO DIAPHRAGM COIL VAGINAL KIT 100 MM, 105 MM, 50 MM	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
ORTHO DIAPHRAGM FLAT VAGINAL KIT 55 MM, 60 MM, 65 MM, 70 MM, 75 MM, 80 MM, 85 MM, 90 MM, 95 MM	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
GLUCOSE MONITORING TEST SUPPLIES**		
ACCU-CHEK FASTCLIX LANCET KIT	2	QL (1 EA per 180 days)
ACCU-CHEK FASTCLIX LANCETS	2	102 lancets per 30 days or 306 lancets for 90 days are covered for members who are not on insulin. 204 lancets per 30 days or 612 lancets per 90 days are covered for members who are receiving insulin. 51 lancets per 30 days or 153 lancets per 90 days are covered for members on a continuous glucose monitoring system.; QL (102 EA per 30 days)
ACCU-CHEK MULTICLIX LANCETS	2	102 lancets per 30 days or 306 lancets for 90 days are covered for members who are not on insulin. 204 lancets per 30 days or 612 lancets per 90 days are covered for members who are receiving insulin. 51 lancets per 30 days or 153 lancets per 90 days are covered for members on a continuous glucose monitoring system.; QL (102 EA per 30 days)
ACCU-CHEK SOFTCLIX LANCET DEV KIT	2	QL (1 EA per 180 days)

Drug Name	Tier	Notes
ACCU-CHEK SOFTCLIX LANCETS	2	100 lancets per 30 days or 300 lancets for 90 days are covered for members who are not on insulin. 200 lancets per 30 days or lancets per 90 days are covered for members who are receiving insulin. 50 lancets per 30 days or 150 lancets per 90 days are covered for members on a continuous glucose monitoring system.; QL (100 EA per 30 days)
DEXCOM G6 RECEIVER DEVICE	3	PA; QL (1 EA per 365 days)
DEXCOM G6 SENSOR	3	PA; QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER	3	PA; QL (1 EA per 90 days)
DEXCOM G7 RECEIVER DEVICE	3	PA; QL (1 EA per 365 Days)
DEXCOM G7 SENSOR	3	PA; QL (3 EA per 30 Days)
FREESTYLE LIBRE 14 DAY READER DEVICE	3	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR	3	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR	3	ST; QL (2 EA per 28 Days)
FREESTYLE LIBRE 2 READER DEVICE	3	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 2 SENSOR	3	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	3	ST; QL (2 EA per 28 Days)
FREESTYLE LIBRE 3 READER DEVICE	3	ST; QL (1 EA per 365 days)
FREESTYLE LIBRE 3 SENSOR	3	ST; QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE	3	ST; QL (1 EA per 365 days)
GUARDIAN 4 GLUCOSE SENSOR	3	PA; QL (5 EA per 30 days)
GUARDIAN 4 TRANSMITTER	3	PA; QL (1 EA per 365 days)
GUARDIAN LINK 3 TRANSMITTER	3	PA; QL (1 EA per 365 days)
GUARDIAN SENSOR (3)	3	PA; QL (5 EA per 30 days)
guardian sensor 3	3	PA; QL (5 EA per 30 days)
INSULIN ADMINISTRATION SUPPLIES**		
MINIMED GUARDIAN LINK 3	3	PA; QL (1 EA per 365 days)
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT	4	PA; QL (1 EA per 365 days)
OMNIPOD 5 DEXG7G6 PODS GEN 5	4	PA; QL (10 Pods per 30 days)
OMNIPOD 5 LIBRE2 PLUS G6 KIT	4	PA; QL (1 EA per 365 days)
OMNIPOD 5 LIBRE2 PLUS G6 PODS	4	PA; QL (10 Pods per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT	4	PA; QL (1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	4	PA; QL (10 EA per 30 days)
NEEDLES & SYRINGES**		
BD INSULIN SYRINGE ULTRAFINE 31G X 5/16" 1 ML	2	
BD PEN NEEDLE MINI U/F 31G X 5 MM	2	QL (100 EA per 30 days)
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM	2	QL (100 EA per 30 days)

Drug Name	Tier	Notes
BD PEN NEEDLE NANO U/F 32G X 4 MM	2	QL (100 EA per 30 days)
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM	2	QL (100 EA per 30 days)
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM	2	QL (100 EA per 30 days)
BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM	2	QL (100 EA per 30 days)
BD PEN NEEDLE SHORT U/F 31G X 8 MM	2	QL (100 EA per 30 days)
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM	2	QL (100 EA per 30 days)
NOVOFINE PEN NEEDLE 32G X 6 MM	2	
NOVOTWIST PEN NEEDLE 32G X 5 MM	2	
pen needles 3/16" 31g x 5 mm	2	QL (100 EA per 30 days)
pen needles 5/16" 30g x 8 mm	2	QL (100 EA per 30 days)
PEAK FLOW METERS**		
ASSESS PEAK FLOW METER DEVICE	3	
SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES**		
AEROCHAMBER PLUS FLO-VU	4	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
AEROCHAMBER PLUS FLOW VU	4	AeroChamber Plus Flow VU NDC-04351-0798-10 is available at tier 1.; QL (2 EA per 180 days)
AEROCHAMBER Z-STAT PLUS	2	QL (2 EA per 180 days)
EASIVENT	4	QL (2 EA per 180 days)
E-Z SPACER DEVICE	4	QL (2 EA per 180 days)
LITEAIRE DEVICE	2	QL (2 EA per 180 days)
MICROCHAMBER	2	QL (2 EA per 180 days)
MICROSPACER	2	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND	2	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-LG MASK DEVICE	2	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-MD MASK	2	QL (2 EA per 180 days)
OPTICHAMBER DIAMOND-SM MASK	2	QL (2 EA per 180 days)
OPTIHALER	2	QL (2 EA per 180 days)
POCKET CHAMBER DEVICE	2	QL (2 EA per 180 days)
MIGRAINE PRODUCTS		
CGRP RECEPTOR ANTAGONISTS - MONOCOLONAL ANTIBODIES**		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML	3	PA; QL (1 ML per 28 days)
ERGOT COMBINATIONS**		
CAFERGOT ORAL TABLET 1-100 MG	4	QL (40 EA per 30 days)
MIGRAINE PRODUCTS**		

Drug Name	Tier	Notes
dihydroergotamine mesylate injection solution 1 mg/ml	4	QL (8 ML per 30 days)
dihydroergotamine mesylate nasal solution 4 mg/ml	5	ST; QL (8 ML per 30 days)
ERGOMAR SUBLINGUAL TABLET SUBLINGUAL 2 MG	4	ST; QL (12 EA per 30 days)
SELECTIVE SEROTONIN AGONISTS 5-HT(1)**		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	4	ST; QL (18 EA per 30 days)
eletriptan hydrobromide oral tablet 20 mg, 40 mg	4	ST; QL (18 EA per 30 days)
frovatriptan succinate oral tablet 2.5 mg	4	ST; QL (18 EA per 30 days)
IMITREX STATDOSE SYSTEM SUBCUTANEOUS SOLUTION AUTO-INJECTOR 4 MG/0.5ML	MB	
IMITREX SUBCUTANEOUS SOLUTION 6 MG/0.5ML	MB	
naratriptan hcl oral tablet 1 mg	4	QL (18 EA per 30 days)
naratriptan hcl oral tablet 2.5 mg	2	QL (18 EA per 30 days)
rizatriptan benzoate oral tablet 10 mg, 5 mg	2	QL (18 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	2	QL (18 EA per 30 days)
sumatriptan nasal solution 20 mg/act, 5 mg/act	2	QL (6 EA per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	2	QL (18 EA per 30 days)
sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml	2	QL (2 ML per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml	2	QL (2 ML per 30 days)
sumatriptan succinate subcutaneous solution prefilled syringe 6 mg/0.5ml	2	QL (2 ML per 30 days)
zolmitriptan oral tablet 2.5 mg, 5 mg	2	ST; QL (18 EA per 30 days)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	4	ST; QL (18 EA per 30 days)
ZOMIG NASAL SOLUTION 2.5 MG, 5 MG	4	QL (6 EA per 30 days)
MINERALS & ELECTROLYTES		
BICARBONATES**		
sodium acetate intravenous solution 2 meq/ml	2	
CALCIUM**		
CALPHOSAN INJECTION SOLUTION 50-50 MG/10ML	MB	
ELECTROLYTES & DEXTROSE**		
dextrose in lactated ringers intravenous solution 5 %	MB	
dextrose-nacl intravenous solution 5-0.9 %	MB	
dextrose-sodium chloride intravenous solution 5-0.9 %	MB	
ELECTROLYTES PARENTERAL**		

Drug Name	Tier	Notes
lactated ringers intravenous solution	MB	
FLUORIDE**		
FLURA-DROPS ORAL SOLUTION 0.275 (0.125 F) MG/DROP	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
FLURA-DROPS ORAL SOLUTION 0.55 (0.25 F) MG/DROP	$0	$0 Copay per PPACA guidelines.; AL (Min 1 Years and 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 chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	$0	$0 Copay Preventative Services.; AL (Max 6 Years)
MAGNESIUM**		
magnesium sulfate in d5w intravenous solution 1-5 gm/100ml-%	MB	
magnesium sulfate injection solution 50 %	MB	
magnesium sulfate intravenous solution 2 gm/50ml, 20 gm/500ml, 4 gm/100ml, 4 gm/50ml, 40 gm/1000ml	MB	
POTASSIUM**		
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	2	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	2	
KLOR-CON ORAL PACKET 20 MEQ	2	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	2	
KLOR-CON/EF ORAL TABLET EFFERVESCENT 25 MEQ	2	
potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq	2	
potassium chloride er oral capsule extended release 10 meq, 8 meq	2	
potassium chloride er oral tablet extended release 10 meq, 8 meq	2	
potassium chloride intravenous solution 2 meq/ml	MB	
potassium chloride oral packet 20 meq	2	
potassium chloride oral solution 20 meq/15ml (10%)	2	
ZINC**		
zinc sulfate intravenous solution 3 mg/ml	MB	

Drug Name	Tier	Notes
MISCELLANEOUS THERAPEUTIC CLASSES		
ANTILEPROTICS**		
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS**		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (4 ML per 28 days); SP
CHELATING AGENTS**		
penicillamine oral capsule 250 mg	5	PA; QL (240 EA per 30 days)
penicillamine oral tablet 250 mg	5	PA; QL (240 EA per 30 days)
CYCLOSPORINE ANALOGS**		
cyclosporine intravenous solution 50 mg/ml	MB	
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	2	
cyclosporine modified oral solution 100 mg/ml	2	
cyclosporine oral capsule 100 mg, 25 mg	2	
GENGRAF ORAL SOLUTION 100 MG/ML	3	
SANDIMMUNE INTRAVENOUS SOLUTION 50 MG/ML	MB	
SANDIMMUNE ORAL SOLUTION 100 MG/ML	3	
ENZYMES**		
HYLENEX INJECTION SOLUTION 150 UNIT/ML	MB	PA
IMMUNE GLOBULIN IMMUNOSUPPRESSANTS**		
ATGAM INTRAVENOUS INJECTABLE 50 MG/ML	MB	
ATGAM INTRAVENOUS SOLUTION 50 MG/ML	MB	
THYMOGLOBULIN INTRAVENOUS SOLUTION RECONSTITUTED 25 MG	MB	
IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES**		
lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg	5	PA; LA; DX (Non-ASO Plans: Diagnosis Validation Required)
lenalidomide oral capsule 2.5 mg, 20 mg	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP

Drug Name	Tier	Notes
REVLIMID ORAL CAPSULE 2.5 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS**		
mycophenolate mofetil oral capsule 250 mg	2	
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	5	PA; AL (Max 12 Years)
mycophenolate mofetil oral tablet 500 mg	2	
MACROLIDE IMMUNOSUPPRESSANTS**		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG	4	PA; QL (30 EA per 30 days)
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 1 MG	5	PA; QL (120 EA per 30 days)
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG	5	PA; QL (90 EA per 30 days)
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg	5	PA; SP
everolimus oral tablet 1 mg	5	PA
HECORIA ORAL CAPSULE 0.5 MG, 1 MG, 5 MG	2	
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML	MB	
sirolimus oral solution 1 mg/ml	5	QL (60 ML per 30 days)
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	4	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	2	
MONOCLONAL ANTIBODIES**		
GAMIFANT INTRAVENOUS SOLUTION 10 MG/2ML, 50 MG/10ML	MB	PA
SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG	MB	
ZENAPAX INTRAVENOUS CONCENTRATE 25 MG/5ML	MB	
POTASSIUM REMOVING AGENTS**		
KIONEX COMBINATION SUSPENSION 15 GM/60ML	2	
KIONEX ORAL POWDER	2	
KIONEX ORAL SUSPENSION 15 GM/60ML	2	
LOKELMA ORAL PACKET 10 GM	5	PA; QL (30 EA per 30 days)
LOKELMA ORAL PACKET 5 GM	5	PA; QL (90 EA per 30 days)
sodium polystyrene sulfonate oral powder	2	
VELTASSA ORAL PACKET 1 GM	5	PA; QL (30 EA per 30 Days)
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM, 8.4 GM	5	PA; QL (30 EA per 30 days)

Drug Name	Tier	Notes
PURINE ANALOGS**		
azathioprine oral tablet 50 mg	2	
azathioprine sodium injection solution reconstituted 100 mg	MB	
SCLEROSING AGENTS**		
ETHAMOLIN INTRAVENOUS SOLUTION 5 %	MB	
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL**		
lidocaine viscous mouth/throat solution 2 %	2	
ANTI-INFECTIVES - THROAT**		
clotrimazole mouth/throat troche 10 mg	2	
nystatin mouth/throat suspension 100000 unit/ml	2	
ANTISEPTICS - MOUTH/THROAT**		
chlorhexidine gluconate mouth/throat solution 0.12 %	2	
PAROEX MOUTH/THROAT SOLUTION 0.12 %	2	
PERIOGARD MOUTH/THROAT SOLUTION 0.12 %	2	
SALIVA STIMULANTS**		
cevimeline hcl oral capsule 30 mg	4	ST; QL (90 EA per 30 days)
pilocarpine hcl oral tablet 5 mg, 7.5 mg	2	QL (90 EA per 30 days)
STEROIDS - MOUTH/THROAT/DENTAL**		
ORALONE MOUTH/THROAT PASTE 0.1 %	2	QL (5 GM per 30 days)
triamcinolone acetonide mouth/throat paste 0.1 %	2	QL (5 GM per 30 days)
MULTIVITAMINS		
PED VITAMINS ACD W/ FLUORIDE**		
triple-vitamin/fluoride oral solution 0.25 mg/ml	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
tri-vit/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
tri-vitamin/fluoride oral solution 0.25 mg/ml, 0.5 mg/ml	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
vitamins acd-fluoride oral solution 0.25 mg/ml	$0	$0 Copay per PPACA guidelines.; AL (Max 6 Years)
PRENATAL MV & MIN W/FE-FA**		
completenate oral tablet chewable 29-1 mg	3	
CO-NATAL FA ORAL TABLET	3	
INATAL ADVANCE ORAL TABLET 90-1 MG	3	
INATAL GT ORAL TABLET	3	
INATAL ULTRA ORAL TABLET , 90-1 MG	3	

Drug Name	Tier	Notes
multi prenatal oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
M-VIT ORAL TABLET	3	
MYNATAL ADVANCE ORAL TABLET	3	
MYNATAL ORAL TABLET 90-1 MG	3	
natal-v rx oral tablet 29-1 mg	3	
NIVA-PLUS ORAL TABLET 27-1 MG	3	
OBSTETRIX EC (WITH DOCUSATE) ORAL TABLET 29-1 MG	3	
OBSTETRIX EC ORAL TABLET 29-1 MG	3	
OBTREX ORAL TABLET	3	
O-CAL FA ORAL TABLET 27-1 MG	3	
pnv folic acid + iron oral tablet 27-1 mg	3	
pnv prenatal plus multivitamin oral tablet 27-1 mg	3	
pnv tabs 29-1 oral tablet 29-1 mg	3	
pnv-vp-u oral capsule 106.5-1 mg	3	
prenaplus oral tablet 27-1 mg	3	
prenatabs fa oral tablet	3	
PRENATABS RX ORAL TABLET 29-1 MG	3	
prenatal 19 oral tablet chewable , 29-1 mg	3	
PRENATAL AD ORAL TABLET	3	
prenatal formula oral tablet 27-1 mg	3	
prenatal low iron oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
prenatal low iron oral tablet 27-1 mg	3	
PRENATAL MULTIVITAMIN-ULTRA ORAL TABLET	3	
prenatal one daily oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
prenatal oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
prenatal oral tablet 27-1 mg	3	
prenatal plus iron oral tablet 29-1 mg	3	
prenatal plus oral tablet 27-1 mg	3	
prenatal plus/iron oral tablet 27-1 mg	3	
prenatal vitamin oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
prenatal vitamins plus oral tablet 27-1 mg	3	
PRENATAL/FOLIC ACID ORAL TABLET	3	

Drug Name	Tier	Notes
PRENATAL-U ORAL CAPSULE 106.5-1 MG	3	
preplus oral tablet 27-1 mg	3	
pretab oral tablet 29-1 mg	3	
right step prenatal oral tablet 27-0.8 mg	$0	$0 Copay per PPACA guidelines; AL (Max 55 Years)
se-natal 19 oral tablet chewable 29-1 mg	3	
THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG	3	
triadvance oral tablet 90-1 mg	3	
TRICARE ORAL TABLET	3	
trinatal gt oral tablet 90-1 mg	3	
trinatal ultra oral tablet 90-1 mg	3	
TRIVEEN-U ORAL CAPSULE 106.5-1 MG	3	
ULTRA NATALCARE ORAL TABLET 90-1 MG	3	
ultra tabs oral tablet	3	
venatal-fa oral tablet 29-1 mg	3	
VINATE GT ORAL TABLET 90-1 MG	3	
vinate ultra oral tablet	3	
virt-advance oral tablet 90-1 mg	3	
virt-vite gt oral tablet 90-1 mg	3	
vol-plus oral tablet 27-1 mg	3	
vol-tab rx oral tablet 29-1 mg	3	
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS**		
baclofen intrathecal solution 10 mg/20ml	MB	
baclofen oral tablet 10 mg, 20 mg	2	
chlorzoxazone oral tablet 500 mg	2	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	2	
LIORESAL INTRATHECAL SOLUTION 0.05 MG/ML	MB	
metaxalone oral tablet 800 mg	4	ST; QL (120 EA per 30 days)
methocarbamol injection solution 1000 mg/10ml	MB	
methocarbamol oral tablet 500 mg, 750 mg	2	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	2	
orphenadrine citrate injection solution 30 mg/ml	MB	
tizanidine hcl oral tablet 2 mg, 4 mg	2	

Drug Name	Tier	Notes
DIRECT MUSCLE RELAXANTS**		
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	2	
MUSCLE RELAXANT COMBINATIONS**		
norgesic forte oral tablet 50-770-60 mg	4	PA; QL (4 EA per 1 day)
VISCOSUPPLEMENTS**		
DUROLANE INTRA-ARTICULAR PREFILLED SYRINGE 60 MG/3ML	MB	PA
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL ANTIBIOTICS**		
BACTROBAN NASAL NASAL OINTMENT 2 %	3	
NASAL ANTICHOLINERGICS**		
ipratropium bromide nasal solution 0.03 %, 0.06 %	2	
NASAL ANTIHISTAMINES**		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	2	
olopatadine hcl nasal solution 0.6 %	4	PA; QL (30.5 GM per 30 days)
NASAL STEROIDS**		
BECONASE AQ NASAL SUSPENSION 42 MCG/SPRAY	4	ST
budesonide nasal suspension 32 mcg/act	4	ST
flunisolide nasal solution 25 mcg/act (0.025%)	3	
flunisolide nasal solution 29 mcg/act (0.025%)	2	
fluticasone propionate nasal suspension 50 mcg/act	2	
mometasone furoate nasal suspension 50 mcg/act	4	ST
NASACORT AQ NASAL AEROSOL, SOLUTION 55 MCG/ACT	2	
TOPICAL DECONGESTANTS**		
ADRENALIN NASAL SOLUTION 0.1 %	MB	
NEUROMUSCULAR AGENTS		
BENZATHIAZOLES**		
riluzole oral tablet 50 mg	2	
DEPOLARIZING MUSCLE RELAXANTS**		
ANECTINE INJECTION SOLUTION 20 MG/ML	MB	
QUELICIN INJECTION SOLUTION 20 MG/ML	MB	
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS**		
BOTOX INJECTION SOLUTION RECONSTITUTED 200 UNIT	MB	PA

Drug Name	Tier	Notes
MYOBLOC INTRAMUSCULAR SOLUTION 10000 UNIT/2ML, 2500 UNIT/0.5ML, 5000 UNIT/ML	MB	PA
NONDEPOLARIZING MUSCLE RELAXANTS**		
atracurium besylate intravenous solution 100 mg/10ml	2	
NUTRIENTS		
AMINO ACIDS-SINGLE**		
n-acetyl-l-cysteine oral capsule 600 mg	2	
CARBOHYDRATES**		
dextrose intravenous solution 5 %	MB	
OPHTHALMIC AGENTS		
BETA-BLOCKERS - OPHTHALMIC COMBINATIONS**		
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	4	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	2	
BETA-BLOCKERS - OPHTHALMIC**		
betaxolol hcl ophthalmic solution 0.5 %	2	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 %	3	
carteolol hcl ophthalmic solution 1 %	2	
levobunolol hcl ophthalmic solution 0.25 %, 0.5 %	2	
metipranolol ophthalmic solution 0.3 %	3	
timolol maleate (once-daily) ophthalmic solution 0.5 %	4	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	2	
CYCLOPLEGIC MYDRIATICS**		
atropine sulfate ophthalmic ointment 1 %	2	
atropine sulfate ophthalmic solution 1 %	3	
cyclopentolate hcl ophthalmic solution 1 %, 2 %	2	
HOMATROPAIRE OPHTHALMIC SOLUTION 5 %	2	
homatropine hbr ophthalmic solution 5 %	2	
ISOPTO HOMATROPINE OPHTHALMIC SOLUTION 2 %	3	
ISOPTO HYOSCINE OPHTHALMIC SOLUTION 0.25 %	3	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	2	
tropicamide ophthalmic solution 0.5 %, 1 %	2	

Drug Name	Tier	Notes
MIOTICS - CHOLINESTERASE INHIBITORS**		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 %	3	
MIOTICS - DIRECT ACTING**		
ISOPTO CARBACHOL OPHTHALMIC SOLUTION 1.5 %, 3 %	3	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	2	
OPHTHALMIC ANTIALLERGIC**		
ALOCRIL OPHTHALMIC SOLUTION 2 %	4	
ALOMIDE OPHTHALMIC SOLUTION 0.1 %	3	
azelastine hcl ophthalmic solution 0.05 %	2	
bepotastine besilate ophthalmic solution 1.5 %	4	PA
cromolyn sodium ophthalmic solution 4 %	2	
EMADINE OPHTHALMIC SOLUTION 0.05 %	3	
epinastine hcl ophthalmic solution 0.05 %	2	
OPHTHALMIC ANTIBIOTICS**		
bacitracin ophthalmic ointment 500 unit/gm	3	
CILOXAN OPHTHALMIC OINTMENT 0.3 %	3	
ciprofloxacin hcl ophthalmic solution 0.3 %	2	
erythromycin ophthalmic ointment 5 mg/gm	$0	$0 Copay for members 1 year of age or younger per PPACA guidelines; AL (Max 1 Years)
GENTAK OPHTHALMIC OINTMENT 0.3 %	2	
gentamicin sulfate ophthalmic ointment 0.3 %	2	
gentamicin sulfate ophthalmic solution 0.3 %	2	
MITOSOL OPHTHALMIC KIT 0.2 MG	MB	
moxifloxacin hcl ophthalmic solution 0.5 %	4	
ofloxacin ophthalmic solution 0.3 %	2	
tobramycin ophthalmic solution 0.3 %	2	
TOBREX OPHTHALMIC OINTMENT 0.3 %	4	
OPHTHALMIC ANTIFUNGAL**		
NATACYN OPHTHALMIC SUSPENSION 5 %	4	PA; QL (30 ML per 30 days)
OPHTHALMIC ANTI-INFECTIVE COMBINATIONS**		
ak-poly-bac ophthalmic ointment 500-10000 unit/gm	2	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	2	

Drug Name	Tier	Notes
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	2	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	2	
NEO-POLYCIN OPHTHALMIC OINTMENT 3.5-400-10000	2	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	2	
OPHTHALMIC ANTIVIRALS**		
trifluridine ophthalmic solution 1 %	2	
OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS**		
brinzolamide ophthalmic suspension 1 %	4	
dorzolamide hcl ophthalmic solution 2 %	2	
OPHTHALMIC IMMUNOMODULATORS**		
cyclosporine ophthalmic emulsion 0.05 %	4	QL (60 EA per 30 days)
OPHTHALMIC LOCAL ANESTHETICS**		
proparacaine hcl ophthalmic solution 0.5 %	2	
OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS**		
bromfenac sodium ophthalmic solution 0.09 %	4	ST; QL (5 ML per 90 days)
diclofenac sodium ophthalmic solution 0.1 %	2	
flurbiprofen sodium ophthalmic solution 0.03 %	2	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	2	
OPHTHALMIC RHO KINASE INHIBITORS**		
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	3	ST
OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS**		
apraclonidine hcl ophthalmic solution 0.5 %	2	
brimonidine tartrate ophthalmic solution 0.1 %	3	
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	2	
OPHTHALMIC STEROID COMBINATIONS**		
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	2	
BLEPHAMIDE OPHTHALMIC SUSPENSION 10-0.2 %	3	

Drug Name	Tier	Notes
BLEPHAMIDE S.O.P. OPHTHALMIC OINTMENT 10-0.2 %	3	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	2	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	2	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	4	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	2	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	3	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 %	3	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
OPHTHALMIC STEROIDS**		
ALREX OPHTHALMIC SUSPENSION 0.2 %	4	ST
dexamethasone sodium phosphate ophthalmic solution 0.1 %	2	
difluprednate ophthalmic emulsion 0.05 %	4	ST; QL (5 ML per 30 days)
DUREZOL OPHTHALMIC EMULSION 0.05 %	4	ST; QL (5 ML per 30 days)
fluorometholone ophthalmic suspension 0.1 %	2	
FML FORTE OPHTHALMIC SUSPENSION 0.25 %	3	
FML OPHTHALMIC OINTMENT 0.1 %	3	
LOTEMAX SM OPHTHALMIC GEL 0.38 %	3	ST
loteprednol etabonate ophthalmic gel 0.5 %	4	ST
loteprednol etabonate ophthalmic suspension 0.5 %	4	ST
MAXIDEX OPHTHALMIC SUSPENSION 0.1 %	4	
PRED MILD OPHTHALMIC SUSPENSION 0.12 %	3	
prednisolone acetate ophthalmic suspension 1 %	2	
prednisolone sodium phosphate ophthalmic solution 1 %	4	
VEXOL OPHTHALMIC SUSPENSION 1 %	4	
OPHTHALMIC SULFONAMIDES**		
sulfacetamide sodium ophthalmic solution 10 %	2	
OPHTHALMIC SURGICAL AIDS - COMBINATIONS**		
OMIDRIA INTRAOCULAR SOLUTION 1-0.3 %	MB	
PROSTAGLANDINS - OPHTHALMIC**		
latanoprost ophthalmic solution 0.005 %	2	

Drug Name	Tier	Notes
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	
travoprost (bak free) ophthalmic solution 0.004 %	4	
VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS**		
EYLEA HD INTRAVITREAL SOLUTION 8 MG/0.07ML	MB	
EYLEA INTRAVITREAL SOLUTION 2 MG/0.05ML	MB	
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE 2 MG/0.05ML	MB	
LUCENTIS INTRAOCULAR SOLUTION 0.3 MG/0.05ML, 0.5 MG/0.05ML	MB	
LUCENTIS INTRAVITREAL SOLUTION 0.3 MG/0.05ML, 0.5 MG/0.05ML	MB	
LUCENTIS INTRAVITREAL SOLUTION PREFILLED SYRINGE 0.3 MG/0.05ML, 0.5 MG/0.05ML	MB	
PAVBLU INTRAVITREAL SOLUTION 2 MG/0.05ML	MB	
PAVBLU INTRAVITREAL SOLUTION PREFILLED SYRINGE 2 MG/0.05ML	MB	
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS**		
acetic acid otic solution 2 %	2	
acetic acid-aluminum acetate otic solution 2 %	3	
OTIC ANALGESIC COMBINATIONS**		
antipyrine-benzocaine otic solution 5.4-1.4 %	2	
OTIC ANTI-INFECTIVES**		
ofloxacin otic solution 0.3 %	2	
OTIC STEROID-ANTI-INFECTIVE COMBINATIONS**		
CIPRO HC OTIC SUSPENSION 0.2-1 %	4	PA
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	4	ST; QL (7.5 ML per 30 days); AL (Max 12 Years)
neomycin-polymyxin-hc otic solution 3.5-10000-1	2	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	2	
OTIC STEROIDS**		
fluocinolone acetonide otic oil 0.01 %	2	
hydrocortisone-acetic acid otic solution 1-2 %	2	
OXYTOCICS		
ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS**		

Drug Name	Tier	Notes
carboprost tromethamine intramuscular solution 250 mcg/ml	MB	
PREPIDIL VAGINAL GEL 0.5 MG/3GM	4	
OXYTOCICS**		
methylergonovine maleate injection solution 0.2 mg/ml	4	
methylergonovine maleate oral tablet 0.2 mg	4	
oxytocin injection solution 10 unit/ml	MB	
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
ANTITOXINS-ANTIVENINS**		
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
IMMUNE SERUMS**		
HYPERRHO S/D INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT, 250 UNIT	MB	
HYPERTET S/D INTRAMUSCULAR INJECTABLE 250 UNIT/ML	MB	
kedrab intramuscular solution 150 unit/ml	MB	
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 250 UNIT	MB	
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 1500 UNIT	MB	
RHOPHYLAC INJECTION SOLUTION PREFILLED SYRINGE 1500 UNIT/2ML	MB	
WINRHO SDF INJECTION SOLUTION 1500 UNIT/1.3ML, 15000 UNIT/13ML, 2500 UNIT/2.2ML, 5000 UNIT/4.4ML	MB	
PENICILLINS		
AMINOPENICILLINS**		

Drug Name	Tier	Notes
amoxicillin oral capsule 250 mg, 500 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.)
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	2	
amoxicillin oral tablet 500 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.)
amoxicillin oral tablet 875 mg	2	
amoxicillin oral tablet chewable 125 mg, 250 mg	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ampicillin oral capsule 250 mg	2	
ampicillin oral capsule 500 mg	3	
ampicillin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	3	
NATURAL PENICILLINS**		
BICILLIN L-A INTRAMUSCULAR SUSPENSION 600000 UNIT/ML	MB	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 600000 UNIT/ML	MB	

Drug Name	Tier	Notes
penicillin g procaine intramuscular suspension 600000 unit/ml	MB	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	2	
penicillin v potassium oral tablet 250 mg, 500 mg	2	
PFIZERPEN INJECTION SOLUTION RECONSTITUTED 5000000 UNIT	MB	
PENICILLIN COMBINATIONS**		
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	2	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	2	
amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg	3	
ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm	MB	
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML	MB	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML	MB	
ZOSYN INTRAVENOUS SOLUTION RECONSTITUTED 2.25 (2-0.25) GM	MB	
PENICILLINASE-RESISTANT PENICILLINS**		
BACTOCILL IN DEXTROSE INTRAVENOUS SOLUTION 1 GM/50ML	MB	
dicloxacillin sodium oral capsule 250 mg, 500 mg	2	
PHARMACEUTICAL ADJUVANTS		
PARENTERAL VEHICLES**		
saline bacteriostatic injection solution 0.9 %	2	
PROGESTINS		
PROGESTINS**		
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	2	
megestrol acetate oral suspension 625 mg/5ml	2	PA
norethindrone acetate oral tablet 5 mg	2	
progesterone intramuscular oil 50 mg/ml	MB	
progesterone micronized oral capsule 100 mg, 200 mg	2	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ALCOHOL DETERRENTS**		

Drug Name	Tier	Notes
acamprosate calcium oral tablet delayed release 333 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days)
disulfiram oral tablet 250 mg	2	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
ANTI-CATAPLECTIC AGENTS**		
sodium oxybate oral solution 500 mg/ml	5	PA; LA; QL (540 ML per 30 days); AL (Min 7 Years)
BENZODIAZEPINES & TRICYCLIC AGENTS**		
chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
CHOLINOMIMETICS - ACHE INHIBITORS**		
donepezil hcl oral tablet 10 mg	2	QL (30 EA per 30 days)
donepezil hcl oral tablet 5 mg	2	QL (60 EA per 30 days)
donepezil hcl oral tablet dispersible 10 mg, 5 mg	2	PA; QL (30 EA per 30 days)
EXELON ORAL SOLUTION 2 MG/ML	4	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	2	
galantamine hydrobromide oral solution 4 mg/ml	3	

Drug Name	Tier	Notes
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	2	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	4	
FIBROMYALGIA AGENT - SNRIS**		
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	4	PA; QL (60 EA per 30 days)
MOVEMENT DISORDER DRUG THERAPY**		
AUSTEDO ORAL TABLET 12 MG	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days); SP
AUSTEDO ORAL TABLET 6 MG, 9 MG	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days); SP
tetrabenazine oral tablet 12.5 mg	5	PA; QL (90 EA per 30 days); SP
tetrabenazine oral tablet 25 mg	5	PA; QL (120 EA per 30 days); SP
MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS**		
teriflunomide oral tablet 14 mg, 7 mg	2	QL (30 EA per 30 days); SP
MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES**		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (20 EA per 326 days); SP
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (8 EA per 326 days); SP
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (10 EA per 326 days); SP

Drug Name	Tier	Notes
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (12 EA per 326 days); SP
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (14 EA per 326 days); SP
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (16 EA per 326 days); SP
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG	5	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (18 EA per 326 days); SP
MULTIPLE SCLEROSIS AGENTS - INTERFERONS**		
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML	5	DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 28 days); SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	5	DX (Non-ASO Plans: Diagnosis Validation Required); QL (1 EA per 28 days); SP
MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES**		
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS**		
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	2	DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days); SP
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	2	DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS**		
dalfampridine er oral tablet extended release 12 hour 10 mg	4	DX (Non-ASO Plans: Diagnosis Validation Required); QL (60 EA per 30 days)
MULTIPLE SCLEROSIS AGENTS**		
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	DX (Non-ASO Plans: Diagnosis Validation Required); QL (30 ML per 30 days); SP
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	DX (Non-ASO Plans: Diagnosis Validation Required); QL (12 ML per 28 days); SP
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS**		

Drug Name	Tier	Notes
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	4	ST; QL (30 EA per 30 days)
memantine hcl oral solution 2 mg/ml	2	
memantine hcl oral tablet 10 mg, 5 mg	2	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	3	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
PSEUDOBULBAR AFFECT AGENT COMBINATIONS**		
NUEDEXTA ORAL CAPSULE 20-10 MG	5	PA; QL (60 EA per 30 days)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.**		
ergoloid mesylates oral tablet 1 mg	3	
pimozide oral tablet 1 mg, 2 mg	4	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
SMOKING DETERRENTS**		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 day courses per 365 days.; QL (360 EA per 365 days)
goodsense nicotine mouth/throat gum 2 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (4300 EA per 365 days)
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (4300 EA per 365 days)

Drug Name	Tier	Notes
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (3600 EA per 365 days)
nicotine transdermal kit 21-14-7 mg/24hr	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	$0	$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (182 EA per 365 days)
NICOTROL INHALATION INHALER 10 MG	$0	ST; $0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (3024 EA per 365 days)
NICOTROL NS NASAL SOLUTION 10 MG/ML	$0	ST; $0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (1440 ML per 365 days)
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	$0	QL (106 EA per 365 days)
varenicline tartrate oral tablet 0.5 mg, 1 mg	$0	QL (360 EA per 365 days)
varenicline tartrate(continue) oral tablet 1 mg	$0	QL (360 EA per 365 days)
SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS**		
fingolimod hcl oral capsule 0.5 mg	4	
MAYZENT ORAL TABLET 0.25 MG	5	PA; QL (120 EA per 30 days); SP
MAYZENT ORAL TABLET 1 MG	5	PA; QL (30 EA per 30 Days); SP
MAYZENT ORAL TABLET 2 MG	5	PA; QL (30 EA per 30 days); SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG, 7 X 0.25 MG	5	PA; QL (1 pack per 365 Days); SP
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG	4	
THIENBENZODIAZEPINES & OPIOID ANTAGONISTS**		
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	PA; BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
RESPIRATORY AGENTS - MISC.		

Drug Name	Tier	Notes
CFTR POTENTIATORS**		
KALYDECO ORAL PACKET 13.4 MG	5	PA; QL (2 packets per 1 day); AL (Max 6 Years); SP
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG	5	PA; QL (60 EA per 30 days); AL (Max 6 Years); SP
KALYDECO ORAL TABLET 150 MG	5	PA; QL (60 EA per 30 days); AL (Min 6 Years); SP
CYSTIC FIBROSIS AGENT - COMBINATIONS**		
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; QL (120 EA per 30 days); SP
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	5	PA; QL (60 EA per 30 days); AL (Min 6 Years and Max 12 Years); SP
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG	5	PA; QL (90 EA per 30 days); SP
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	5	PA; QL (2 packets per 1 day); SP
HYDROLYTIC ENZYMES**		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	LA
PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS**		
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA; QL (60 EA per 30 days); SP
SULFONAMIDES		
SULFONAMIDES**		
sulfadiazine oral tablet 500 mg	2	
TETRACYCLINES		
GLYCYLCYCLINES**		
tigecycline intravenous solution reconstituted 50 mg	MB	
TYGACIL INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	
TETRACYCLINES**		
demeclocycline hcl oral tablet 150 mg, 300 mg	4	

Drug Name	Tier	Notes
doxycycline hyclate oral capsule 100 mg, 50 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
doxycycline hyclate oral tablet 100 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
doxycycline hyclate oral tablet 20 mg	2	
doxycycline monohydrate oral capsule 100 mg, 50 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.)
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	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.)
MINOCIN INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	2	

Drug Name	Tier	Notes
SEYSARA ORAL TABLET 100 MG	4	ST
tetracycline hcl oral capsule 250 mg, 500 mg	3	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
THYROID AGENTS		
ANTITHYROID AGENTS**		
methimazole oral tablet 10 mg, 5 mg	2	
propylthiouracil oral tablet 50 mg	2	
THYROID HORMONES**		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG	3	
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	2	
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	2	
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	2	
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	2	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	2	
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	3	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	2	
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG	2	
WESTHROID ORAL TABLET 130 MG, 16.25 MG, 195 MG, 260 MG, 32.5 MG, 325 MG, 65 MG, 97.5 MG	3	
TOXOIDS		

Drug Name	Tier	Notes
TOXOID COMBINATIONS**		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5	$0	$0 Copay Preventative Services.
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5	$0	$0 Copay 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 Preventative Services.
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTICHOLINERGIC COMBINATIONS**		
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	2	
ANTISPASMODICS**		
BENTYL INTRAMUSCULAR SOLUTION 10 MG/ML	MB	
dicyclomine hcl oral capsule 10 mg	2	
dicyclomine hcl oral solution 10 mg/5ml	2	
dicyclomine hcl oral tablet 20 mg	2	
BELLADONNA ALKALOIDS**		
hyoscyamine sulfate er oral tablet extended release 12 hour 0.375 mg	2	
hyoscyamine sulfate oral elixir 0.125 mg/5ml	2	
hyoscyamine sulfate oral solution 0.125 mg/ml	2	
hyoscyamine sulfate oral tablet 0.125 mg	2	
hyoscyamine sulfate oral tablet dispersible 0.125 mg	2	
hyoscyamine sulfate sublingual tablet sublingual 0.125 mg	2	
LEVSIN INJECTION SOLUTION 0.5 MG/ML	MB	
NULEV ORAL TABLET DISPERSIBLE 0.125 MG	2	
H-2 ANTAGONISTS**		
cimetidine hcl oral solution 300 mg/5ml	2	
cimetidine oral tablet 300 mg, 400 mg, 800 mg	2	
famotidine oral suspension reconstituted 40 mg/5ml	2	
famotidine oral tablet 20 mg, 40 mg	2	
nizatidine oral capsule 150 mg, 300 mg	3	

Drug Name	Tier	Notes
ranitidine hcl injection solution 1000 mg/40ml, 150 mg/6ml, 50 mg/2ml	MB	
ranitidine hcl oral syrup 15 mg/ml, 150 mg/10ml, 75 mg/5ml	2	
ranitidine hcl oral tablet 150 mg, 300 mg	2	
MISC. ANTI-ULCER**		
sucralfate oral suspension 1 gm/10ml	4	QL (1200 ML per 30 days); AL (Max 12 Years)
sucralfate oral tablet 1 gm	2	
PROTON PUMP INHIBITORS**		
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	4	PA; QL (30 EA per 30 days)
esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg	2	QL (30 EA per 30 days)
lansoprazole oral capsule delayed release 15 mg, 30 mg	4	QL (60 EA per 30 days)
lansoprazole oral tablet dispersible 15 mg, 30 mg	4	PA
omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg	2	QL (60 EA per 30 days)
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	2	QL (60 EA per 30 days)
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	2	QL (60 EA per 30 days)
PROTONIX INTRAVENOUS SOLUTION RECONSTITUTED 40 MG	MB	
rabeprazole sodium oral tablet delayed release 20 mg	2	QL (60 EA per 30 days)
QUATERNARY ANTICHOLINERGICS**		
glycopyrrolate injection solution 0.2 mg/ml, 0.4 mg/2ml, 1 mg/5ml, 4 mg/20ml	2	
glycopyrrolate oral tablet 1 mg, 2 mg	2	
propantheline bromide oral tablet 15 mg	3	
ULCER DRUGS - PROSTAGLANDINS**		
misoprostol oral tablet 100 mcg, 200 mcg	2	
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)**		
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	4	ST; QL (30 EA per 30 days)
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	2	
oxybutynin chloride oral syrup 5 mg/5ml	2	
oxybutynin chloride oral tablet 5 mg	2	

Drug Name	Tier	Notes
OXYTROL FOR WOMEN TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR	4	PA; QL (8 EA per 28 days)
solifenacin succinate oral tablet 10 mg, 5 mg	2	QL (30 EA per 30 days)
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	4	QL (30 EA per 30 days)
tolterodine tartrate oral tablet 1 mg, 2 mg	2	
trospium chloride er oral capsule extended release 24 hour 60 mg	4	ST
trospium chloride oral tablet 20 mg	4	
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS**		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	2	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS**		
flavoxate hcl oral tablet 100 mg	2	
VACCINES		
BACTERIAL VACCINES**		
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML	$0	$0 ($0 Copay per PPACA guidelines.); QL (0.5 ML per 1 Lifetime)
MENACTRA INTRAMUSCULAR INJECTABLE	$0	$0 Copay Preventative Services.
MENACTRA INTRAMUSCULAR SOLUTION	$0	$0 Copay for Preventative Services.
MENOMUNE SUBCUTANEOUS INJECTABLE	$0	$0 Copay Preventative Services
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML	$0	
MENVEO INTRAMUSCULAR SOLUTION	$0	$0 Copay for Preventative Services.
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	$0	$0 Copay Preventative Services.
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	$0	
PNEUMOVAX 23 INJECTION INJECTABLE 25 MCG/0.5ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
PNEUMOVAX 23 INJECTION SOLUTION 25 MCG/0.5ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
PREVNAR 13 INTRAMUSCULAR SUSPENSION	$0	$0 Copay 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	

Drug Name	Tier	Notes
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	$0 Copay Preventative Services
MIXED VACCINE COMBINATIONS**		
COMVAX INTRAMUSCULAR SUSPENSION 7.5-5 MCG/0.5ML	$0	$0 Copay Preventative Services.
VIRAL VACCINE COMBINATIONS**		
M-M-R II INJECTION SOLUTION RECONSTITUTED	$0	
M-M-R II SUBCUTANEOUS INJECTABLE	$0	$0 Copay Preventative Services.
PROQUAD SUBCUTANEOUS INJECTABLE	$0	$0 Copay Preventative Services.
TWINRIX INTRAMUSCULAR SUSPENSION 720-20	$0	$0 Copay Preventative Services.
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	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION	$0	$0 Copay Preventative Services.; QL (0.5 ML per 180 days)
AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	$0 Copay Preventative Services.; 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)
ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML	$0	$0 Copay Preventative Services.
ENGERIX-B INTRAMUSCULAR INJECTABLE 10 MCG/0.5ML, 20 MCG/ML	$0	$0 Copay Preventative Services.
FLUAD QUADRIVALENT INTRAMUSCULAR PREFILLED SYRINGE 0.5 ML	$0	
FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML	$0	PA; $0 Copay for Preventative Services.; QL (0.5 ML per 180 days)
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)

Drug Name	Tier	Notes
FLULAVAL INTRAMUSCULAR SUSPENSION	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	$0 Copay 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	$0 Copay Preventative Services; QL (1 EA per 180 days); AL (Min 2 Years and Max 49 Years)
FLUZONE HIGH-DOSE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.7 ML	$0	QL (0.7 ML per 180 days); AL (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION , 0.5 ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.25 ML, 0.5 ML	$0	$0 Copay Preventative Services; QL (0.5 ML per 180 days)
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML	$0	$0 Copay Preventative Services.
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720 EL U/0.5ML	$0	$0 Copay Preventative Services.
HEPLISAV-B INTRAMUSCULAR SOLUTION 20 MCG/0.5ML	$0	QL (1 ML per 1 day)
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)
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	$0 Copay Preventative; 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	
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 Preventative Services.
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	$0	$0 copay Per PPACA Guidelines; QL (2 vial per 1 Lifetime); AL (Min 50 Years)
SPIKEVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML	$0	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 50 UNIT/ML	$0	$0 Copay Preventative Services.
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML	$0	$0 Copay Preventative Services.
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML	$0	$0 Copay Preventative Services.
ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED 19400 UNT/0.65ML	$0	PA; QL (1 EA Max Qty Per Fill Retail); AL (Min 60 Years)
VAGINAL AND RELATED PRODUCTS		
IMIDAZOLE-RELATED ANTIFUNGALS**		
GYNAZOLE-1 VAGINAL CREAM 2 %	4	
terconazole vaginal cream 0.4 %, 0.8 %	2	
terconazole vaginal suppository 80 mg	2	
SPERMICIDES**		
ENCARE VAGINAL SUPPOSITORY 100 MG	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
OPTIONS CONCEPTROL VAGINAL GEL 4 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)

Drug Name	Tier	Notes
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
SHUR-SEAL CONTRACEPTIVE VAGINAL GEL 2 %	$0	
TODAY SPONGE VAGINAL 1000 MG	$0	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 %	$0	$0 Copay per PPACA guidelines.; AL (Max 55 Years)
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**		
clindamycin phosphate vaginal cream 2 %	2	
metronidazole vaginal gel 0.75 %	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.)
VAGINAL ESTROGENS**		
estradiol vaginal cream 0.1 mg/gm	2	
estradiol vaginal tablet 10 mcg	2	
ESTRING VAGINAL RING 7.5 MCG/24HR	4	QL (1 EA per 90 days)
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR	4	QL (1 EA per 90 days)
PREMARIN VAGINAL CREAM 0.625 MG/GM	3	
YUVAFEM VAGINAL TABLET 10 MCG	2	
VAGINAL PROGESTINS**		
CRINONE VAGINAL GEL 8 %	4	PA
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS**		
epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml	2	
SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML	2	
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS**		
droxidopa oral capsule 100 mg, 200 mg, 300 mg	5	PA

Drug Name	Tier	Notes
VASOPRESSORS**		
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	2	
phenylephrine hcl injection solution 10 mg/ml	MB	
VITAMINS		
VITAMIN B-1**		
thiamine hcl injection solution 100 mg/ml	MB	
VITAMIN B-6**		
pyridoxine hcl injection solution 100 mg/ml	MB	
VITAMIN D**		
ergocalciferol oral capsule 1.25 mg (50000 ut)	2	
ergocalciferol oral solution 8000 unit/ml	2	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)	2	
VITAMIN K**		
phytonadione oral tablet 5 mg	5	

Medical Benefit

Drug Name	Tier	Notes
ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG	MB	PA
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML	MB	SP
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ALIQOPA INTRAVENOUS SOLUTION RECONSTITUTED 60 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
amifostine intravenous solution reconstituted 500 mg	MB	PA
ANZEMET INTRAVENOUS SOLUTION 20 MG/ML	MB	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 300 MCG/ML	MB	PA
azacitidine injection suspension reconstituted 100 mg	MB	
AZEDRA DOSIMETRIC INTRAVENOUS SOLUTION 15 MCI/ML	MB	PA; QL (1 EA per 30 days)
AZEDRA THERAPEUTIC INTRAVENOUS SOLUTION 15 MCI/ML	MB	PA; QL (2 EA per 30 days)
BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
BD POSIFLUSH INTRAVENOUS SOLUTION 0.9 %	MB	
BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG, 400 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
benztropine mesylate injection solution 1 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
BERINERT INTRAVENOUS KIT 500 UNIT	5	PA; QL (2 EA per 28 days); SP
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	MB	
BICNU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	
BLINCYTO INTRAVENOUS SOLUTION RECONSTITUTED 35 MCG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)

Drug Name	Tier	Notes
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT	MB	PA
CEREBYX INJECTION SOLUTION 100 MG PE/2ML	MB	
CERVARIX INTRAMUSCULAR SUSPENSION	MB	$0 Copay Preventative Services.; AL (Min 19 Years and Max 26 Years)
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	5	PA; SP
CUBICIN INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
CUBICIN RF INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
daptomycin intravenous solution reconstituted 500 mg	MB	
DEXFERRUM INJECTION SOLUTION 50 MG/ML	MB	
doripenem intravenous solution reconstituted 250 mg, 500 mg	MB	
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT	MB	PA
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG	MB	PA; SP
ertapenem sodium injection solution reconstituted 1 gm	MB	
ERWINAZE INJECTION SOLUTION RECONSTITUTED 10000 UNIT	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ETHYOL INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	PA
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML	MB	PA; QL (6 ML per 180 days)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 0.5 GM/10ML, 10 GM/100ML, 10 GM/200ML, 2.5 GM/50ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML	MB	PA
fluphenazine hcl injection solution 2.5 mg/ml	MB	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)

Drug Name	Tier	Notes
FOSCAVIR INTRAVENOUS SOLUTION 24 MG/ML	MB	
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 40 GM/400ML, 5 GM/50ML	MB	PA
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)
GAZYVA INTRAVENOUS SOLUTION 1000 MG/40ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE 30 MG/3ML	MB	PA; QL (2 ML per 180 days)
heparin (porcine) in d5w intravenous solution 40-5 unit/ml-%, 50-5 unit/ml-%	MB	
heparin (porcine) in nacl injection solution 2-0.9 unit/ml-%	MB	
heparin lock flush intravenous solution 2 unit/ml	MB	
heparin sod (porcine) in d5w intravenous solution 100 unit/ml	MB	
heparin sodium (porcine) injection solution 2500 unit/ml	MB	
heparin sodium (porcine) intravenous solution 2000 unit/ml	MB	
heparin sodium flush intravenous kit 10-0.9 unit/ml-%, 100-0.9 unit/ml-%	MB	
IMFINZI INTRAVENOUS SOLUTION 120 MG/2.4ML, 500 MG/10ML	MB	PA
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	MB	
INFED INJECTION SOLUTION 50 MG/ML	MB	
INJECTAFER INTRAVENOUS SOLUTION 750 MG/15ML	MB	
JELMYTO SOLUTION RECONSTITUTED 80 (2 X 40) MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required); QL (17 EA per 1 day)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML	MB	PA
KENDALL SODIUM CHLORIDE FLUSH INTRAVENOUS SOLUTION 0.9 %	MB	
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 10 MG, 30 MG, 60 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
LARTRUVO INTRAVENOUS SOLUTION 500 MG/50ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)

Drug Name	Tier	Notes
LUMOXITI INTRAVENOUS SOLUTION RECONSTITUTED 1 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	MB	PA NOT required if billed with DX codes F64.1 - F64.9.
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	MB	PA not required if billed with Dx codes F64.1 - F64.9.
MARQIBO INTRAVENOUS SUSPENSION 5 MG/31ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
methyldopate hcl intravenous solution 250 mg/5ml	MB	
micafungin sodium intravenous solution reconstituted 100 mg	MB	
MONOJECT FLUSH SYRINGE INTRAVENOUS SOLUTION 0.9 %	MB	
MONOJECT SODIUM CHLORIDE FLUSH INTRAVENOUS SOLUTION 0.9 %	MB	
na ferric gluc cplx in sucrose intravenous solution 12.5 mg/ml	MB	
normal saline flush intravenous solution 0.9 %	MB	
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required); SP
ONPATTRO INTRAVENOUS SOLUTION 10 MG/5ML	MB	PA
OPDIVO INTRAVENOUS SOLUTION 100 MG/10ML, 240 MG/24ML, 40 MG/4ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
PERJETA INTRAVENOUS SOLUTION 420 MG/14ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
potassium chloride in nacl intravenous solution 20-0.9 meq/l-%	MB	
POTELIGEO INTRAVENOUS SOLUTION 20 MG/5ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
procainamide hcl injection solution 100 mg/ml, 500 mg/ml	MB	
PROVENGE INTRAVENOUS SUSPENSION	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
romidepsin intravenous solution 27.5 mg/5.5ml	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
saline flush intravenous solution 0.9 %	MB	
SALINE FLUSH ZR INTRAVENOUS SOLUTION 0.9 %	MB	

Drug Name	Tier	Notes
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
sodium chloride flush intravenous solution 0.9 %	MB	
sodium chloride intravenous solution 0.9 %	MB	
SWABFLUSH SALINE FLUSH INTRAVENOUS SOLUTION 0.9 %	MB	
TESTOPEL IMPLANT PELLET 75 MG	MB	PA; QL (6 EA per 90 days)
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED 420 MG	MB	
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED 180 MG	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; Specialty Pharmacy Required if drug is filled through pharmacy benefit; SP
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	MB	PA
VARIZIG INTRAMUSCULAR SOLUTION RECONSTITUTED 125 UNIT	MB	PA
VENOFER INTRAVENOUS SOLUTION 20 MG/ML	MB	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	5	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (1 EA per 28 days)
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	MB	PA; SP
YERVOY INTRAVENOUS SOLUTION 200 MG/40ML, 50 MG/10ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML, 200 MG/8ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	MB	PA; DX (Non-ASO Plans: Diagnosis Validation Required)
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG	MB	

Drug Name	Tier	Notes
zoledronic acid intravenous concentrate 4 mg/5ml	MB	
zoledronic acid intravenous solution 5 mg/100ml	MB	