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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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); NDS
methamphetamine hcl oral tablet 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 (150 EA per 30 days); AL (Min 6 Years and Max 18 Years)
ANALEPTICS**		
caffeine citrate intravenous solution 60 mg/3ml	2	
caffeine citrate oral solution 20 mg/ml, 60 mg/3ml	2	
ANOREXIANTS NON-AMPHETAMINE**		
benzphetamine hcl oral tablet 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)
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)

Drug Name	Tier	Notes
phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg	4	QL (1 EA per 1 day)
ANTI-OBESITY AGENT COMBINATIONS*		
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG	4	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)
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)

Drug Name	Tier	Notes
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 er(diffus) oral tablet extended release 27 mg, 54 mg	2	QL (30 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl er(diffus) oral tablet extended release 36 mg	2	QL (60 EA per 30 days); AL (Min 6 Years)
methylphenidate hcl oral solution 10 mg/5ml	2	PA; QL (450 ML per 30 days); AL (Min 6 Years and Max 12 Years)
methylphenidate hcl oral solution 5 mg/5ml	2	PA; QL (180 ML per 30 days); AL (Min 6 Years and Max 12 Years)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	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**		
gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%	MB	
neomycin sulfate oral tablet 500 mg	2	
tobramycin inhalation nebulization solution 300 mg/5ml	5	NDS; SP
tobramycin sulfate injection solution 1.2 gm/30ml, 10 mg/ml, 80 mg/2ml	MB	
tobramycin sulfate injection solution reconstituted 1.2 gm	MB	
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS**		
RINVOQ LQ ORAL SOLUTION 1 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (360 ML per 30 days); NDS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG	5	PA; DX (Diagnosis Validation Required); QL (90 EA per 365 days); NDS; SP

Drug Name	Tier	Notes
tofacitinib citrate er oral tablet extended release 24 hour 11 mg	5	PA; QL (30 EA per 30 days); SP
tofacitinib citrate er oral tablet extended release 24 hour 22 mg	5	PA; QL (112 EA per 180 days); SP
tofacitinib citrate oral solution 1 mg/ml	5	PA; QL (300 ML per 30 days); SP
tofacitinib citrate oral tablet 10 mg, 5 mg	5	PA; QL (60 EA per 30 days); SP
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES**		
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (3.2 EA per 28 days); NDS; SP
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML	5	PA; DX (Diagnosis Validation Required); QL (0.4 ML per 28 days); NDS; SP
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML	5	PA; DX (Diagnosis Validation Required); QL (0.4 ML per 28 days); NDS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (3.2 ML per 28 days); NDS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (3.2 ML per 28 days); NDS; SP
HUMIRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP

Drug Name	Tier	Notes
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (4 EA per 28 days); NDS; SP
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
YUFLYMA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 29 days); NDS; SP
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; SP
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 28 days); NDS; 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**		
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML	5	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	5	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML	MB	PA; DX (Diagnosis Validation Required); STI (05/2025: 2026 Addition); SP
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	5	PA; DX (Diagnosis Validation Required); STI (05/2025: 2026 Addition); QL (3.6 ML per 28 days); NDS; SP

Drug Name	Tier	Notes
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	5	PA; DX (Diagnosis Validation Required); STI (05/2025: 2026 Addition); QL (3.6 ML per 28 days); NDS; SP
NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS**		
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	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	
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	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 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	
TOLECTIN DS ORAL CAPSULE 400 MG	3	
tolmetin sodium oral capsule 400 mg	3	
tolmetin sodium oral tablet 600 mg	3	
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**		

Drug Name	Tier	Notes
OTEZLA ORAL TABLET 30 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; 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 (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.4ML	5	PA; DX (Diagnosis Validation Required); QL (1.6 ML per 28 days); NDS; SP
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML	5	PA; DX (Diagnosis Validation Required); QL (2.8 ML per 28 days); NDS; SP
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS**		
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (2 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (2 ML per 28 days); NDS; SP
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
ANALGESICS - NONNARCOTIC		
ANALGESICS-SEDATIVES**		
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 81 mg	$0	AL (Min 45 Years)

Drug Name	Tier	Notes
aspirin low dose oral tablet delayed release 81 mg	$0	AL (Min 45 Years)
aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
aspirin oral tablet chewable 81 mg	$0	AL (Min 45 Years)
aspirin oral tablet delayed release 325 mg, 81 mg	$0	AL (Min 45 Years)
BAYER ASPIRIN ORAL TABLET 325 MG	$0	AL (Min 45 Years)
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG	$0	AL (Min 45 Years)
childrens aspirin oral tablet chewable 81 mg	$0	AL (Min 45 Years)
cvs aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
diflunisal oral tablet 500 mg	2	
eq aspirin low dose oral tablet chewable 81 mg	$0	AL (Min 45 Years)
eq aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
gnp aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
gnp aspirin oral tablet delayed release 325 mg, 81 mg	$0	AL (Min 45 Years)
MEDI-FIRST ASPIRIN ORAL TABLET 325 MG	$0	AL (Min 45 Years)
MEDIQUE ASPIRIN ORAL TABLET 325 MG	$0	AL (Min 45 Years)
qc aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
qc aspirin oral tablet delayed release 325 mg	$0	AL (Min 45 Years)
qc childrens aspirin oral tablet chewable 81 mg	$0	AL (Min 45 Years)
salsalate oral tablet 500 mg, 750 mg	2	
sb aspirin oral tablet 325 mg	$0	AL (Min 45 Years)
sb childrens aspirin oral tablet chewable 81 mg	$0	AL (Min 45 Years)
ST JOSEPH ASPIRIN ORAL TABLET DELAYED RELEASE 81 MG	$0	AL (Min 45 Years)
ANALGESICS - OPIOID		
CODEINE COMBINATIONS**		
acetaminophen-codeine oral solution 120-12 mg/5ml, 300-30 mg/12.5ml	2	PA; 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; QL (13 EA per 1 day); AL (Min 12 Years)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	2	PA; QL (6 EA per 1 day); AL (Min 12 Years)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	2	PA; QL (6 EA per 1 day); AL (Min 12 Years)
HYDROCODONE COMBINATIONS**		
hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml	2	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)
OPIOID AGONISTS**		

Drug Name	Tier	Notes
codeine sulfate oral tablet 15 mg, 30 mg	2	PA; QL (180 EA per 30 days); AL (Min 12 Years)
codeine sulfate oral tablet 60 mg	3	PA; 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 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	QL (30 EA per 30 days)
hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 8 mg	4	
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)
levorphanol tartrate oral tablet 2 mg	4	QL (180 EA per 30 days)
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, 50 mg, 60 mg, 80 mg	4	ST; 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 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; QL (90 EA per 30 days); AL (Min 12 Years)
tramadol hcl er oral tablet extended release 24 hour 200 mg	4	PA; QL (30 EA per 30 days); AL (Min 12 Years)

Drug Name	Tier	Notes
tramadol hcl oral tablet 50 mg	2	PA; QL (240 EA per 30 days); AL (Min 12 Years)
OPIOID COMBINATIONS**		
ENDOCET ORAL TABLET 2.5-325 MG	2	QL (12 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)
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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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); NDS
TRAMADOL COMBINATIONS**		
tramadol-acetaminophen oral tablet 37.5-325 mg	2	PA; QL (300 EA per 30 days); AL (Min 12 Years)

Drug Name	Tier	Notes
ANDROGENS-ANABOLIC		
ANDROGENS**		
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**		
hydrocortisone rectal enema 100 mg/60ml	2	
RECTAL ANESTHETIC/STEROIDS**		
lidocaine-hydrocort (perianal) external cream 3-0.5 %	2	
PROCTOFOAM HC EXTERNAL FOAM 1-1 %	3	
RECTAL LOCAL ANESTHETICS**		
PROCTOFOAM EXTERNAL FOAM 1 %	4	
RECTAL STEROIDS**		
hydrocortisone (perianal) external cream 2.5 %	2	
PROCTO-MED HC EXTERNAL CREAM 2.5 %	2	
PROCTOSOL HC EXTERNAL CREAM 2.5 %	2	
PROCTOZONE-HC EXTERNAL 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

Drug Name	Tier	Notes
NITRATES**		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 5 mg	2	
isosorbide dinitrate oral tablet 30 mg	3	
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	
NITRO-BID TRANSDERMAL OINTMENT 2 %	3	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg	2	
nitroglycerin sublingual tablet sublingual 0.6 mg	3	
nitroglycerin transdermal ointment 2 %	3	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	2	
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.)

Drug Name	Tier	Notes
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.)
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**		

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
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)
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 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	

Drug Name	Tier	Notes
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		
5-LIPOXYGENASE INHIBITORS**		
zileuton er oral tablet extended release 12 hour 600 mg	5	PA; QL (120 EA per 30 days); NDS; SP
ADRENERGIC COMBINATIONS**		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	QL (60 EA per 30 days)
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	3	QL (20.4 GM 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)
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 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)
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)
ANTI-IGE MONOCLONAL ANTIBODIES**		
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; NDS; SP
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML	MB	PA; NDS; SP
ANTI-INFLAMMATORY AGENTS**		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	2	
BETA ADRENERGICS**		

Drug Name	Tier	Notes
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	2	
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	
isoproterenol hcl injection solution 0.2 mg/ml	MB	
levalbuterol tartrate inhalation aerosol 45 mcg/act	4	QL (30 GM per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	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	
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	
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	3	QL (12.2 GM per 30 days)
ALVESCO INHALATION AEROSOL SOLUTION 80 MCG/ACT	3	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)
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT, 220 MCG/INH	3	QL (1 EA per 30 days)

Drug Name	Tier	Notes
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 110 MCG/INH, 220 MCG/ACT, 220 MCG/INH	3	QL (1 EA per 30 days)
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT, 220 MCG/INH	3	QL (1 EA per 30 days)
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	QL (13 GM per 30 days)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml	2	QL (120 ML per 30 days)
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	
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	
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)
rivaroxaban oral tablet 2.5 mg	3	QL (2 EA per 1 Day)
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 (102 EA per 365 days)
HEPARINS AND HEPARINOID-LIKE AGENTS**		

Drug Name	Tier	Notes
BD HEPARIN POSIFLUSH INTRAVENOUS SOLUTION 10 UNIT/ML, 100 UNIT/ML	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 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) pf injection solution 1000 unit/ml, 5000 unit/0.5ml	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
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 - 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)

Drug Name	Tier	Notes
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)
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); AL (Min 2 Years)
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML	5	ST; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML	5	ST; QL (5 packs per 30 days); AL (Min 2 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	5	ST; QL (10 EA per 30 days); AL (Min 2 Years)
ANTICONVULSANTS - MISC.**		
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	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 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.)
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.)

Drug Name	Tier	Notes
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.)
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)

Drug Name	Tier	Notes
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)
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, 500 mg/5ml	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.)

Drug Name	Tier	Notes
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.)
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	
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.)

Drug Name	Tier	Notes
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**		
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.)

Drug Name	Tier	Notes
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.)
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.)
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.**		

Drug Name	Tier	Notes
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)
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.)
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	
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	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML	3	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML	3	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS**		

Drug Name	Tier	Notes
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 12.5-30 mg, 25-15 mg, 25-30 mg, 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)
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)

Drug Name	Tier	Notes
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	4	ST; QL (45 ML per 30 days)
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 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)
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 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML	4	PA; QL (18 ML per 30 days)
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)

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
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)
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)
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)

Drug Name	Tier	Notes
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)
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)
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)

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
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)
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 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 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 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)

Drug Name	Tier	Notes
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)
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); NDS
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)**		
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	3	PA; QL (2 ML per 28 days); NDS
MEGLITINIDE ANALOGUES**		
nateglinide oral tablet 120 mg, 60 mg	1	
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	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**		
dapagliflozin oral tablet 10 mg, 5 mg	3	ST; QL (30 EA per 30 days)
dapagliflozin propanediol 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**		
dapaglifloz base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-500 mg	3	ST; QL (30 EA per 30 days)
dapaglifloz base-metformin er oral tablet extended release 24 hour 5-1000 mg	3	ST; QL (60 EA per 30 days)
dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg	3	ST; QL (30 EA per 30 days)
dapagliflozin pro-metformin er oral tablet extended release 24 hour 5-1000 mg	3	ST; QL (60 EA per 30 days)
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG	3	ST; QL (60 EA per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	3	ST; QL (60 EA per 30 days)

Drug Name	Tier	Notes
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**		
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
glipizide oral tablet 10 mg, 5 mg	1	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	1	
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	1	
SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS**		
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	2	ST
THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS**		
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	2	ST
THIAZOLIDINEDIONES**		
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		
ANTIDOTES AND SPECIFIC ANTAGONISTS**		
ACETADOTE INTRAVENOUS SOLUTION 200 MG/ML	MB	
ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	
DESFERAL INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
fomepizole intravenous solution 1.5 gm/1.5ml	MB	

Drug Name	Tier	Notes
PROTOPAM CHLORIDE INTRAVENOUS SOLUTION RECONSTITUTED 1 GM	MB	
OPIOID ANTAGONISTS**		
naloxone hcl injection solution 0.4 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 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.)
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 50 MG	4	PA; QL (4 EA per 30 days)

Drug Name	Tier	Notes
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	
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS**		
aprepitant oral capsule 125 mg, 40 mg	4	PA; QL (1 EA per 30 days)
aprepitant oral capsule 80 & 125 mg, 80 mg	4	PA; QL (3 EA per 30 days)
aprepitant oral capsule therapy pack 80 & 125 mg	4	PA; 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**		
griseofulvin microsize oral suspension 125 mg/5ml	2	
griseofulvin ultramicrosize oral tablet 125 mg	4	
nystatin oral tablet 500000 unit	2	

Drug Name	Tier	Notes
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	
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.)

Drug Name	Tier	Notes
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**		
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 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	

Drug Name	Tier	Notes
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	
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	4	ST
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	
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 SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	3	PA; QL (2 ML per 28 days); NDS
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	3	PA; QL (2 ML per 28 days); NDS
ANTIHYPERTENSIVES		
ACE INHIBITOR & CALCIUM CHANNEL BLOCKER COMBINATIONS**		
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	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	

Drug Name	Tier	Notes
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	
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	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	2	

Drug Name	Tier	Notes
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)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	2	
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 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	
TENORETIC 100 ORAL TABLET 100-25 MG	2	

Drug Name	Tier	Notes
TENORETIC 50 ORAL TABLET 50-25 MG	2	
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.**		
CONTEPO INTRAVENOUS SOLUTION RECONSTITUTED 6 GM	MB	
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	
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)
ANTI-INFECTIVE MISC. - COMBINATIONS**		
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	

Drug Name	Tier	Notes
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 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)
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 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	
URINARY ANTI-INFECTIVES**		

Drug Name	Tier	Notes
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)
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	3	
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS**		
FIRDAPSE ORAL TABLET 10 MG	5	PA; LA; QL (240 EA per 30 days); SP
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		
ANTIMYCOBACTERIAL AGENTS**		
isoniazid oral syrup 50 mg/5ml	3	
isoniazid oral tablet 100 mg	2	
isoniazid oral tablet 300 mg	3	
PRIFTIN ORAL TABLET 150 MG	4	
pyrazinamide oral tablet 500 mg	3	
rifabutin oral capsule 150 mg	5	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS**		
busulfan intravenous solution 6 mg/ml	MB	DX (Diagnosis Validation Required)
carboplatin intravenous solution 50 mg/5ml	MB	DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
cisplatin intravenous solution 100 mg/100ml, 50 mg/50ml	MB	DX (Diagnosis Validation Required)
MYLERAN ORAL TABLET 2 MG	5	PA; DX (Diagnosis Validation Required); NDS; SP
oxaliplatin intravenous solution 50 mg/10ml	MB	DX (Diagnosis Validation Required)
thiotepa injection solution reconstituted 15 mg	MB	DX (Diagnosis Validation Required)
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED 4 MG	MB	PA; DX (Diagnosis Validation Required)
ANDROGEN BIOSYNTHESIS INHIBITORS**		
abiraterone acetate oral tablet 250 mg	4	QL (120 EA per 30 days); NDS
ANTIADRENALS**		
LYSODREN ORAL TABLET 500 MG	5	
ANTIANDROGENS**		
bicalutamide oral tablet 50 mg	2	DX (Diagnosis Validation Required)
ERLEADA ORAL TABLET 240 MG	5	PA; DX (Diagnosis Validation Required); QL (1 EA per 1 day); SP
ERLEADA ORAL TABLET 60 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
NUBEQA ORAL TABLET 300 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS
XTANDI ORAL CAPSULE 40 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
XTANDI ORAL TABLET 40 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
XTANDI ORAL TABLET 80 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; 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 Validation Required)
ANTIMETABOLITES**		
capecitabine oral tablet 150 mg, 500 mg	4	DX (Diagnosis Validation Required); NDS
cytarabine (pf) injection solution 100 mg/ml	MB	DX (Diagnosis Validation Required)
fludarabine phosphate intravenous solution 50 mg/2ml	MB	DX (Diagnosis Validation Required)
FOLOTYN INTRAVENOUS SOLUTION 20 MG/ML, 40 MG/2ML	MB	

Drug Name	Tier	Notes
mercaptopurine oral tablet 50 mg	2	DX (Diagnosis Validation Required)
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	2	DX (Diagnosis Validation Required)
methotrexate sodium injection solution 250 mg/10ml, 50 mg/2ml	2	DX (Diagnosis Validation Required)
methotrexate sodium injection solution reconstituted 1 gm	2	DX (Diagnosis Validation Required)
methotrexate sodium oral tablet 2.5 mg	2	DX (Diagnosis Validation Required)
nelarabine intravenous solution 5 mg/ml	MB	DX (Diagnosis Validation Required)
pralatrexate intravenous solution 20 mg/ml, 40 mg/2ml	MB	
TABLOID ORAL TABLET 40 MG	5	PA; DX (Diagnosis Validation Required); NDS; SP
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	3	DX (Diagnosis Validation Required)
XATMEP ORAL SOLUTION 2.5 MG/ML	5	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - ALK INHIBITORS**		
ALECENSA ORAL CAPSULE 150 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (240 EA per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
ALUNBRIG ORAL TABLET 30 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days)
LORBRENA ORAL TABLET 100 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
LORBRENA ORAL TABLET 25 MG	5	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS; SP
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
ANTINEOPLASTIC - ANTI-BCMA ANTIBODY-DRUG COMPLEX**		
BLENREP INTRAVENOUS SOLUTION RECONSTITUTED 70 MG	MB	PA
ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES**		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	PA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES**		
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA; DX (Diagnosis Validation Required)
TRUXIMA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA
ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX**		
BESPONSA INTRAVENOUS SOLUTION RECONSTITUTED 0.9 MG	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD30 ANTIBODY-DRUG COMPLEX**		
ADCETRIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX**		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED 4.5 MG	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES**		
DARZALEX INTRAVENOUS SOLUTION 100 MG/5ML, 400 MG/20ML	MB	PA; DX (Diagnosis Validation Required)
SARCLISA INTRAVENOUS SOLUTION 100 MG/5ML, 500 MG/25ML	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-CD79B ANTIBODY-DRUG COMPLEX**		
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 140 MG	MB	PA; DX (Diagnosis Validation Required)
POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 30 MG	MB	PA; DX (Diagnosis Validation Required); NDS
ANTINEOPLASTIC - ANTI-HER2 AGENTS**		
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	MB	DX (Diagnosis Validation Required)
TUKYSA ORAL TABLET 150 MG, 50 MG	5	PA; LA; DX (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 (Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES**		
LIBTAYO INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
OPDIVO INTRAVENOUS SOLUTION 120 MG/12ML	MB	PA; DX (Diagnosis Validation Required)
TEVIMBRA INTRAVENOUS SOLUTION 100 MG/10ML	MB	PA
ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES**		
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES**		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED 300 MG, 400 MG	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - BCL-2 INHIBITORS**		
VENCLEXTA ORAL TABLET 10 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days)
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	5	PA; LA; DX (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
bosutinib oral tablet 100 mg	5	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); SP
bosutinib oral tablet 400 mg, 500 mg	5	PA; DX (Diagnosis Validation Required); 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); NDS; SP
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 (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
nilotinib d-tartrate oral capsule 150 mg, 200 mg, 50 mg	5	PA; QL (4 EA per 1 day); NDS; SP
nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg	5	PA; QL (120 EA per 30 days); NDS; SP
ANTINEOPLASTIC - BISPECIFIC T-CELL ENGAGERS**		

Drug Name	Tier	Notes
LUNSUMIO VELO SUBCUTANEOUS SOLUTION 45 MG/ML, 5 MG/0.5ML	MB	
ANTINEOPLASTIC - BRAF KINASE INHIBITORS**		
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS; SP
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
ZELBORAF ORAL TABLET 240 MG	5	PA; DX (Diagnosis Validation Required); QL (240 EA per 30 days); NDS; SP
ANTINEOPLASTIC - BTK INHIBITORS**		
BRUKINSA ORAL CAPSULE 80 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
BRUKINSA ORAL TABLET 160 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
CALQUENCE ORAL TABLET 100 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (1 EA per 1 day); NDS
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA; LA; DX (Diagnosis Validation Required); QL (6 ML per 1 day); NDS
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (28 EA per 28 days)
JAYPIRCA ORAL TABLET 100 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); SP
JAYPIRCA ORAL TABLET 50 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
ANTINEOPLASTIC - EGFR INHIBITORS**		
ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML, 200 MG/100ML	MB	PA; DX (Diagnosis Validation Required)
erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
gefitinib oral tablet 250 mg	5	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days)

Drug Name	Tier	Notes
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
ANTINEOPLASTIC - FGFR KINASE INHIBITORS**		
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	5	PA; DX (Diagnosis Validation Required); SP
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (14 EA per 21 days)
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS**		
DAURISMO ORAL TABLET 100 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
DAURISMO ORAL TABLET 25 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
ERIVEDGE ORAL CAPSULE 150 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
ODOMZO ORAL CAPSULE 200 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); SP
ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS**		
ZOLINZA ORAL CAPSULE 100 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
ANTINEOPLASTIC - IMMUNOMODULATORS**		
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	5	PA; QL (21 EA per 28 days); NDS; SP
ANTINEOPLASTIC - KRAS INHIBITORS**		
KRAZATI ORAL TABLET 200 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS
LUMAKRAS ORAL TABLET 120 MG	5	PA; DX (Diagnosis Validation Required); QL (8 EA per 1 day); NDS; SP
LUMAKRAS ORAL TABLET 320 MG	5	PA; DX (Diagnosis Validation Required); QL (3 EA per 1 day); SP
ANTINEOPLASTIC - MEK INHIBITORS**		

Drug Name	Tier	Notes
MEKINIST ORAL TABLET 0.5 MG	5	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); NDS; SP
MEKINIST ORAL TABLET 2 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
MEKTOVI ORAL TABLET 15 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (180 EA per 30 days)
ANTINEOPLASTIC - MET INHIBITORS**		
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
ANTINEOPLASTIC - METHYLTRANSFERASE INHIBITORS**		
TAZVERIK ORAL TABLET 200 MG	5	PA; LA; DX (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 (Diagnosis Validation Required); NDS; SP
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	5	PA; DX (Diagnosis Validation Required); NDS; SP
TORISEL INTRAVENOUS SOLUTION 25 MG/ML	MB	DX (Diagnosis Validation Required)
ANTINEOPLASTIC - MULTIKINASE INHIBITORS**		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
CAPRELSA ORAL TABLET 100 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (30 EA per 30 days)
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA; LA; DX (Diagnosis Validation Required)
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA; LA; DX (Diagnosis Validation Required)
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA; LA; DX (Diagnosis Validation Required)
lapatinib ditosylate oral tablet 250 mg	5	PA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); NDS; SP
NERLYNX ORAL TABLET 40 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (180 EA per 30 days); SP

Drug Name	Tier	Notes
pazopanib hcl oral tablet 200 mg	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
QINLOCK ORAL TABLET 50 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (90 EA per 30 days)
RYDAPT ORAL CAPSULE 25 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days)
sorafenib tosylate oral tablet 200 mg	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); SP
STIVARGA ORAL TABLET 40 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	5	PA; DX (Diagnosis Validation Required); NDS; SP
XOSPATA ORAL TABLET 40 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (90 EA per 30 days)
ANTINEOPLASTIC - MULTIPLE RECEPTOR ANTIBODIES**		
RYBREVANT INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS**		
AYVAKIT ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
ANTINEOPLASTIC - RET INHIBITORS**		
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (2 EA per 1 day); NDS
RETEVMO ORAL TABLET 40 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (3 EA per 1 day); NDS
ANTINEOPLASTIC - TROPOMYOSIN RECEPTOR KINASE INHIBITORS**		
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG	5	PA; DX (Diagnosis Validation Required); NDS; SP
ANTINEOPLASTIC - XPO1 INHIBITORS**		
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (8 EA per 28 days)
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (8 EA per 28 days)
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (4 EA per 28 days)
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; LA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG	5	PA; DX (Diagnosis Validation Required); QL (4 EA per 28 days); NDS; SP
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (4 EA per 28 days)
ANTINEOPLASTIC ANTIBIOTICS**		
bleomycin sulfate injection solution reconstituted 15 unit	MB	DX (Diagnosis Validation Required)
ELLENCE INTRAVENOUS SOLUTION 200 MG/100ML	MB	DX (Diagnosis Validation Required)
IDAMYCIN PFS INTRAVENOUS SOLUTION 5 MG/5ML	MB	DX (Diagnosis Validation Required)
mitomycin intravenous solution reconstituted 5 mg	MB	DX (Diagnosis Validation Required)
mitoxantrone hcl intravenous concentrate 25 mg/12.5ml	MB	DX (Diagnosis Validation Required)
valrubicin intravesical solution 40 mg/ml	MB	DX (Diagnosis Validation Required)
ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES**		
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA; DX (Diagnosis Validation Required)
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG	MB	PA; DX (Diagnosis Validation Required)
ANTINEOPLASTIC COMBINATIONS**		
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1800-30000 MG-UT/15ML	MB	PA; DX (Diagnosis Validation Required)
INQOVI ORAL TABLET 35-100 MG	5	PA; DX (Diagnosis Validation Required); QL (5 EA per 28 days); NDS; SP
KEYTRUDA QLEX SUBCUTANEOUS SOLUTION 395-4800 MG -UNT/2.4ML, 790-9600 MG -UNT/4.8ML	MB	PA; DX (Diagnosis Validation Required)
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA; DX (Diagnosis Validation Required); QL (40 EA per 28 days); SP
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 300-5000 MG -UT/2.5ML	MB	SP
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 600-10000 MG-UT/5ML	MB	PA; DX (Diagnosis Validation Required)
RYBREVANT FASPRO SUBCUTANEOUS SOLUTION 1600-20000 MG-UT/10ML, 2240-28000 MG-UT/14ML	MB	PA; SP
RYBREVANT FASPRO SUBCUTANEOUS SOLUTION 2400-30000 MG-UT/15ML, 3520-44000 MG-UT/22ML	MB	
TECENTRIQ HYBREZA SUBCUTANEOUS SOLUTION 1875-30000 MG-UT/15ML	MB	PA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
VYXEOS INTRAVENOUS SUSPENSION RECONSTITUTED 44-100 MG	MB	PA
ANTINEOPLASTIC ENZYMES**		
ONCASPAR INJECTION SOLUTION 750 UNIT/ML	MB	PA; DX (Diagnosis Validation Required); NDS
ANTINEOPLASTICS - PHOTOACTIVATED AGENTS**		
PHOTOFRIN INTRAVENOUS SOLUTION RECONSTITUTED 75 MG	MB	
ANTINEOPLASTICS MISC.**		
dacarbazine intravenous solution reconstituted 100 mg	MB	DX (Diagnosis Validation Required)
hydroxyurea oral capsule 500 mg	2	DX (Diagnosis Validation Required)
MATULANE ORAL CAPSULE 50 MG	5	PA; DX (Diagnosis Validation Required); SP
NIPENT INTRAVENOUS SOLUTION RECONSTITUTED 10 MG	MB	DX (Diagnosis Validation Required)
TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML	MB	DX (Diagnosis Validation Required)
AROMATASE INHIBITORS**		
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 hcl intravenous solution reconstituted 250 mg	MB	
dexrazoxane intravenous solution reconstituted 250 mg	MB	
CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS**		

Drug Name	Tier	Notes
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA; DX (Diagnosis Validation Required); QL (21 EA per 28 days); NDS; SP
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	5	PA; DX (Diagnosis Validation Required); QL (21 EA per 28 days); NDS; SP
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (21 EA per 28 days)
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (42 EA per 28 days)
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (63 EA per 28 days)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); 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	
VYKOURA INJECTION SOLUTION 350 MG/35ML, 50 MG/5ML, 500 MG/50ML	MB	
IMIDAZOTETRAZINES**		
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 250 mg, 5 mg	4	PA; DX (Diagnosis Validation Required); NDS
temozolomide oral capsule 20 mg	4	PA; DX (Diagnosis Validation Required)
ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS**		
TIBSOVO ORAL TABLET 250 MG	5	PA; LA; DX (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 (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
LHRH ANALOGS**		
leuprolide acetate injection kit 1 mg/0.2ml	MB	DX (Diagnosis Validation Required)
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 7.5 MG	MB	DX (Diagnosis Validation Required)
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	MB	DX (Diagnosis Validation Required)
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	MB	DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	MB	PA; DX (Diagnosis Validation Required)
MITOTIC INHIBITORS**		
docetaxel intravenous concentrate 160 mg/8ml, 20 mg/ml, 80 mg/4ml	MB	DX (Diagnosis Validation Required)
ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	DX (Diagnosis Validation Required)
etoposide oral capsule 50 mg	4	DX (Diagnosis Validation Required)
IXEMPRA KIT INTRAVENOUS SOLUTION RECONSTITUTED 15 MG, 45 MG	MB	DX (Diagnosis Validation Required)
vinblastine sulfate intravenous solution 1 mg/ml	MB	DX (Diagnosis Validation Required)
NITROGEN MUSTARDS AND RELATED ANALOGUES**		
cyclophosphamide injection solution reconstituted 1 gm	MB	DX (Diagnosis Validation Required)
cyclophosphamide intravenous solution 1 gm/5ml, 500 mg/2.5ml	MB	
cyclophosphamide oral capsule 25 mg, 50 mg	4	DX (Diagnosis Validation Required)
IFEX INTRAVENOUS SOLUTION RECONSTITUTED 1 GM	MB	DX (Diagnosis Validation Required)
LEUKERAN ORAL TABLET 2 MG	5	PA; DX (Diagnosis Validation Required); NDS; SP
NITROSOUREAS**		
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	4	PA; DX (Diagnosis Validation Required)
PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS**		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days)
ITOVEBI ORAL TABLET 3 MG	5	PA; DX (Diagnosis Validation Required); QL (2 EA per 1 day); NDS; SP
ITOVEBI ORAL TABLET 9 MG	5	PA; DX (Diagnosis Validation Required); QL (1 EA per 1 day); NDS; SP
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA; DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA; DX (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 (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA; LA; DX (Diagnosis Validation Required); QL (60 EA per 30 days)

Drug Name	Tier	Notes
POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS**		
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
PROGESTINS-ANTINEOPLASTIC**		
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 (Diagnosis Validation Required); QL (30 EA per 30 days); SP
ORSERDU ORAL TABLET 86 MG	5	PA; DX (Diagnosis Validation Required); QL (90 EA per 30 days); SP
SELECTIVE RETINOID X RECEPTOR AGONISTS**		
bexarotene oral capsule 75 mg	5	PA; DX (Diagnosis Validation Required); NDS; SP
TOPOISOMERASE I INHIBITORS**		
CAMPTOSAR INTRAVENOUS SOLUTION 40 MG/2ML	MB	DX (Diagnosis Validation Required)
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG	5	PA; DX (Diagnosis Validation Required); NDS; 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 (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP

Drug Name	Tier	Notes
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA; DX (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 (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 (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 (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 (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 (Diagnosis Validation Required); QL (90 EA per 30 days); SP
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA; DX (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 (Diagnosis Validation Required); QL (60 EA per 30 days); SP
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS**		
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.)
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.)

Drug Name	Tier	Notes
ANTIPARKINSON DOPAMINERGICS**		
amantadine hcl oral capsule 100 mg	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
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**		

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); NDS; 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.)
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.)

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 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)
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); SP
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**		
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)

Drug Name	Tier	Notes
FANAPT TITRATION PACK A 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); NDS
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); NDS
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); NDS

Drug Name	Tier	Notes
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); NDS
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); NDS
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); NDS
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); NDS

Drug Name	Tier	Notes
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); NDS
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); NDS
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); NDS

Drug Name	Tier	Notes
risperidone oral solution 1 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 (480 ML per 30 days); AL (Min 5 Years)
risperidone oral tablet 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 (90 EA per 30 days); AL (Min 5 Years)
risperidone oral tablet 0.5 mg, 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 (60 EA per 30 days); AL (Min 5 Years)
risperidone oral tablet 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 (120 EA per 30 days); AL (Min 5 Years)

Drug Name	Tier	Notes
risperidone oral tablet dispersible 0.25 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 5 Years)
risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 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 5 Years)
risperidone oral tablet dispersible 4 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); 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost 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 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.)
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**		

Drug Name	Tier	Notes
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	BH (Formulary prescription drugs used for the treatment of mental illness, behavioral health or substance use may be covered at zero cost share. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (750 ML per 30 days); AL (Min 6 Years)
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	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
aripiprazole oral tablet dispersible 10 mg, 15 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 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); NDS
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); NDS

Drug Name	Tier	Notes
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); NDS
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); NDS
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**		
olanzapine oral tablet 10 mg, 15 mg, 2.5 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 (30 EA per 30 days); AL (Min 6 Years)

Drug Name	Tier	Notes
olanzapine oral tablet dispersible 10 mg, 15 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.); 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**		
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)

Drug Name	Tier	Notes
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)
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)

Drug Name	Tier	Notes
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)
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)

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

Drug Name	Tier	Notes
lamivudine-zidovudine oral tablet 150-300 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
ODEFSEY ORAL TABLET 200-25-25 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
PREZCOBIX ORAL TABLET 675-150 MG	$0	$0 (Zero Dollar Copay); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually 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
PREZCOBIX ORAL TABLET 800-150 MG	$0	$0 (Zero Dollar Copay); STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans. Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
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 - CAPSID INHIBITORS**		
YEZTUGO ORAL TABLET 300 MG	$0	
YEZTUGO SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML	$0	
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)

Drug Name	Tier	Notes
SELZENTRY ORAL SOLUTION 20 MG/ML	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR**		
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML	MB	
ANTIRETROVIRALS - GP120-DIRECTED ATTACHMENT INHIBITOR**		
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
ANTIRETROVIRALS - INTEGRASE INHIBITORS**		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML	$0	
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 50 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	$0	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (180 EA per 30 days); AL (Max 12 Years)
ANTIRETROVIRALS - PROTEASE INHIBITORS**		
APTIVUS ORAL CAPSULE 250 MG	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (120 EA per 30 days)
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)

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

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

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

Drug Name	Tier	Notes
emtricitabine oral capsule 200 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
lamivudine oral solution 10 mg/ml	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (900 ML per 30 days)
lamivudine oral tablet 150 mg	$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	
zidovudine oral capsule 100 mg	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); QL (60 EA per 30 days)
zidovudine oral syrup 50 mg/5ml	$0	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); 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)

Drug Name	Tier	Notes
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)
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**		

Drug Name	Tier	Notes
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	4	$0 ($0 Copay); QL (40 EA per 365 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	4	$0 ($0 Copay); QL (60 EA per 365 days)
CMV AGENTS**		
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)
HEPATITIS B AGENTS**		
entecavir oral tablet 0.5 mg, 1 mg	5	PA; QL (30 EA per 30 days); NDS; SP
lamivudine oral tablet 100 mg	2	QL (30 EA per 30 days)
VEMLIDY ORAL TABLET 25 MG	5	QL (30 EA per 30 days); NDS; SP
HEPATITIS C AGENT - COMBINATIONS**		
MAVYRET ORAL PACKET 50-20 MG	5	PA; QL (150 EA per 30 days); NDS; SP
MAVYRET ORAL TABLET 100-40 MG	5	PA; QL (3 EA per 1 day); NDS; SP
sofosbuvir-velpatasvir oral tablet 400-100 mg	5	PA; QL (84 EA per 365 days); NDS; SP
HEPATITIS C AGENTS**		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	PA; NDS; 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; NDS
ribavirin oral tablet 200 mg	4	PA; NDS
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.)

Drug Name	Tier	Notes
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.)
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**		

Drug Name	Tier	Notes
rimantadine hcl oral tablet 100 mg	3	
MISC. ANTIVIRALS**		
LAGEVRIO ORAL CAPSULE 200 MG	4	QL (80 EA per 365 days)
VEKLURY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	
NEURAMINIDASE INHIBITORS**		
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)
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**		
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**		

Drug Name	Tier	Notes
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	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	
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, 34 mg, 8.5 mg	4	ST; QL (30 EA per 30 days)
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	
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**		

Drug Name	Tier	Notes
digoxin oral tablet 125 mcg, 250 mcg	2	
LANOXIN INJECTION SOLUTION 0.25 MG/ML	MB	
INOTROPES**		
dobutamine hcl intravenous solution 12.5 mg/ml, 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)
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	2	QL (60 EA per 30 days)
PERIPHERAL VASODILATORS**		
papaverine hcl injection solution 30 mg/ml	4	PA
PROSTAGLANDIN VASODILATORS**		
treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 50 mg/20ml	MB	PA
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS**		
ambrisentan oral tablet 10 mg, 5 mg	5	PA; QL (30 EA per 30 days); NDS; SP
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS**		
sildenafil citrate oral tablet 20 mg	4	QL (90 EA per 30 days)
tadalafil (pah) oral tablet 20 mg	1	
CEPHALOSPORINS		
CEPHALOSPORIN COMBINATIONS**		
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	

Drug Name	Tier	Notes
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 tablet 250 mg, 500 mg	2	
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	
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	
ceftriaxone sodium intravenous solution reconstituted 1 gm, 2 gm	MB	
CEPHALOSPORINS - 5TH GENERATION**		
ceftaroline fosamil intravenous solution reconstituted 400 mg, 600 mg	MB	

Drug Name	Tier	Notes
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	MB	
CONTRACEPTIVES		
BIPHASIC CONTRACEPTIVES - ORAL**		
AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	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	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG	4	PA
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	
alyacen 1/35 oral tablet 1-35 mg-mcg	$0	
APRI ORAL TABLET 0.15-30 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	
AUROVELA FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
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	
BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
briellyn oral tablet 0.4-35 mg-mcg	2	
CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG	$0	
DASETTA 1/35 (28) ORAL TABLET 1-35 MG-MCG	$0	
DELYLA ORAL TABLET 0.1-20 MG-MCG	$0	

Drug Name	Tier	Notes
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	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	$0	
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	$0	
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	
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	
HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	$0	
JASMIEL ORAL TABLET 3-0.02 MG	2	
JULEBER ORAL TABLET 0.15-30 MG-MCG	$0	
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	
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
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	
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	
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
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	
LORYNA ORAL TABLET 3-0.02 MG	2	
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	$0	
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 FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	$0	
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	$0	
MILI ORAL TABLET 0.25-35 MG-MCG	$0	
MONO-LINYAH ORAL TABLET 0.25-35 MG-MCG	$0	
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
NECON 1/35 (28) ORAL TABLET 1-35 MG-MCG	$0	
NIKKI ORAL TABLET 3-0.02 MG	2	
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	$0	
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	
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	2	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	$0	
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	$0	
ORSYTHIA ORAL TABLET 0.1-20 MG-MCG	$0	
PHILITH ORAL TABLET 0.4-35 MG-MCG	2	
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	2	
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	$0	
SOLIA ORAL TABLET 0.15-30 MG-MCG	$0	
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	$0	

Drug Name	Tier	Notes
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	
WERA ORAL TABLET 0.5-35 MG-MCG	2	
WYMZYA FE ORAL TABLET CHEWABLE 0.4-35 MG-MCG	2	
ZUMANDIMINE ORAL TABLET 3-0.03 MG	2	
COMBINATION CONTRACEPTIVES - TRANSDERMAL**		
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	$0	
XULANE TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR	$0	
ZAFEMY TRANSDERMAL PATCH WEEKLY 150-35 MCG/24HR	$0	
COMBINATION CONTRACEPTIVES - VAGINAL**		
ELURYNG VAGINAL RING 0.12-0.015 MG/24HR	$0	
ENILLORING VAGINAL RING 0.12-0.015 MG/24HR	$0	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	$0	
HALOETTE VAGINAL RING 0.12-0.015 MG/24HR	$0	
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	
EMERGENCY CONTRACEPTIVES**		
AFTERA ORAL TABLET 1.5 MG	$0	
ELLA ORAL TABLET 30 MG	$0	
levonorgestrel oral tablet 1.5 mg	$0	
MY WAY ORAL TABLET 1.5 MG	$0	
OPCICON ONE-STEP ORAL TABLET 1.5 MG	$0	

Drug Name	Tier	Notes
TAKE ACTION ORAL TABLET 1.5 MG	$0	
EXTENDED-CYCLE CONTRACEPTIVES - ORAL**		
ASHLYNA ORAL TABLET 0.15-0.03 &0.01 MG	$0	
CAMRESE LO ORAL TABLET 0.1-0.02 & 0.01 MG	$0	
CAMRESE ORAL TABLET 0.15-0.03 &0.01 MG	$0	
DAYSEE ORAL TABLET 0.15-0.03 &0.01 MG	$0	
ICLEVIA ORAL TABLET 0.15-0.03 MG	$0	
INTROVALE ORAL TABLET 0.15-0.03 MG	$0	
JAIMIESS ORAL TABLET 0.15-0.03 &0.01 MG	$0	
JOLESSA ORAL TABLET 0.15-0.03 MG	$0	
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 &0.01 mg, 0.15-0.03 mg	$0	
LOJAIMIESS ORAL TABLET 0.1-0.02 & 0.01 MG	$0	
SETLAKIN ORAL TABLET 0.15-0.03 MG	$0	
SIMPESSE ORAL TABLET 0.15-0.03 &0.01 MG	$0	
PROGESTIN CONTRACEPTIVES - IMPLANTS**		
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG	$0	QL (1 EA per 5 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	
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/DAY, 21 MCG/DAY	$0	QL (1 EA per 8 Years)
PROGESTIN CONTRACEPTIVES - ORAL**		
CAMILA ORAL TABLET 0.35 MG	$0	
DEBLITANE ORAL TABLET 0.35 MG	$0	
ERRIN ORAL TABLET 0.35 MG	$0	
HEATHER ORAL TABLET 0.35 MG	$0	
JENCYCLA ORAL TABLET 0.35 MG	$0	

Drug Name	Tier	Notes
LYLEQ ORAL TABLET 0.35 MG	$0	
LYZA ORAL TABLET 0.35 MG	$0	
NORA-BE ORAL TABLET 0.35 MG	$0	
norethindrone oral tablet 0.35 mg	$0	
NORLYDA ORAL TABLET 0.35 MG	$0	
NORLYROC ORAL TABLET 0.35 MG	$0	
OPILL ORAL TABLET 0.075 MG	$0	
SHAROBEL ORAL TABLET 0.35 MG	$0	
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	
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	
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	$0	
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	$0	
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	
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	
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	
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	
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	

Drug Name	Tier	Notes
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	
TRINESSA (28) ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	$0	
TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG	$0	
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	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	$0	
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS**		
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	
hydrocortisone sod suc (pf) injection solution reconstituted 100 mg	MB	
KENALOG-40 INJECTION SUSPENSION 40 MG/ML	MB	
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	

Drug Name	Tier	Notes
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-MEDROL (PF) INJECTION SOLUTION RECONSTITUTED 1000 MG, 125 MG, 40 MG, 500 MG	MB	
SOLU-MEDROL INJECTION SOLUTION RECONSTITUTED 1000 MG, 2 GM, 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**		
guaiatussin ac oral syrup 100-10 mg/5ml	2	PA; AL (Min 12 Years)
guaifenesin-codeine oral solution 100-10 mg/5ml	2	PA; 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; AL (Min 12 Years)
DERMATOLOGICALS		
ACNE ANTIBIOTICS**		
clindamycin phos (once-daily) external gel 1 %	2	QL (60 ML per 30 days)
clindamycin phos (twice-daily) 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	

Drug Name	Tier	Notes
sulfacetamide sodium (acne) external lotion 10 %	4	
ACNE COMBINATIONS**		
benzoyl peroxide-erythromycin external gel 5-3 %	2	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-5 %	4	
sulfacetamide sodium-sulfur external cream 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	AL (Max 40 Years)
adapalene external gel 0.1 %	2	AL (Max 40 Years)
AMNESTEEM ORAL CAPSULE 10 MG	4	
AMNESTEEM ORAL CAPSULE 20 MG, 40 MG	4	AL (Max 40 Years)
AZELEX EXTERNAL CREAM 20 %	4	
benzoyl peroxide wash external liquid 10 %	2	
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	4	QL (60 EA per 30 days)
isotretinoin oral capsule 10 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg	4	QL (60 EA per 30 days); AL (Min 12 Years)
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	2	AL (Max 40 Years)
tretinoin external gel 0.01 %, 0.025 %	2	AL (Max 40 Years)
ZENATANE ORAL CAPSULE 10 MG	4	QL (60 EA per 30 days)
ZENATANE ORAL CAPSULE 20 MG, 30 MG, 40 MG	4	QL (60 EA per 30 days); AL (Max 40 Years)
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS**		
VEREGEN EXTERNAL OINTMENT 15 %	4	PA; QL (15 GM per 30 days)
ANTIBIOTICS - TOPICAL**		
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	
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	

Drug Name	Tier	Notes
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	
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); NDS; SP
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
IMULDOSA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 ML per 56 days); SP
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 kit per 84 days); NDS; SP
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 kit per 84 days); NDS; SP
STEQEYMA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; QL (0.5 ML per 84 days); SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
STEQEYMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 ML per 56 days); SP
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML	5	PA; DX (Diagnosis Validation Required); QL (0.25 ML per 28 days); NDS; SP
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 28 days); NDS; SP

Drug Name	Tier	Notes
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 ML per 28 days); NDS; SP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5	PA; DX (Diagnosis Validation Required); QL (0.5 ML per 84 days); SP
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 ML per 56 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 %, 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; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML	5	PA; DX (Diagnosis Validation Required); QL (2.28 ML per 28 days); NDS; SP
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
BURN PRODUCTS**		
silver sulfadiazine external cream 1 %	2	
CORTICOSTEROIDS - TOPICAL**		
alclometasone dipropionate external cream 0.05 %	2	

Drug Name	Tier	Notes
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 prop emollient base external cream 0.05 %	2	QL (60 GM per 30 days)
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)
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	
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	QL (60 GM per 30 days)
halobetasol propionate external cream 0.05 %	2	

Drug Name	Tier	Notes
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	
mometasone furoate external cream 0.1 %	2	
mometasone furoate external ointment 0.1 %	2	
mometasone furoate external solution 0.1 %	2	
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**		
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**		

Drug Name	Tier	Notes
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 solution 4 %	2	
MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL**		
pimecrolimus external cream 1 %	4	QL (120 GM per 365 days); AL (Min 2 Years)
tacrolimus external ointment 0.03 %, 0.1 %	4	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	
LEVULAN KERASTICK EXTERNAL SOLUTION RECONSTITUTED 20 %	MB	
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	
SCABICIDES & PEDICULICIDES**		
ivermectin external lotion 0.5 %	4	ST
malathion external lotion 0.5 %	4	ST; QL (60 ML per 90 days)
permethrin external cream 5 %	2	
TOPICAL ANESTHETIC COMBINATIONS**		

Drug Name	Tier	Notes
ANECREAM EXTERNAL KIT 4 %	4	
lidocaine-prilocaine external cream 2.5-2.5 %	4	
LIDOCREAM EXTERNAL KIT 4 %	4	
TOPICAL STEROID COMBINATIONS**		
calcipotriene-betameth diprop external ointment 0.005-0.064 %	4	
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC DRUGS**		
CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG	MB	
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	MB	QL (1 Course per 1 Lifetime); SP
DIAGNOSTIC TESTS**		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP	2	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK GUIDE TEST IN VITRO STRIP	2	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
ACCU-CHEK SMARTVIEW IN VITRO STRIP	2	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
KETOSTIX IN VITRO STRIP	3	
RADIOGRAPHIC CONTRAST MEDIA - IRON OXIDE**		
FERABRIGHT INTRAVENOUS SOLUTION 300 MG/10ML, 510 MG/17ML	MB	
DIGESTIVE AIDS		
DIGESTIVE ENZYMES**		

Drug Name	Tier	Notes
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**		
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	
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	

Drug Name	Tier	Notes
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	1	
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS**		
mifepristone oral tablet 200 mg	$0	
BISPHOSPHONATES**		
alendronate sodium oral tablet 10 mg, 35 mg, 70 mg	2	
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**		
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	
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); NDS; SP
ORILISSA ORAL TABLET 200 MG	5	PA; QL (60 EA per 30 days); NDS; SP
GROWTH HORMONES**		
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	5	PA; NDS; SP
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS**		

Drug Name	Tier	Notes
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; NDS; SP
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS**		
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 30 MG	MB	
SUPPRELIN LA SUBCUTANEOUS KIT 50 MG	MB	
NEUROKININ 3 (NK3) RECEPTOR ANTAGONISTS**		
VEOZAH ORAL TABLET 45 MG	4	PA; QL (2 EA per 1 day); AL (Min 18 Years); NDS
PARATHYROID HORMONE AND DERIVATIVES**		
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML	5	PA; NDS; SP
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	5	PA; NDS; SP
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5	PA; NDS; 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
RANK LIGAND (RANKL) INHIBITORS**		
BOSAYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	

Drug Name	Tier	Notes
ENOBY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	
JUBBONTI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	SP
WYOST SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	SP
XTRENBO SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	
SCLEROSTIN INHIBITORS**		
EVENITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 105 MG/1.17ML	MB	PA; SP
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)**		
raloxifene hcl oral tablet 60 mg	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	
VASOPRESSIN**		
DDAVP INJECTION SOLUTION 4 MCG/ML	MB	
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 & 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	
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	

Drug Name	Tier	Notes
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, 0.075 MG/24HR, 0.1 MG/24HR	4	QL (8 EA per 28 days)
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML	MB	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML	MB	
DOTTI TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	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	
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)
ESTROGEL TRANSDERMAL GEL 0.75 MG/1.25 GM (0.06%)	4	
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	QL (8 EA per 28 days)
PREMARIN INJECTION SOLUTION RECONSTITUTED 25 MG	MB	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	
FLUOROQUINOLONES		
FLUOROQUINOLONES**		

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 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	
levofloxacin in d5w intravenous solution 250 mg/50ml	MB	
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.)

Drug Name	Tier	Notes
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.)
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	
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**		
IMULDOSA INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA; DX (Diagnosis Validation Required)
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	MB	PA; DX (Diagnosis Validation Required); QL (30 ML per 365 days)

Drug Name	Tier	Notes
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	5	PA; DX (Diagnosis Validation Required); QL (1.2 ML per 56 days); NDS; SP
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	5	PA; DX (Diagnosis Validation Required); QL (2.4 ML per 56 days); NDS; SP
STEQEYMA INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA; DX (Diagnosis Validation Required)
YESINTEK INTRAVENOUS SOLUTION 130 MG/26ML	MB	PA; DX (Diagnosis Validation Required)
INTESTINAL ACIDIFIERS**		
generlac oral solution 10 gm/15ml	2	
lactulose encephalopathy oral solution 10 gm/15ml	2	
PHOSPHATE BINDER AGENTS**		
calcium acetate (phos binder) oral capsule 667 mg	2	
calcium acetate (phos binder) oral tablet 667 mg	2	
ferric citrate oral tablet 1 gm 210 mg(fe)	5	PA; QL (12 EA per 1 day)
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)
sevelamer carbonate oral tablet 800 mg	5	
sevelamer hcl oral tablet 400 mg	3	
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 (Diagnosis Validation Required)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG	5	PA; DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (3 EA per 28 days); NDS; SP
GENITOURINARY AGENTS - MISCELLANEOUS		
5-ALPHA REDUCTASE INHIBITORS**		
dutasteride oral capsule 0.5 mg	4	

Drug Name	Tier	Notes
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**		
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	2	
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**		
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT	5	PA; NDS
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	5	PA; NDS
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT	5	PA; NDS
FIBRYGA INTRAVENOUS SOLUTION RECONSTITUTED	MB	

Drug Name	Tier	Notes
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT	5	PA; NDS
KCENTRA INTRAVENOUS KIT 1000 UNIT, 500 UNIT	MB	
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	5	PA; NDS
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	5	PA; NDS
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	5	PA; NDS
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG	5	PA; NDS
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	5	PA; NDS
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	5	PA; NDS
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit	5	PA; NDS
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	5	PA; NDS
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	5	PA; NDS
BRADYKININ B2 RECEPTOR ANTAGONISTS**		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	5	PA; QL (18 ML per 28 days); NDS; SP
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML	5	PA; QL (18 ML per 28 days); NDS; SP
C1 ESTERASE INHIBITORS**		
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	MB	PA; NDS; SP
COMPLEMENT C5 INHIBITORS**		
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA; DX (Diagnosis Validation Required)
ULTOMIRIS INTRAVENOUS SOLUTION 1100 MG/11ML, 300 MG/3ML	MB	PA; DX (Diagnosis Validation Required)
COMPLEMENT MASP-2 INHIBITORS**		
YARTEMLEA INTRAVENOUS SOLUTION 370 MG/2ML	MB	SP

Drug Name	Tier	Notes
DIRECT-ACTING P2Y12 INHIBITORS**		
ticagrelor oral tablet 60 mg, 90 mg	2	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	
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**		
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); NDS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (2 ML per 28 days); NDS; SP
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	5	PA; QL (4 ML per 28 days); NDS; SP
PLATELET AGGREGATION INHIBITOR COMBINATIONS**		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	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, 5 mg	2	

Drug Name	Tier	Notes
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; NDS
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML	MB	PA; NDS
RETACRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA; QL (12 ML per 28 days); NDS; SP
RETACRIT INJECTION SOLUTION 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML	MB	PA; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	MB	PA; QL (4 ML per 28 days)
FOLIC ACID/FOLATES**		
cvs folic acid oral tablet 800 mcg	$0	AL (Max 55 Years)
folic acid oral tablet 1 mg	2	
folic acid oral tablet 400 mcg, 800 mcg	$0	AL (Max 55 Years)
gnp folic acid oral tablet 400 mcg	$0	AL (Max 55 Years)
kp folic acid oral tablet 800 mcg	$0	AL (Max 55 Years)
yl folic acid oral tablet 400 mcg	$0	AL (Max 55 Years)
GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)**		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; NDS; SP
NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML	MB	
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; NDS; SP
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML	MB	PA; NDS; SP
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	MB	PA; NDS; SP
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; NDS; SP

Drug Name	Tier	Notes
IRON**		
ferretts ips oral solution 40 mg/15ml	$0	AL (Max 12 Years)
FERRIMIN 150 ORAL TABLET 150 MG	$0	AL (Max 12 Years)
ferumoxytol intravenous solution 510 mg/17ml	MB	
INJECTAFER INTRAVENOUS SOLUTION 100 MG/2ML	MB	
NOVAFERRUM PEDIATRIC DROPS ORAL LIQUID 15 MG/ML	$0	AL (Max 12 Years)
THROMBOPOIETIN (TPO) RECEPTOR AGONISTS**		
MULPLETA ORAL TABLET 3 MG	5	PA; QL (7 EA per 7 days); NDS; 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	
tranexamic acid oral tablet 650 mg	2	QL (30 EA per 30 days)
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS**		
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)

Drug Name	Tier	Notes
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.)
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)

Drug Name	Tier	Notes
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**		
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)

Drug Name	Tier	Notes
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**		
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)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	$0	
peg-3350/electrolytes oral solution reconstituted 236 gm	2	QL (8000 ML per 30 days)
PEG-PREP ORAL KIT 5-210 MG-GM	4	

Drug Name	Tier	Notes
ELECTROLYTE-BASED OSMOTIC LAXATIVES**		
magnesium citrate oral solution 1.745 gm/30ml	2	
LAXATIVES - MISCELLANEOUS**		
lactulose oral solution 10 gm/15ml, 20 gm/30ml	2	
peg 3350 oral powder 17 gm/scoop	2	
polyethylene glycol 3350 oral powder 17 gm/scoop	2	
LOCAL ANESTHETICS-PARENTERAL		
LOCAL ANESTHETICS - AMIDES**		
EXPAREL INJECTION SUSPENSION 1.3 %	MB	
NAROPIN INJECTION SOLUTION 2 MG/ML	MB	
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**		

Drug Name	Tier	Notes
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	2	
clarithromycin oral tablet 250 mg, 500 mg	2	
ERYTHROMYCINS**		
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML	4	PA; STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.); AL (Max 12 Years)
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 oral tablet delayed release 250 mg, 333 mg, 500 mg	4	STI (Formulary prescription drugs used for the prevention or treatment of sexually transmitted infections will be covered at zero cost share. Cost sharing applies for non-sexually transmitted infections. * High Deductible Health Plan copays/coinsurances are subject to deductible first. Coverage at no cost share is subject to applicable benefit plans.)
FIDAXOMICIN**		
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	5	PA; QL (10 ML per 1 day)
MEDICAL DEVICES AND SUPPLIES		

Drug Name	Tier	Notes
CERVICAL CAPS**		
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM	$0	
CONDOMS - FEMALE**		
FC2 FEMALE CONDOM	$0	
CONDOMS - MALE**		
condoms	$0	
DUREX REALFEEL DEVICE	$0	
premium condoms lubricated	$0	
TROJAN	$0	
DIAPHRAGMS**		
CAYA VAGINAL DIAPHRAGM	$0	
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM	$0	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 %	$0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 %	$0	
GLUCOSE MONITORING TEST SUPPLIES**		
ACCU-CHEK FASTCLIX LANCET KIT	2	QL (1 EA per 180 days)
ACCU-CHEK FASTCLIX LANCETS	2	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).

Drug Name	Tier	Notes
ACCU-CHEK GUIDE KIT W/DEVICE	$0	$0 (NOTE: Roche Free Meter Program Pharmacies can Submit BIN 610524 PCN 1016 Grp 40026479 ID 969608977 Assistance call 1-800-657-7613); QL (1 glucometer from Roche Free Meter Program per 24 Monthss)
ACCU-CHEK GUIDE ME KIT W/DEVICE	$0	$0 (NOTE: Roche Free Meter Program Pharmacies can Submit BIN 610524 PCN 1016 Grp 40026479 ID 969608977 Assistance call 1-800-657-7613); QL (1 glucometer from Roche Free Meter Program per 24 Monthss)
ACCU-CHEK SOFTCLIX LANCET DEV KIT	2	QL (1 EA per 180 days)
ACCU-CHEK SOFTCLIX LANCETS	2	Blood Glucose Test strip and lancet limits for members: 100 every 90 days for those not using insulin, 300 every 90 days for those using insulin, and 200 every 365 days for those using a continuous glucose monitor (CGM).
DEXCOM G6 RECEIVER DEVICE	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 15 DAY SENSOR	3	PA; QL (2 EA per 30 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)
MICROLET NEXT LANCETS	2	QL (3.4 EA per 1 day)
MINIMED INSTINCT GLUC SENSOR	3	PA; QL (2 EA per 30 days)

Drug Name	Tier	Notes
INSULIN ADMINISTRATION SUPPLIES**		
OMNIPOD 5 LIBRE INTRO KIT	4	PA; QL (1 EA per 365 days); NDS
OMNIPOD 5 LIBRE PODS	4	PA; QL (10 Pods per 30 days); NDS
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 KIT	4	PA; QL (1 EA per 365 days); NDS
OMNIPOD 5 LIBRE2 PLUS G6 PODS	4	PA; QL (10 Pods per 30 days); NDS
OMNIPOD DASH INTRO (GEN 4) KIT	4	PA; QL (1 EA per 365 days); NDS
OMNIPOD DASH PODS (GEN 4)	4	PA; QL (10 EA per 30 days); NDS
NEEDLES & SYRINGES**		
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)
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 SHORT ULTRAFINE 31G X 8 MM	2	QL (100 EA per 30 days)
NOVOFINE PEN NEEDLE 32G X 6 MM	2	
PEAK FLOW METERS**		
ASSESS PEAK FLOW METER DEVICE	3	
SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES**		
AEROCHAMBER PLUS FLO-VU	4	QL (2 EA per 180 days)
AEROCHAMBER PLUS FLOW VU	4	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)
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)
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); NDS
MIGRAINE PRODUCTS**		
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)

Drug Name	Tier	Notes
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	
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 subcutaneous solution auto-injector 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	
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**		
lactated ringers intravenous solution	MB	
FLUORIDE**		
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	$0	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	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**		

Drug Name	Tier	Notes
KLOR-CON 10 TABLET EXTENDED RELEASE 10 MEQ ORAL	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	
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	
MISCELLANEOUS THERAPEUTIC CLASSES		
ANTILEPROTICS**		
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; DX (Diagnosis Validation Required); NDS; SP
B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS**		
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; SP
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	PA; DX (Diagnosis Validation Required); QL (4 ML per 28 days); NDS; 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 modified oral capsule 100 mg, 25 mg, 50 mg	2	
cyclosporine modified oral solution 100 mg/ml	2	

Drug Name	Tier	Notes
cyclosporine oral capsule 100 mg, 25 mg	2	
GENGRAF ORAL SOLUTION 100 MG/ML	3	
SANDIMMUNE INTRAVENOUS SOLUTION 50 MG/ML	MB	
ENZYMES**		
HYLENEX INJECTION SOLUTION 150 UNIT/ML	MB	PA
IMMUNE GLOBULIN IMMUNOSUPPRESSANTS**		
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 (Diagnosis Validation Required); NDS
lenalidomide oral capsule 2.5 mg, 20 mg	5	PA; DX (Diagnosis Validation Required); NDS; SP
REVLIMID ORAL CAPSULE 2.5 MG	5	PA; DX (Diagnosis Validation Required); NDS; 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**		
everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg	5	PA; NDS; SP
everolimus oral tablet 1 mg	5	PA
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 er oral capsule extended release 24 hour 0.5 mg	4	PA; QL (30 EA per 30 days)
tacrolimus er oral capsule extended release 24 hour 1 mg	5	PA; QL (120 EA per 30 days)
tacrolimus er oral capsule extended release 24 hour 5 mg	5	PA; QL (90 EA per 30 days)
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	2	
MONOCLONAL ANTIBODIES**		

Drug Name	Tier	Notes
GAMIFANT INTRAVENOUS SOLUTION 10 MG/2ML, 50 MG/10ML	MB	PA
SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG	MB	
POTASSIUM REMOVING AGENTS**		
KIONEX COMBINATION 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, 16.8 GM, 25.2 GM, 8.4 GM	5	PA; QL (30 EA per 30 days)
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		
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	
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		
PRENATAL MV & MIN W/FE-FA**		
completenate oral tablet chewable 29-1 mg	3	
CO-NATAL FA ORAL TABLET	3	
INATAL GT ORAL TABLET	3	
multi prenatal oral tablet 27-0.8 mg	$0	AL (Max 55 Years)
NIVA-PLUS ORAL TABLET 27-1 MG	3	

Drug Name	Tier	Notes
OBTREX ORAL TABLET	3	
pnv prenatal plus multivitamin oral tablet 27-1 mg	3	
PRENATABS RX ORAL TABLET 29-1 MG	3	
prenatal 19 oral tablet chewable , 29-1 mg	3	
prenatal one daily oral tablet 27-0.8 mg	$0	AL (Max 55 Years)
prenatal oral tablet 27-0.8 mg	$0	AL (Max 55 Years)
prenatal oral tablet 27-1 mg	3	
prenatal plus oral tablet 27-1 mg	3	
PRENATAL-U ORAL CAPSULE 106.5-1 MG	3	
right step prenatal oral tablet 27-0.8 mg	$0	AL (Max 55 Years)
se-natal 19 oral tablet chewable 29-1 mg	3	
THERANATAL CORE NUTRITION ORAL TABLET 27-1 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	
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; NDS
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL ANTICHOLINERGICS**		

Drug Name	Tier	Notes
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**		
budesonide nasal suspension 32 mcg/act	4	ST
flunisolide nasal solution 25 mcg/act (0.025%)	3	
fluticasone propionate nasal suspension 50 mcg/act	2	
mometasone furoate nasal suspension 50 mcg/act	4	ST
TOPICAL DECONGESTANTS**		
ADRENALIN NASAL SOLUTION 0.1 %	MB	
NEUROMUSCULAR AGENTS		
ALS AGENTS - MISCELLANEOUS**		
RADICAVA INTRAVENOUS SOLUTION 30 MG/100ML	MB	PA
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
MYOBLOC INTRAMUSCULAR SOLUTION 10000 UNIT/2ML, 2500 UNIT/0.5ML, 5000 UNIT/ML	MB	PA
XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT, 50 UNIT	MB	PA
NONDEPOLARIZING MUSCLE RELAXANTS**		
atracurium besylate intravenous solution 100 mg/10ml	2	
NUTRIENTS		
CARBOHYDRATES**		
dextrose intravenous solution 5 %	MB	
OPHTHALMIC AGENTS		
BETA-BLOCKERS - OPHTHALMIC COMBINATIONS**		
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	4	

Drug Name	Tier	Notes
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 0.5 %	2	
timolol maleate (once-daily) ophthalmic solution 0.5 %	4	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	2	
CYCLOPLEGIC MYDRIATICS**		
atropine sulfate ophthalmic solution 1 %	3	
cyclopentolate hcl ophthalmic solution 1 %	2	
HOMATROPAIRE OPHTHALMIC SOLUTION 5 %	2	
phenylephrine hcl ophthalmic solution 10 %, 2.5 %	2	
tropicamide ophthalmic solution 0.5 %, 1 %	2	
MIOTICS - CHOLINESTERASE INHIBITORS**		
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 %	3	
MIOTICS - DIRECT ACTING**		
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	2	
OPHTHALMIC - MULTIPLE RECEPTOR ANGIOGENESIS INHIBITORS**		
VABYSMO INTRAVITREAL SOLUTION 6 MG/0.05ML	MB	PA; NDS
VABYSMO INTRAVITREAL SOLUTION PREFILLED SYRINGE 6 MG/0.05ML	MB	PA; NDS
OPHTHALMIC ANTIALLERGIC**		
ALOCRIL OPHTHALMIC SOLUTION 2 %	4	
azelastine hcl ophthalmic solution 0.05 %	2	
bepotastine besilate ophthalmic solution 1.5 %	4	PA
cromolyn sodium ophthalmic solution 4 %	2	
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	AL (Max 1 Years)

Drug Name	Tier	Notes
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**		
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	2	
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 (pf) ophthalmic emulsion 0.05 %	4	QL (60 EA per 30 days)
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**		
diclofenac sodium ophthalmic solution 0.1 %	2	
flurbiprofen sodium ophthalmic solution 0.03 %	2	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	2	
OPHTHALMIC PHOTOENHANCERS**		
EPIOXA HD/ EPIOXA OPHTHALMIC PREFILLED SYRINGE KIT 0.239 & 0.177 %	MB	

Drug Name	Tier	Notes
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	
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	
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	

Drug Name	Tier	Notes
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	
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	
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	
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**		
carboprost tromethamine intramuscular solution 250 mcg/ml	MB	
PREPIDIL VAGINAL GEL 0.5 MG/3GM	4	

Drug Name	Tier	Notes
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**		
GAMMAGARD ERC INJECTION SOLUTION 10 GM/100ML, 5 GM/50ML	MB	PA; NDS
GAMMAGARD INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 30 GM/300ML, 5 GM/50ML	MB	PA; NDS
GAMMAGARD INJECTION SOLUTION 20 GM/200ML	MB	PA
GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM	MB	PA; NDS
qivigy intravenous solution 10 gm/100ml, 5 gm/50ml	MB	
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	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 500 mg	3	
NATURAL PENICILLINS**		
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 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**		

Drug Name	Tier	Notes
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	
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	
PENICILLINASE-RESISTANT PENICILLINS**		
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	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ALCOHOL DETERRENTS**		
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)

Drug Name	Tier	Notes
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); NDS
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)
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	2	
galantamine hydrobromide oral solution 4 mg/ml	3	
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**		

Drug Name	Tier	Notes
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); NDS; 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); NDS; SP
tetrabenazine oral tablet 12.5 mg	5	PA; QL (90 EA per 30 days); NDS; SP
tetrabenazine oral tablet 25 mg	5	PA; QL (120 EA per 30 days); NDS; SP
MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS**		
teriflunomide oral tablet 14 mg, 7 mg	2	QL (30 EA per 30 days); NDS
MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES**		
cladribine (10 tabs) oral tablet therapy pack 10 mg	5	PA; DX (Diagnosis Validation Required); QL (20 EA per 326 days); SP
cladribine (4 tabs) oral tablet therapy pack 10 mg	5	PA; DX (Diagnosis Validation Required); QL (8 EA per 326 days); SP
cladribine (5 tabs) oral tablet therapy pack 10 mg	5	PA; DX (Diagnosis Validation Required); QL (10 EA per 326 days); SP
cladribine (6 tabs) oral tablet therapy pack 10 mg	5	PA; DX (Diagnosis Validation Required); QL (12 EA per 326 days); SP
cladribine (7 tabs) oral tablet therapy pack 10 mg	5	PA; DX (Diagnosis Validation Required); QL (14 EA per 326 days); SP
cladribine (8 tabs) oral tablet therapy pack 10 mg	5	PA; DX (Diagnosis Validation Required); QL (16 EA per 326 days); SP

Drug Name	Tier	Notes
cladribine (9 tabs) oral tablet therapy pack 10 mg	5	PA; DX (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 (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	5	DX (Diagnosis Validation Required); QL (1 EA per 28 days); NDS; SP
MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES**		
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML	MB	PA; DX (Diagnosis Validation Required)
MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS**		
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	2	DX (Diagnosis Validation Required); QL (60 EA per 30 days); NDS; SP
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	2	DX (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 (Diagnosis Validation Required); QL (60 EA per 30 days); NDS
MULTIPLE SCLEROSIS AGENTS**		
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	DX (Diagnosis Validation Required); QL (30 ML per 30 days); NDS; SP
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	DX (Diagnosis Validation Required); QL (12 ML per 28 days); NDS; SP
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS**		
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	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**		

Drug Name	Tier	Notes
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.**		
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	QL (360 EA per 365 days)
gnp nicotine transdermal patch 24 hour 21 mg/24hr	$0	QL (182 EA per 365 days)
goodsense nicotine mouth/throat gum 2 mg	$0	QL (4300 EA per 365 days)
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	$0	QL (4300 EA per 365 days)
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	$0	QL (3600 EA per 365 days)
nicotine transdermal kit 21-14-7 mg/24hr	$0	
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	$0	QL (182 EA per 365 days)
NICOTROL NS NASAL SOLUTION 10 MG/ML	$0	ST; 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	

Drug Name	Tier	Notes
MAYZENT ORAL TABLET 0.25 MG	5	PA; DX (Diagnosis Validation Required); QL (120 EA per 30 days); NDS; SP
MAYZENT ORAL TABLET 1 MG, 2 MG	5	PA; DX (Diagnosis Validation Required); QL (30 EA per 30 days); NDS; SP
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG, 7 X 0.25 MG	5	PA; DX (Diagnosis Validation Required); QL (1 pack per 365 days); NDS; 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.		
CFTR POTENTIATORS**		
KALYDECO ORAL PACKET 13.4 MG	5	PA; QL (2 packets per 1 day); AL (Max 6 Years); NDS; SP
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG	5	PA; QL (60 EA per 30 days); AL (Max 6 Years); NDS; SP
KALYDECO ORAL TABLET 150 MG	5	PA; QL (60 EA per 30 days); AL (Min 6 Years); NDS; SP
CYSTIC FIBROSIS AGENT - COMBINATIONS**		
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; QL (120 EA per 30 days); NDS; 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); NDS; 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); NDS; SP
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG	5	PA; QL (2 packets per 1 day); NDS; SP
HYDROLYTIC ENZYMES**		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	LA; NDS
PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS**		

Drug Name	Tier	Notes
nintedanib esylate 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	
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	
SEYSARA ORAL TABLET 100 MG	4	NDS

Drug Name	Tier	Notes
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	
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	
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	
TOXOIDS		
TOXOID COMBINATIONS**		
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5	$0	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5	$0	
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTICHOLINERGIC COMBINATIONS**		

Drug Name	Tier	Notes
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	
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	
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)
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)

Drug Name	Tier	Notes
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 +rfid injection solution 0.2 mg/ml	2	
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	
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 tablet 5 mg	2	
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 - BETA-3 ADRENERGIC AGONISTS**		
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	4	ST; QL (1 EA per 1 day)
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**		

Drug Name	Tier	Notes
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML	$0	$0 ($0 Copay per PPACA guidelines.); QL (0.5 ML per 1 Lifetime)
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML	$0	
MENVEO INTRAMUSCULAR SOLUTION	$0	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	$0	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	$0	
PNEUMOVAX 23 INJECTION SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	$0	QL (0.5 ML per 180 days)
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	QL (0.5 ML per 1 Lifetime)
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	
VIRAL VACCINE COMBINATIONS**		
M-M-R II INJECTION SOLUTION RECONSTITUTED	$0	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	$0	
VIRAL VACCINES**		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML	$0	AL (Min 60 Years)
AFLURIA INTRAMUSCULAR SUSPENSION	$0	QL (0.5 ML per 180 days)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	QL (0.5 ML per 180 days)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML	$0	AL (Min 60 Years)
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML	$0	
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)
FLUMIST NASAL LIQUID	$0	QL (0.5 mL per 180 days); AL (Min 2 Years and Max 49 Years)
FLUZONE INTRAMUSCULAR SUSPENSION	$0	QL (0.5 ML per 180 days)
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720 EL U/0.5ML	$0	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML	$0	
MNEXSPIKE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 10 MCG/0.2ML	$0	AL (Min 12 Years)
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML	$0	$0 ($0 dollar copay)

Drug Name	Tier	Notes
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	$0	
SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML	$0	$0 ($0 Copay); QL (2 vials per 1 Lifetime); AL (Min 50 Years)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	$0	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	
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML	$0	
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	
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 %	$0	
TODAY SPONGE VAGINAL 1000 MG	$0	
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 %	$0	
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 %	$0	
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 tablet 10 mcg	2	
ESTRING VAGINAL RING 7.5 MCG/24HR	4	QL (1 EA per 90 days)

Drug Name	Tier	Notes
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	
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS**		
droxidopa oral capsule 100 mg, 200 mg, 300 mg	5	PA
VASOPRESSORS**		
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	2	
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	
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; DX (Diagnosis Validation Required)
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML	MB	DX (Diagnosis Validation Required); NDS; SP
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG	MB	PA; DX (Diagnosis Validation Required)
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML	MB	PA; NDS
azacitidine injection suspension reconstituted 100 mg	MB	DX (Diagnosis Validation Required)
BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML	MB	PA; DX (Diagnosis Validation Required)
BD POSIFLUSH INTRAVENOUS SOLUTION 0.9 %	MB	
BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	PA; DX (Diagnosis Validation Required)
BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG, 400 MG	MB	PA; DX (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); NDS; SP
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	MB	
BLINCYTO INTRAVENOUS SOLUTION RECONSTITUTED 35 MCG	MB	PA; DX (Diagnosis Validation Required)
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT	MB	PA
CEREBYX INJECTION SOLUTION 100 MG PE/2ML	MB	
CINRYZE INTRAVENOUS SOLUTION RECONSTITUTED 500 UNIT	5	PA; NDS; SP
CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA; DX (Diagnosis Validation Required)
daptomycin intravenous solution reconstituted 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	DX (Diagnosis Validation Required)
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG	MB	PA; DX (Diagnosis Validation Required); NDS; SP

Drug Name	Tier	Notes
ertapenem sodium injection solution reconstituted 1 gm	MB	
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML	MB	PA; QL (6 ML per 180 days)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/200ML, 20 GM/400ML, 5 GM/100ML	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.)
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	AL (Min 9 Years and Max 45 Years)
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	$0	AL (Min 9 Years and Max 45 Years)
GAZYVA INTRAVENOUS SOLUTION 1000 MG/40ML	MB	PA; DX (Diagnosis Validation Required)
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE 30 MG/3ML	MB	PA; QL (2 ML per 180 days)
heparin sod (porcine) in d5w intravenous solution 100 unit/ml	MB	
IMFINZI INTRAVENOUS SOLUTION 120 MG/2.4ML, 500 MG/10ML	MB	PA; DX (Diagnosis Validation Required)
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	MB	
INFED INJECTION SOLUTION 50 MG/ML	MB	
INJECTAFER INTRAVENOUS SOLUTION 750 MG/15ML	MB	
JELMYTO KIT 2 X 40 MG	MB	PA; DX (Diagnosis Validation Required); QL (17 EA per 1 day)
JELMYTO SOLUTION RECONSTITUTED 80 (2 X 40) MG	MB	PA; DX (Diagnosis Validation Required); QL (17 EA per 1 day)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML	MB	PA
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA; DX (Diagnosis Validation Required)
KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 10 MG, 30 MG, 60 MG	MB	PA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG	MB	DX (Diagnosis Validation Required)
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	MB	DX (Diagnosis Validation Required)
LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG	MB	
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG	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 (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 (Diagnosis Validation Required)
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	MB	PA; DX (Diagnosis Validation Required)
PERJETA INTRAVENOUS SOLUTION 420 MG/14ML	MB	PA; DX (Diagnosis Validation Required)
potassium chloride in nacl intravenous solution 20-0.9 meq/l-%	MB	
POTELIGEO INTRAVENOUS SOLUTION 20 MG/5ML	MB	PA; DX (Diagnosis Validation Required)
procainamide hcl injection solution 100 mg/ml, 500 mg/ml	MB	
saline flush intravenous solution 0.9 %	MB	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG	MB	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG	$0	
sodium chloride flush intravenous solution 0.9 %	MB	
sodium chloride 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	DX (Diagnosis Validation Required)
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED 180 MG	MB	PA; DX (Diagnosis Validation Required)

Drug Name	Tier	Notes
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML	MB	PA; DX (Diagnosis Validation Required); SP
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA; NDS; SP
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	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); NDS
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	MB	PA; NDS; SP
YERVOY INTRAVENOUS SOLUTION 200 MG/40ML, 50 MG/10ML	MB	PA; DX (Diagnosis Validation Required)
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML, 200 MG/8ML	MB	PA; DX (Diagnosis Validation Required)
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	MB	PA; DX (Diagnosis Validation Required)
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG	MB	DX (Diagnosis Validation Required)
zoledronic acid intravenous concentrate 4 mg/5ml	MB	
zoledronic acid intravenous solution 5 mg/100ml	MB	