

## PHP Commercial Limited Services Plans (Non-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).

Some medications may be excluded as determined by benefit.

### **Presbyterian Commercial Limited Services Plan Formulary**

#### **Do you need a prior authorization?**

Some formulary drugs need to have a prior authorization. This means you (your appointed representative) or your provider will need to ask Presbyterian for permission before prescribing the drug for you. The Commercial Limited services Formulary only covers prenatal vitamins, preferred insulin, preferred diabetes testing supplies, preferred insulin syringes, formulary oral diabetic medications, preferred oral immunosuppressive drugs, and office administered medical drugs.

#### **What if your drug is not on the formulary?**









You may need a drug that is not on the Presbyterian Commercial Limited Services Formulary or is not approved to treat your condition. In these cases, you (your appointed representative) or your provider will need to request Presbyterian for an exception to the formulary drug list.

#### **Important**




The Formulary is **subject to change**. Presbyterian may decide to switch a formulary brand name drug to a generic drug when it becomes available.








# Presbyterian Commercial Limited Services Formulary

## Definition of Status

Icon	Status	Definition
	Tier 1	Preferred Generic
	Tier 2	Preferred Brand
	Tier 3	Non-Preferred Drugs
	Non-formulary	Non-Formulary drugs require an exception to the formulary due to allergy, adverse reactions, or no response to all formulary drugs.
	Medical Benefit	A Medical Drug is any drug administered by a Health Care Professional and is typically given in the member's home, physician's office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require Prior Authorization please see the Presbyterian Pharmacy website at <a href="http://www.phs.org">www.phs.org</a> .
	\$0	Zero Dollar Copay; PPACA Preventative Services
	Medical Exception	A drug that is not on the Plan's formulary. An exception may be requested by a prescriber, a member, or their appointed representative. The prescriber must provide information to support the medical exception request by fax, phone, or regular mail
	Non-Formulary	Non-formulary drugs require an exception to the formulary due to allergy, adverse reactions, or no response to all formulary drugs.

## 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.
	Excluded Drug	Benefit Exclusion Not a Covered Benefit
	Generic Indicator	A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand name

		drug. Generally, generic drugs cost less than brand name drugs.
	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 twenty-five dollars (\$25.00)* per thirty-day supply. *Copays are subject to deductible first.
	Member Note	Member Note
	Notes	User Note 1
	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.
	Quantity Limit	Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your doctor and pharmacists check that the medications are used appropriately and promote patient safety. Presbyterian uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits.
	Specialty Pharmacy	Most Specialty Pharmaceuticals require Prior Authorization and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than \$600 for up to a 30-day supply. Specialty Pharmaceuticals are not available through the retail or mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill up to a 15-day supply to ensure patients can tolerate the new medication.
	Step Therapy	Step Therapy promotes the appropriate use of equally effective but lower-cost formulary drugs first. With this program, prior use of one or more "prerequisite" drugs is required before a step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drug.

CURRENT AS OF 11/18/2022

Drug Name	Tier	Notes
<b>*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*</b>		
<b>*ANALEPTICS***</b>		
<i>caffeine citrate intravenous solution 60 mg/3ml</i>	MB	
<b>*ANALGESICS - ANTI-INFLAMMATORY*</b>		
<b>*INTERLEUKIN-6 RECEPTOR INHIBITORS***</b>		
<b>ACTEMRA INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML</b>	MB	PA
<b>*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)***</b>		
<i>ibuprofen lysine intravenous solution 10 mg/ml</i>	MB	
<b>*SELECTIVE COSTIMULATION MODULATORS***</b>		
<b>ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG</b>	MB	PA
<b>*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS***</b>		
<b>ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG</b>	MB	PA
<b>*ANALGESICS - NONNARCOTIC*</b>		
<b>*ANALGESICS OTHER***</b>		
<b>DURACLON EPIDURAL SOLUTION 100 MCG/ML</b>	MB	
<b>*SALICYLATES***</b>		
aspirin 81 oral tablet chewable 81 mg	\$0	\$0 Copay PPACA Guidelines.
aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
aspirin oral tablet delayed release 325 mg, 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
Bayer Aspirin Oral Tablet 325 MG	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
childrens aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
cvs aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
ec-81 aspirin oral tablet delayed release 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
eq aspirin low dose oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)

<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
eq aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
eq aspirin oral tablet delayed release 325 mg, 500 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
eq childrens aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
eqi aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
gnp aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
gnp aspirin oral tablet delayed release 325 mg, 81 mg	\$0	\$0 copay per PPACA guidelines.
hm aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.
hm aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.
kp aspirin oral tablet delayed release 81 mg	\$0	\$0 copay per PPACA guidelines.
mm aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.
Norwich Aspirin Oral Tablet 325 MG	\$0	\$0 copay per PPACA guidelines.
px aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.
px aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
px enteric aspirin oral tablet delayed release 325 mg, 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
qc aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
qc aspirin oral tablet delayed release 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
qc childrens aspirin oral tablet chewable 81 mg	\$0	\$0 Copay PPACA Guidelines.; AG (Min 45 Years)
ra aspirin oral tablet 325 mg, 500 mg	\$0	\$0 Copay PPACA Guidelines.; AG (Min 45 Years)
ra childrens aspirin oral tablet chewable 81 mg	\$0	\$0 Copay PPACA Guidelines.; AG (Min 45 Years)
sb aspirin oral tablet 325 mg	\$0	\$0 Copay PPACA Guidelines.; AG (Min 45 Years)
sb aspirin oral tablet delayed release 81 mg	\$0	\$0 Copay PPACA Guidelines.; AG (Min 45 Years)
sb childrens aspirin oral tablet chewable 81 mg	\$0	\$0 Copay PPACA Guidelines.; AG (Min 45 Years)
sm aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
sm childrens aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
St Joseph Aspirin Oral Tablet Delayed Release 81 MG	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)

Drug Name	Tier	Notes
tgt aspirin oral tablet 325 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
tgt aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
tgt aspirin oral tablet delayed release 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
tgt childrens aspirin oral tablet chewable 81 mg	\$0	\$0 copay per PPACA guidelines.; AG (Min 45 Years)
<b>*ANALGESICS - OPIOID*</b>		
<b>*OPIOID AGONISTS***</b>		
<i>methadone hcl injection solution 10 mg/ml</i>	MB	
<b>*OPIOID PARTIAL AGONISTS***</b>		
<b>BUPRENEX INJECTION SOLUTION 0.3 MG/ML</b>	MB	
<i>butorphanol tartrate injection solution 1 mg/ml</i>	MB	
<b>*ANDROGENS-ANABOLIC*</b>		
<b>*ANDROGENS***</b>		
<b>TESTOPEL IMPLANT PELLETT 75 MG</b>	MB	PA
<b>*ANTIARRHYTHMICS*</b>		
<b>*ANTIARRHYTHMICS - MISC.***</b>		
<b>ADENOCARD INTRAVENOUS SOLUTION 6 MG/2ML</b>	MB	
<b>*ANTIARRHYTHMICS TYPE I-A***</b>		
<i>procainamide hcl injection solution 100 mg/ml, 500 mg/ml</i>	MB	
<i>quinidine gluconate injection solution 80 mg/ml</i>	MB	
<b>*ANTIARRHYTHMICS TYPE I-B***</b>		
<i>lidocaine in d5w intravenous solution 3-5 mg/ml-%</i>	MB	
<b>*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*</b>		
<b>*ANTI-IGE MONOCLONAL ANTIBODIES***</b>		
<b>XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML</b>	MB	PA
<b>XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG</b>	MB	PA
<b>*BETA ADRENERGICS***</b>		
<i>isoproterenol hcl injection solution 0.2 mg/ml</i>	MB	
<b>*XANTHINES***</b>		
<i>aminophylline intravenous solution 25 mg/ml</i>	MB	
<b>*ANTICOAGULANTS*</b>		

Drug Name	Tier	Notes
<b>*HEPARINS AND HEPARINOID-LIKE AGENTS***</b>		
<i>heparin (porcine) in d5w intravenous solution 40-5 unit/ml-%, 50-5 unit/ml-%</i>	MB	
<i>heparin (porcine) in nacl injection solution 100-0.45 unit/ml-%, 2-0.9 unit/ml-%, 50-0.45 unit/ml-%</i>	MB	
<i>heparin sod (porcine) in d5w intravenous solution 100 unit/ml</i>	MB	
<i>heparin sodium flush intravenous kit 100-0.9 unit/ml-%</i>	MB	
<b>*THROMBIN INHIBITORS - SELECTIVE DIRECT &amp; REVERSIBLE***</b>		
<i>argatroban in sodium chloride intravenous solution 50 mg/50ml</i>	MB	
<b>*ANTICONSULSANTS*</b>		
<b>*HYDANTOINS***</b>		
<i>fosphenytoin sodium injection solution 100 mg pe/2ml, 500 mg pe/10ml</i>	MB	
<b>*ANTIDEPRESSANTS*</b>		
<b>*N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS***</b>		
<b>SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE</b>	MB	PA
<b>SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE</b>	MB	PA
<b>*ANTIDIABETICS*</b>		
<b>*ALPHA-GLUCOSIDASE INHIBITORS***</b>		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<b>*ANTIDIABETIC - AMYLIN ANALOGS***</b>		
<b>SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML</b>	3	PA
<b>SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML</b>	3	PA
<b>*BIGUANIDES***</b>		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	1	
<i>metformin hcl oral tablet 1000 mg, 500 mg, 850 mg</i>	1	
<b>*DIABETIC OTHER***</b>		
<b>BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE</b>	2	
<b>BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE</b>	2	

Drug Name	Tier	Notes
<i>glucagon emergency injection kit 1 mg</i>	3	
<i>glucagon emergency injection solution reconstituted 1 mg/ml</i>	2	
<b>*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS***</b>		
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	2	ST; QL (30 EA per 30 days)
<b>JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG</b>	2	ST; QL (30 EA per 30 days)
<b>ONGLYZA ORAL TABLET 2.5 MG, 5 MG</b>	3	PA; QL (30 EA per 30 days)
<b>*DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS***</b>		
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	2	ST; QL (60 EA per 30 days)
<b>JANUMET ORAL TABLET 50-1000 MG, 50-500 MG</b>	2	ST; QL (60 EA per 30 days)
<b>JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG</b>	2	ST; QL (30 EA per 30 days)
<b>JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG</b>	2	ST; QL (60 EA per 30 days)
<b>KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG</b>	3	PA; QL (60 EA per 60 days)
<b>KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG, 5-500 MG</b>	3	PA; QL (30 EA per 30 days)
<b>*DPP-4 INHIBITOR-THIAZOLIDINEDIONE COMBINATIONS***</b>		
<i>alogliptin-pioglitazone oral tablet 12.5-15 mg, 12.5-30 mg, 12.5-45 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	2	ST; QL (30 EA per 30 days)
<b>*HUMAN INSULIN***</b>		
<b>HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML</b>	3	ST; QL (45 ML per 30 days)
<b>HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</b>	3	ST; QL (50 ML per 30 days)
<b>HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML</b>	3	ST; QL (45 ML per 30 days)
<b>HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML</b>	3	ST; QL (50 ML per 30 days)
<b>HUMULIN R INJECTION SOLUTION 100 UNIT/ML</b>	3	ST; QL (50 ML per 30 days)
<b>HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML</b>	3	PA; QL (1 ML per 1 day)
<b>HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML</b>	3	PA; QL (18 ML per 30 days)
<i>insulin asp prot &amp; asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	2	CB; QL (45 ML per 30 days)



<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i>	2	CB; QL (45 ML per 30 days)
<i>insulin aspart injection solution 100 unit/ml</i>	2	CB; QL (50 ML per 30 days)
<i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml</i>	2	CB; QL (45 ML per 30 days)
<i>insulin aspart prot &amp; aspart subcutaneous suspension (70-30) 100 unit/ml</i>	2	CB; QL (50 ML per 30 days)
<i>insulin aspart subcutaneous solution 100 unit/ml</i>	2	CB; QL (50 ML per 30 days)
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	2	CB; QL (50 ML per 30 days)
<i>insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml</i>	2	CB; QL (45 ML per 30 days)
<b>LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLIN R INJECTION SOLUTION 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML</b>	2	CB; QL (50 ML per 30 days)
<b>NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)
<b>NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML</b>	2	CB; QL (45 ML per 30 days)

Drug Name	Tier	Notes
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	2	CB; QL (50 ML per 30 days)
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	2	CB; QL (50 ML per 30 days)
NOVOLOG RELION SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	CB; QL (50 ML per 30 days)
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	2	CB; QL (45 ML per 30 days)
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	CB; QL (50 ML per 30 days)
<b>*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)***</b>		
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML	2	ST; QL (3.4 ML per 28 days)
BYDUREON SUBCUTANEOUS PEN-INJECTOR 2 MG	2	ST; QL (4 EA per 28 days)
BYDUREON SUBCUTANEOUS SUSPENSION RECONSTITUTED ER 2 MG	2	ST; QL (4 EA per 28 days)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	2	ST; QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	2	ST; QL (9 ML per 30 days)
<b>*MEGLITINIDE ANALOGUES***</b>		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	1	
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	3	
<b>*MEGLITINIDE-BIGUANIDE COMBINATIONS***</b>		
<i>repaglinide-metformin hcl oral tablet 1-500 mg, 2-500 mg</i>	3	ST
<b>*SGLT2 INHIBITOR - DPP-4 INHIBITOR COMBINATIONS***</b>		
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG	2	ST; QL (30 EA per 30 days)
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS***</b>		
FARXIGA ORAL TABLET 10 MG, 5 MG	2	ST; QL (30 EA per 30 days)
STEGLATRO ORAL TABLET 15 MG, 5 MG	2	ST; QL (30 EA per 30 days)
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB***</b>		
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG	2	ST; QL (60 EA per 30 days)

<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
<b>XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 5-500 MG</b>	3	ST; QL (30 EA per 30 days)
<b>XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG</b>	3	ST; QL (60 EA per 30 days)
<b>*SULFONYLUREA-BIGUANIDE COMBINATIONS***</b>		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	1	
<b>*SULFONYLUREAS***</b>		
<i>chlorpropamide oral tablet 100 mg, 250 mg</i>	2	
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	1	
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	1	
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	1	
<i>tolazamide oral tablet 250 mg, 500 mg</i>	2	
<i>tolbutamide oral tablet 500 mg</i>	2	
<b>*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS***</b>		
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	1	ST
<b>*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS***</b>		
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	ST
<b>*THIAZOLIDINEDIONES***</b>		
<b>AVANDIA ORAL TABLET 2 MG, 4 MG</b>	3	ST
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	1	QL (30 EA per 30 days)
<b>*ANTIDOTES AND SPECIFIC ANTAGONISTS*</b>		
<b>*ANTIDOTES AND SPECIFIC ANTAGONISTS***</b>		
<b>ACETADOTE INTRAVENOUS SOLUTION 200 MG/ML</b>	MB	
<b>ANDEXXA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 200 MG</b>	MB	
<i>bal in oil intramuscular solution 100 mg/ml</i>	MB	

Drug Name	Tier	Notes
<i>calcium disodium versenate injection solution 1 gm/5ml</i>	MB	
<b>DESFERAL INJECTION SOLUTION RECONSTITUTED 500 MG</b>	MB	
<b>DIGIBIND INTRAVENOUS SOLUTION RECONSTITUTED 38 MG</b>	MB	
<b>DIGIFAB INTRAVENOUS SOLUTION RECONSTITUTED 40 MG</b>	MB	
<i>fomepizole intravenous solution 1.5 gm/1.5ml</i>	MB	
<b>*ANTIEMETICS*</b>		
<b>*5-HT3 RECEPTOR ANTAGONISTS***</b>		
<b>ANZEMET INTRAVENOUS SOLUTION 20 MG/ML</b>	MB	PA
<i>palonosetron hcl intravenous solution 0.25 mg/2ml</i>	MB	QL (2 ML per 5 days)
<i>palonosetron hcl intravenous solution 0.25 mg/5ml</i>	MB	QL (5 ML per 5 days)
<b>*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS***</b>		
<b>CINVANTI INTRAVENOUS EMULSION 130 MG/18ML</b>	MB	PA
<i>fosaprepitant dimeglumine intravenous solution reconstituted 150 mg</i>	MB	PA; QL (4 EA per 30 days)
<b>*ANTIFUNGALS*</b>		
<b>*ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)***</b>		
<i>casposfungin acetate intravenous solution reconstituted 50 mg, 70 mg</i>	MB	
<b>ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG</b>	MB	
<i>micafungin sodium intravenous solution reconstituted 100 mg, 50 mg</i>	MB	
<b>*ANTIFUNGALS***</b>		
<b>ABELCET INTRAVENOUS SUSPENSION 5 MG/ML</b>	MB	
<b>AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG</b>	MB	
<b>AMPHOTEC INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG</b>	MB	
<i>amphotericin b injection solution reconstituted 50 mg</i>	MB	
<b>*TRIAZOLES***</b>		
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%</i>	MB	
<b>*ANTIHISTAMINES*</b>		
<b>*ANTIHISTAMINES - ETHANOLAMINES***</b>		

Drug Name	Tier	Notes
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	MB	
<b>*ANTIHYPERLIPIDEMICS*</b>		
<b>*HMG COA REDUCTASE INHIBITORS***</b>		
lovastatin oral tablet 10 mg, 20 mg, 40 mg	\$0	\$0 Copay PPACA Guidelines.
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	\$0	\$0 Copay PPACA Guidelines.
<b>*ANTIHYPERTENSIVES*</b>		
<b>*ANTIADRENERGICS - CENTRALLY ACTING***</b>		
<i>methyl dopate hcl intravenous solution 250 mg/5ml</i>	MB	
<b>*ANTI-INFECTIVE AGENTS - MISC.*</b>		
<b>*CARBAPENEM COMBINATIONS***</b>		
<i>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</i>	MB	
<b>*CARBAPENEMS***</b>		
<i>doripenem intravenous solution reconstituted 500 mg</i>	MB	
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	MB	
<b>*CHLORAMPHENICALS***</b>		
<i>chloramphenicol sod succinate intravenous solution reconstituted 1 gm</i>	MB	
<b>*CYCLIC LIPOPEPTIDES***</b>		
<i>daptomycin intravenous solution reconstituted 500 mg</i>	MB	
<b>*POLYMYXINS***</b>		
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	MB	
<b>*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*</b>		
<b>*ALKYLATING AGENTS***</b>		
<b>ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED 4 MG</b>	MB	PA
<b>*ANTIMETABOLITES***</b>		
<b>ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG</b>	MB	PA
<i>azacitidine injection suspension reconstituted 100 mg</i>	MB	
<b>DACOGEN INTRAVENOUS SOLUTION RECONSTITUTED 50 MG</b>	MB	PA
<b>*ANTINEOPLASTIC - ANTI-BCMA ANTIBODY-DRUG COMPLEX***</b>		

Drug Name	Tier	Notes
BLENREP INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CCR4 ANTIBODIES***</b>		
POTELIGEO INTRAVENOUS SOLUTION 20 MG/5ML	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD19 ANTIBODIES***</b>		
MONJUVI INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD20 ANTIBODIES***</b>		
GAZYVA INTRAVENOUS SOLUTION 1000 MG/40ML	MB	PA
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA
TRUXIMA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD22 ANTIBODIES***</b>		
LUMOXITI INTRAVENOUS SOLUTION RECONSTITUTED 1 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD22 ANTIBODY-DRUG COMPLEX***</b>		
BESPOLSA INTRAVENOUS SOLUTION RECONSTITUTED 0.9 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD30 ANTIBODY-DRUG COMPLEX***</b>		
ADCETRIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD33 ANTIBODY-DRUG COMPLEX***</b>		
MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED 4.5 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CD38 ANTIBODIES***</b>		
DARZALEX INTRAVENOUS SOLUTION 100 MG/5ML, 400 MG/20ML	MB	PA
SARCLISA INTRAVENOUS SOLUTION 100 MG/5ML, 500 MG/25ML	MB	PA
<b>*ANTINEOPLASTIC - ANTI-CTLA-4 ANTIBODIES***</b>		

Drug Name	Tier	Notes
YERVOY INTRAVENOUS SOLUTION 200 MG/40ML, 50 MG/10ML	MB	PA
<b>*ANTINEOPLASTIC - ANTI-HER2 AGENTS***</b>		
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG	MB	
TRAZIMERA INTRAVENOUS SOLUTION RECONSTITUTED 420 MG	MB	
<b>*ANTINEOPLASTIC - ANTI-NECTIN-4 ANTIBODY-DRUG COMPLEX***</b>		
PADCEV INTRAVENOUS SOLUTION RECONSTITUTED 20 MG, 30 MG	MB	PA
<b>*ANTINEOPLASTIC - ANTI-PD-1 ANTIBODIES***</b>		
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	MB	PA
LIBTAYO INTRAVENOUS SOLUTION 350 MG/7ML	MB	PA
OPDIVO INTRAVENOUS SOLUTION 100 MG/10ML, 240 MG/24ML, 40 MG/4ML	MB	PA
<b>*ANTINEOPLASTIC - ANTI-PD-L1 ANTIBODIES***</b>		
BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML	MB	PA
IMFINZI INTRAVENOUS SOLUTION 120 MG/2.4ML, 500 MG/10ML	MB	PA
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML, 840 MG/14ML	MB	PA
<b>*ANTINEOPLASTIC - ANTI-SLAMF7 ANTIBODIES***</b>		
EMPLICITI INTRAVENOUS SOLUTION RECONSTITUTED 300 MG, 400 MG	MB	PA
<b>*ANTINEOPLASTIC - AUTOLOGOUS CELLULAR IMMUNOTHERAPY***</b>		
PROVENGE INTRAVENOUS SUSPENSION	MB	PA
<b>*ANTINEOPLASTIC - BISPECIFIC T-CELL ENGAGERS***</b>		
BLINCYTO INTRAVENOUS SOLUTION RECONSTITUTED 35 MCG	MB	PA
<b>*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS***</b>		
BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	PA

Drug Name	Tier	Notes
<i>romidepsin intravenous solution 27.5 mg/5.5ml</i>	MB	PA
<b>*ANTINEOPLASTIC - MTOR KINASE INHIBITORS***</b>		
<i>temsirolimus intravenous solution 25 mg/ml</i>	MB	
<b>*ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS***</b>		
<b>LARTRUVO INTRAVENOUS SOLUTION 500 MG/50ML</b>	MB	PA
<b>*ANTINEOPLASTIC - PROTEASOME INHIBITORS***</b>		
<b>KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 10 MG, 30 MG, 60 MG</b>	MB	PA
<b>VELCADE INJECTION SOLUTION RECONSTITUTED 3.5 MG</b>	MB	
<b>*ANTINEOPLASTIC ANTIBIOTICS***</b>		
<b>JELMYTO SOLUTION RECONSTITUTED 80 (2 X 40) MG</b>	MB	PA
<i>valrubicin intravesical solution 40 mg/ml</i>	MB	
<b>*ANTINEOPLASTIC ANTIBODY-DRUG COMPLEXES***</b>		
<b>ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG</b>	MB	PA
<b>KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG</b>	MB	PA
<b>*ANTINEOPLASTIC ENZYMES***</b>		
<b>ERWINAZE INJECTION SOLUTION RECONSTITUTED 10000 UNIT</b>	MB	PA
<b>*ANTINEOPLASTIC RADIOPHARMACEUTICALS***</b>		
<b>AZEDRA DOSIMETRIC INTRAVENOUS SOLUTION 15 MCI/ML</b>	MB	PA; QL (1 EA per 30 days)
<b>AZEDRA THERAPEUTIC INTRAVENOUS SOLUTION 15 MCI/ML</b>	MB	PA; QL (1 EA per 30 days)
<b>*ANTINEOPLASTICS MISC.***</b>		
<b>ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML</b>	MB	
<b>TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML</b>	MB	
<b>*CARDIAC PROTECTIVE AGENTS***</b>		
<i>dexrazoxane intravenous solution reconstituted 250 mg</i>	MB	



Drug Name	Tier	Notes
TOTECT INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
ZINECARD INTRAVENOUS SOLUTION RECONSTITUTED 250 MG	MB	
<b>*ESTROGEN RECEPTOR ANTAGONIST***</b>		
<i>fulvestrant intramuscular solution 250 mg/5ml</i>	MB	
<b>*LHRH ANALOGS***</b>		
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	MB	
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	MB	
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	MB	
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	MB	
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	MB	
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	MB	
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG	MB	PA
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG	MB	
<b>*MITOTIC INHIBITORS***</b>		
ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG	MB	PA
MARQIBO INTRAVENOUS SUSPENSION 5 MG/31ML	MB	PA
<b>*NITROGEN MUSTARDS AND RELATED ANALOGUES***</b>		
EVOMELA INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	MB	PA
<b>*NITROSOUREAS***</b>		
<i>carmustine intravenous solution reconstituted 100 mg</i>	MB	
<b>*PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS***</b>		
ALIQOPA INTRAVENOUS SOLUTION RECONSTITUTED 60 MG	MB	PA
<b>*TOPOISOMERASE I INHIBITORS - ANTIBODY-DRUG COMPLEX***</b>		
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED 180 MG	MB	PA

Drug Name	Tier	Notes
<b>*URINARY TRACT PROTECTIVE AGENTS***</b>		
ETHYOL INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	PA
<b>*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITORS***</b>		
CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	MB	PA
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML, 200 MG/8ML	MB	PA
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML	MB	PA
<b>*ANTIPARKINSON AND RELATED THERAPY AGENTS*</b>		
<b>*ANTIPARKINSON ANTICHOLINERGICS***</b>		
COGENTIN INJECTION SOLUTION 1 MG/ML	MB	
<b>*NONERGOLINE DOPAMINE RECEPTOR AGONISTS***</b>		
APOKYN SUBCUTANEOUS SOLUTION 10 MG/ML	MB	PA
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML	MB	
<b>*ANTIPSYCHOTICS/ANTIMANIC AGENTS*</b>		
<b>*PHENOTHIAZINES***</b>		
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	MB	
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	MB	
<i>prochlorperazine edisylate injection solution 10 mg/2ml</i>	MB	
<b>*QUINOLINONE DERIVATIVES***</b>		
ABILIFY INTRAMUSCULAR SOLUTION 9.75 MG/1.3ML	MB	
<i>aripiprazole oral solution 1 mg/ml</i>	MB	
<b>*ANTIVIRALS*</b>		
<b>*ANTIRETROVIRAL COMBINATIONS***</b>		
Descovy Oral Tablet 200-25 MG	\$0	\$0 Copay PPACA Guidelines.; QL (30 EA per 30 days)
emtricitabine-tenofovir df oral tablet 200-300 mg	\$0	\$0 Copay PPACA Guidelines.; QL (30 EA per 30 days)
Truvada Oral Tablet 100-150 MG, 133-200 MG, 167-250 MG	\$0	\$0 Copay PPACA Guidelines.; QL (30 EA per 30 days)

Drug Name	Tier	Notes
<b>*ANTIRETROVIRALS - CD4-DIRECTED POST-ATTACHMENT INHIBITOR***</b>		
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML	MB	
<b>*CMV AGENTS***</b>		
<i>cidofovir intravenous solution 75 mg/ml</i>	MB	
<b>*HERPES AGENTS - PURINE ANALOGUES***</b>		
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	MB	
<b>*BETA BLOCKERS*</b>		
<b>*BETA BLOCKERS CARDIO-SELECTIVE***</b>		
<i>esmolol hcl-sodium chloride intravenous solution 2000 mg/100ml</i>	MB	
<b>*CALCIUM CHANNEL BLOCKERS*</b>		
<b>*CALCIUM CHANNEL BLOCKERS***</b>		
<i>nicardipine hcl in nacl intravenous solution 20-0.9 mg/200ml-%, 40-0.9 mg/200ml-%</i>	MB	
<b>*CARDIOTONICS*</b>		
<b>*CARDIAC GLYCOSIDES***</b>		
<i>digoxin injection solution 0.25 mg/ml</i>	MB	
<b>*INOTROPES***</b>		
<i>dobutamine hcl intravenous solution 250 mg/20ml</i>	MB	
<i>dopamine hcl intravenous solution 40 mg/ml</i>	MB	
<b>*CEPHALOSPORINS*</b>		
<b>*CEPHALOSPORINS - 1ST GENERATION***</b>		
<i>cefazolin sodium injection solution reconstituted 500 mg</i>	MB	
<b>*CEPHALOSPORINS - 2ND GENERATION***</b>		
<i>cefoxitin sodium intravenous solution reconstituted 1 gm</i>	MB	
ZINACEF INJECTION SOLUTION RECONSTITUTED 750 MG	MB	
<b>*CEPHALOSPORINS - 3RD GENERATION***</b>		
<i>cefotaxime sodium injection solution reconstituted 500 mg</i>	MB	

Drug Name	Tier	Notes
<i>ceftazidime injection solution reconstituted 2 gm</i>	MB	
<i>ceftriaxone sodium injection solution reconstituted 1 gm</i>	MB	
<b>CLAFORAN INTRAVENOUS SOLUTION RECONSTITUTED 1 GM</b>	MB	
<b>*CEPHALOSPORINS - 4TH GENERATION***</b>		
<i>cefepime hcl injection solution reconstituted 2 gm</i>	MB	
<b>*CHEMICALS*</b>		
<b>*BULK CHEMICALS - AM'S***</b>		
<i>amikacin powder</i>	MB	
<b>*CONTRACEPTIVES*</b>		
<b>*COMBINATION CONTRACEPTIVES - ORAL***</b>		
Afirmelle Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
alyacen 1/35 oral tablet 1-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.
Apri Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Aubra Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
<b>AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG</b>	1	
<b>AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG</b>	1	
<b>AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)</b>	1	
Aurovela Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Aurovela FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Aviane Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
<b>BLISOVI 24 FE ORAL TABLET 1-20 MG-MCG(24)</b>	1	
Blisovi Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Blisovi FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
<b>CHATEAL ORAL TABLET 0.15-30 MG-MCG</b>	1	
Cryselle-28 Oral Tablet 0.3-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Cyclafem 1/35 Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Cyred Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Dasetta 1/35 Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Delyla Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg	\$0	\$0 Copay PPACA Guidelines.
Elinest Oral Tablet 0.3-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Emoquette Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Enskyce Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.

<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
Estarylla Oral Tablet 0.25-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg	\$0	\$0 Copay PPACA Guidelines.
Falmina Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
Femynor Oral Tablet 0.25-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Gildess FE 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay per PPACA guidelines.
Gildess FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 copay per PPACA guidelines.
<b>HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)</b>	1	
Hailey FE 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Hailey FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
Isibloom Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Juleber Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Junel FE 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Junel FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
<b>JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)</b>	1	
Kalliga Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
Kelnor 1/35 Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
<b>KELNOR 1/50 ORAL TABLET 1-50 MG-MCG</b>	1	
<b>LARIN 24 FE ORAL TABLET 1-20 MG-MCG(24)</b>	1	
Larin Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Larin Fe 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Larissia Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
Lessina Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	\$0	\$0 Copay PPACA Guidelines.
<b>LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG</b>	1	
Loestrin Fe 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Loestrin Fe 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Low-Ogestrel Oral Tablet 0.3-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Lutera Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
<b>MICROGESTIN 24 FE ORAL TABLET 1-20 MG-MCG</b>	1	
Microgestin FE 1.5/30 Oral Tablet 1.5-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Microgestin FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Mili Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Mono-Linyah Oral Tablet 0.25-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
MonoNessa Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay per PPACA guidelines.
Necon 1/35 (28) Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	\$0	\$0 copay Per PPACA Guidelines
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg	\$0	\$0 Copay per PPACA guidelines.
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg(24)</i>	1	

Drug Name	Tier	Notes
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	\$0	\$0 Copay per PPACA guidelines.
Nortrel 1/35 (21) Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Nortrel 1/35 (28) Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Nymyo Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Orsythia Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Pirmella 1/35 Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Previfem Oral Tablet 0.25-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Reclipsen Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Solia Oral Tablet 0.15-30 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Sprintec 28 Oral Tablet 0.25-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Sronyx Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
<b>TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)</b>	1	
Tarina FE 1/20 Oral Tablet 1-20 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Vienva Oral Tablet 0.1-20 MG-MCG	\$0	\$0 Copay PPACA Guidelines.
VyLibra Oral Tablet 0.25-35 MG-MCG	\$0	\$0 copay Per PPACA Guidelines
Zovia 1/35E (28) Oral Tablet 1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
<b>*COMBINATION CONTRACEPTIVES - TRANSDERMAL***</b>		
Xulane Transdermal Patch Weekly 150-35 MCG/24HR	\$0	\$0 Copay per PPACA guidelines.; QL (3 EA per 28 days); AG (Max 55 Years)
Zafemy Transdermal Patch Weekly 150-35 MCG/24HR	\$0	\$0 Copay PPACA Guidelines.
<b>*COMBINATION CONTRACEPTIVES - VAGINAL***</b>		
EluRyng Vaginal Ring 0.12-0.015 MG/24HR	\$0	\$0 Copay PPACA Guidelines.; QL (1 EA per 28 days); AG (Max 55 Years)
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	\$0	\$0 Copay PPACA Guidelines.; QL (1 EA per 28 days); AG (Max 55 Years)
<b>*CONTINUOUS CONTRACEPTIVES - ORAL***</b>		
<i>levonorgestrel-ethinyl estrad oral tablet 90-20 mcg</i>	1	
<b>*COPPER CONTRACEPTIVES - IUD***</b>		
Paragard Intrauterine Copper Intrauterine Intrauterine Device	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<b>*EMERGENCY CONTRACEPTIVES***</b>		
Aftera Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
EContra EZ Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)

<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
Ella Oral Tablet 30 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
levonorgestrel oral tablet 1.5 mg	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
My Way Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Next Choice One Dose Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; QL (3 EA per 365 days); AG (Max 55 Years)
Opcicon One-Step Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Take Action Oral Tablet 1.5 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<b>*EXTENDED-CYCLE CONTRACEPTIVES - ORAL***</b>		
Amethia Lo Oral Tablet 0.1-0.02 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Amethia Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.
Ashlyna Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.
Camrese Lo Oral Tablet 0.1-0.02 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Camrese Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.
Daysee Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.
Iclevia Oral Tablet 0.15-0.03 MG	\$0	\$0 copay Per PPACA Guidelines
Introvale Oral Tablet 0.15-0.03 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Jaimiess Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years); AG (Max 55 Years)
Jolessa Oral Tablet 0.15-0.03 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 mg	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 & 0.01 mg	\$0	\$0 Copay per PPACA guidelines.
LoJaimiess Oral Tablet 0.1-0.02 & 0.01 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years); AG (Max 55 Years)
Quasense Oral Tablet 0.15-0.03 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Setlakin Oral Tablet 0.15-0.03 MG	\$0	\$0 Copay per PPACA guidelines.
Simpesse Oral Tablet 0.15-0.03 & 0.01 MG	\$0	\$0 Copay PPACA Guidelines.
<b>*PROGESTIN CONTRACEPTIVES - INJECTABLE***</b>		
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)

Drug Name	Tier	Notes
<b>*PROGESTIN CONTRACEPTIVES - IUD***</b>		
Kyleena Intrauterine Intrauterine Device 19.5 MG	\$0	\$0 Copay PPACA Guidelines.
<b>*PROGESTIN CONTRACEPTIVES - ORAL***</b>		
Camila Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Deblitane Oral Tablet 0.35 MG	\$0	\$0 Copay Per PPACA Guidelines
Errin Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Heather Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Jencycla Oral Tablet 0.35 MG	\$0	\$0 Copay Per PPACA Guidelines
Jolivette Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Lyleq Oral Tablet 0.35 MG	\$0	\$0 Copay PPACA Guidelines.
Lyza Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Nora-BE Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines
norethindrone oral tablet 0.35 mg	\$0	\$0 Copay per PPACA guidelines.
Norlyda Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Norlyroc Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
Sharobel Oral Tablet 0.35 MG	\$0	\$0 Copay per PPACA guidelines.
<b>*TRIPHASIC CONTRACEPTIVES - ORAL***</b>		
Caziant Oral Tablet 0.1/0.125/0.15 -0.025 MG	\$0	\$0 Copayment per ACA guidelines.
Cesia Oral Tablet 0.1/0.125/0.15 -0.025 MG	\$0	\$0 Copayment per ACA guidelines.
Cyclafem 7/7/7 Oral Tablet 0.5/0.75/1-35 MG-MCG	\$0	\$0 Copay per PPACA guidelines.
Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 MCG	\$0	\$0 Copayment per ACA guidelines.
Levonest Oral Tablet 50-30/75-40/ 125-30 MCG	\$0	\$0 Copayment per ACA guidelines.
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	\$0	\$0 copay Per PPACA Guidelines
Myzilra Oral Tablet 50-30/75-40/ 125-30 MCG	\$0	\$0 Copay per PPACA guidelines.
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	\$0	\$0 Copay per PPACA guidelines.
Tri Femynor Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 Copay per PPACA guidelines.
Tri-Estarylla Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 Copay per PPACA guidelines.
Tri-Linyah Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 Copay per PPACA guidelines.
Tri-Mili Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 copay Per PPACA Guidelines
TriNessa (28) Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 Copay per PPACA guidelines.
Tri-Nymyo Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 copay Per PPACA Guidelines
Tri-Previfem Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 Copay per PPACA guidelines.
Tri-Sprintec Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 Copay per PPACA guidelines.
Trivora (28) Oral Tablet 50-30/75-40/ 125-30 MCG	\$0	\$0 Copay per PPACA guidelines.
Tri-VyLibra Oral Tablet 0.18/0.215/0.25 MG-35 MCG	\$0	\$0 copay Per PPACA Guidelines



Drug Name	Tier	Notes
Velivet Oral Tablet 0.1/0.125/0.15 -0.025 MG	\$0	\$0 Copay per PPACA guidelines.
<b>*CORTICOSTEROIDS*</b>		
<b>*GLUCOCORTICOSTEROIDS***</b>		
<b>DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML, 40 MG/ML, 80 MG/ML</b>	MB	
<i>dexamethasone sodium phosphate injection solution 20 mg/5ml</i>	MB	
<b>*STEROID COMBINATIONS***</b>		
<i>betamethasone combo injection suspension 6 (3-3) mg/ml</i>	MB	
<b>*DERMATOLOGICALS*</b>		
<b>*PHOTODYNAMIC THERAPY AGENTS - TOPICAL ***</b>		
<b>AMELUZ EXTERNAL GEL 10 %</b>	MB	
<b>*DIAGNOSTIC PRODUCTS*</b>		
<b>*DIAGNOSTIC DRUGS***</b>		
<b>ACTHREL INTRAVENOUS SOLUTION RECONSTITUTED 100 MCG</b>	MB	
<b>CORTROSYN INJECTION SOLUTION RECONSTITUTED 0.25 MG</b>	MB	
<i>dipyridamole intravenous solution 5 mg/ml</i>	MB	
<b>*DIAGNOSTIC TESTS***</b>		
<b>ACCU-CHEK AVIVA PLUS IN VITRO STRIP</b>	1	100 test strips per 30 days are covered for members who are not on insulin. 200 test strips per 30 days are covered for members who are receiving insulin.; QL (100 EA per 30 days)
<b>ACCU-CHEK GUIDE IN VITRO STRIP</b>	1	100 test strips per 30 days are covered for members who are not on insulin. 200 test strips per 30 days are covered for members who are receiving insulin.; QL (100 EA per 30 days)
<b>ACCU-CHEK SMARTVIEW IN VITRO STRIP</b>	1	100 test strips per 30 days are covered for members who are not on insulin. 200 test strips per 30 days are covered for members who are receiving insulin.; QL (100 EA per 30 days)
<b>*INFECTION TESTS***</b>		
BD Veritor Home Covid-19 Test In Vitro Kit	\$0	
BinaxNOW COVID-19 Ag Home Test In Vitro Kit	\$0	

Drug Name	Tier	Notes
Carestart COVID-19 Home Test In Vitro Kit	\$0	
ClearDetect COVID-19 AG Home In Vitro Kit	\$0	
Clinitest Rapid COVID-19 Test In Vitro Kit	\$0	
covid-19 at-home test in vitro kit	\$0	
ellume covid-19 home test in vitro kit	\$0	
Flowflex COVID-19 Ag Home Test In Vitro Kit	\$0	
IHealth COVID-19 Rapid Test In Vitro Kit	\$0	
On/Go Covid-19 Antigen Test In Vitro Kit	\$0	
QuickVue At-Home Covid-19 Test In Vitro Kit	\$0	
<b>*DIURETICS*</b>		
<b>*CARBONIC ANHYDRASE INHIBITORS***</b>		
<i>acetazolamide sodium injection solution reconstituted 500 mg</i>	MB	
<b>*THIAZIDES AND THIAZIDE-LIKE DIURETICS***</b>		
<b>SODIUM DIURIL INTRAVENOUS SOLUTION RECONSTITUTED 500 MG</b>	MB	
<b>*ENDOCRINE AND METABOLIC AGENTS - MISC.*</b>		
<b>*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS***</b>		
mifepristone oral tablet 200 mg	\$0	
<b>*BISPHOSPHONATES***</b>		
<i>zoledronic acid intravenous concentrate 4 mg/5ml</i>	MB	
<i>zoledronic acid intravenous solution 4 mg/100ml, 5 mg/100ml</i>	MB	
<b>*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS***</b>		
<i>calcitriol intravenous solution 1 mcg/ml</i>	MB	
<i>doxercalciferol intravenous solution 4 mcg/2ml</i>	MB	
<b>*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS***</b>		
<b>LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG, 7.5 MG</b>	MB	
<b>LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED), 30 MG (PED)</b>	MB	

Drug Name	Tier	Notes
<b>*OVULATION STIMULANTS-GONADOTROPINS***</b>		
chorionic gonadotropin intramuscular solution reconstituted 10000 unit	Not Covered	
Novarel Intramuscular Solution Reconstituted 10000 UNIT	Not Covered	
Pregnyl Intramuscular Solution Reconstituted 10000 UNIT	Not Covered	
<b>*RANK LIGAND (RANKL) INHIBITORS***</b>		
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	MB	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	MB	PA
<b>*SOMATOSTATIC AGENTS***</b>		
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	MB	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT 10 MG, 20 MG, 30 MG	MB	
<b>*X-LINKED HYPOPHOSPHATEMIA (XLH) TREATMENT - AGENTS***</b>		
CRYSVITA SUBCUTANEOUS SOLUTION 10 MG/ML, 20 MG/ML, 30 MG/ML	MB	PA
<b>*ESTROGENS*</b>		
<b>*ESTROGENS***</b>		
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML	MB	
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML	MB	
PREMARIN INJECTION SOLUTION RECONSTITUTED 25 MG	MB	
<b>*FLUOROQUINOLONES*</b>		
<b>*FLUOROQUINOLONES***</b>		
<i>ciprofloxacin in d5w intravenous solution 200 mg/100ml</i>	MB	
<b>*GASTROINTESTINAL AGENTS - MISC.*</b>		
<b>*INTEGRIN RECEPTOR ANTAGONISTS***</b>		
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG	MB	PA
<b>*TUMOR NECROSIS FACTOR ALPHA BLOCKERS***</b>		
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA

<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA
RENFLXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	MB	PA
<b>*HEMATOLOGICAL AGENTS - MISC.*</b>		
<b>*ANTIHEMOPHILIC PRODUCTS***</b>		
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	SP
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT	MB	SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	MB	SP
ALPHANATE/VWF COMPLEX/HUMAN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT	MB	SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1500 UNIT, 500 UNIT	MB	
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT	MB	SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT	MB	SP
FEIBA NF INTRAVENOUS SOLUTION RECONSTITUTED	MB	
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT	MB	SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT	MB	SP
KCENTRA INTRAVENOUS KIT 1000 UNIT, 500 UNIT	MB	
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT	MB	SP
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT	MB	SP
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	SP
MONONINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT	MB	SP
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT	MB	SP

Drug Name	Tier	Notes
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG	MB	SP
NUWIQ INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT	MB	SP
<i>obizur intravenous solution reconstituted 500 unit</i>	MB	SP
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	SP
PROFILNINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT	MB	SP
RIASTAP INTRAVENOUS SOLUTION RECONSTITUTED	MB	SP
<i>rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit</i>	MB	SP
TRETEN INTRAVENOUS SOLUTION RECONSTITUTED 2000-3125 UNIT	MB	SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT	MB	SP
<b>*COMPLEMENT INHIBITORS***</b>		
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30ML	MB	PA
ULTOMIRIS INTRAVENOUS SOLUTION 1100 MG/11ML, 300 MG/30ML, 300 MG/3ML	MB	PA
<b>*GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS***</b>		
INTEGRILIN INTRAVENOUS SOLUTION 75 MG/100ML	MB	
REOPRO INTRAVENOUS SOLUTION 2 MG/ML	MB	
<b>*PLASMA KALLIKREIN INHIBITORS***</b>		
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML	MB	PA
<b>*HEMATOPOIETIC AGENTS*</b>		
<b>*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)***</b>		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	MB	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML	MB	PA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	MB	PA; QL (12 ML per 28 days)
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	MB	PA; QL (4 ml per 28 days)

Drug Name	Tier	Notes
<b>*FOLIC ACID/FOLATES***</b>		
cvs folic acid oral tablet 800 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
FA-8 Oral Tablet 800 MCG	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
folic acid oral tablet 800 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
gnp folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
hm folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
kp folic acid oral tablet 800 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
px folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
ra folic acid oral tablet 400 mcg, 800 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
sm folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
yl folic acid oral tablet 400 mcg	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
<b>*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)***</b>		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML	MB	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	MB	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	MB	PA
<b>*IRON***</b>		
FERAHEME INTRAVENOUS SOLUTION 510 MG/17ML	MB	PA
INFED INJECTION SOLUTION 50 MG/ML	MB	PA
INJECTAFER INTRAVENOUS SOLUTION 750 MG/15ML	MB	PA
<i>na ferric gluc cplx in sucrose intravenous solution 12.5 mg/ml</i>	MB	PA
VENOFER INTRAVENOUS SOLUTION 20 MG/ML	MB	PA
<b>*HEMOSTATICS*</b>		
<b>*HEMOSTATICS - SYSTEMIC***</b>		

Drug Name	Tier	Notes
<i>tranexamic acid intravenous solution 1000 mg/10ml</i>	MB	
<b>*HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS*</b>		
<b>*BARBITURATE HYPNOTICS***</b>		
AMYTAL SODIUM INJECTION SOLUTION RECONSTITUTED 500 MG	MB	
<b>*SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES***</b>		
<i>dexmedetomidine hcl in nacl intravenous solution 200 mcg/50ml, 400 mcg/100ml</i>	MB	
<b>*LAXATIVES*</b>		
<b>*BOWEL EVACUANT COMBINATIONS***</b>		
GaviLyte-C Oral Solution Reconstituted 240 GM	\$0	\$0 Copay PPACA Guidelines.; QL (8000 ML per 365 days); AG (Min 50 Years)
GaviLyte-G Oral Solution Reconstituted 236 GM	\$0	\$0 Copay PPACA Guidelines.; QL (8000 ML per 30 days); AG (Min 50 Years)
Golytely Oral Solution Reconstituted 227.1 GM	\$0	\$0 Copayment per ACA guidelines.; QL (8000 EA per 365 days); AG (Min 50 Years)
peg 3350/electrolytes oral solution reconstituted 240 gm	\$0	\$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AG (Min 50 Years)
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	\$0	\$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AG (Min 50 Years)
peg-3350/electrolytes oral solution reconstituted 236 gm	\$0	\$0 Copay per PPACA guidelines.; QL (8000 ML per 365 days); AG (Min 50 Years)
<b>*LOCAL ANESTHETICS-PARENTERAL*</b>		
<b>*LOCAL ANESTHETICS - AMIDES***</b>		
CARBOCAINE PRESERVATIVE-FREE INJECTION SOLUTION 1 %	MB	
EXPAREL INJECTION SUSPENSION 1.3 %	MB	
<b>*MACROLIDES*</b>		
<b>*AZITHROMYCIN***</b>		
ZITHROMAX INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
<b>*ERYTHROMYCINS***</b>		

Drug Name	Tier	Notes
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	MB	
<b>*MEDICAL DEVICES AND SUPPLIES*</b>		
<b>*CONDOMS - FEMALE***</b>		
FC Female Condom	\$0	\$0 Copay per PPACA guidelines.
FC2 Female Condom	\$0	\$0 Copay per PPACA guidelines.
<b>*CONDOMS - MALE***</b>		
condoms	\$0	\$0 Copay PPACA Guidelines.
<b>*DIAPHRAGMS***</b>		
Caya Vaginal Diaphragm	\$0	\$0 copay per PPACA guidelines.
Omniflex Diaphragm Vaginal Diaphragm	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 60 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 65 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 70 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 75 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 80 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 85 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 90 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
Wide-Seal Diaphragm 95 Vaginal Diaphragm 2 %	\$0	\$0 copay per PPACA guidelines.
<b>*GLUCOSE MONITORING TEST SUPPLIES***</b>		
<b>ACCU-CHEK FASTCLIX LANCETS</b>	1	100 lancets per 30 days are covered for members who are not on insulin. 200 lancets per 30 days are covered for members who are receiving insulin.; QL (102 EA per 30 days)
<b>ACCU-CHEK MULTICLIX LANCETS</b>	1	100 lancets per 30 days are covered for members who are not on insulin. 200 lancets per 30 days are covered for members who are receiving insulin.
<b>ACCU-CHEK SOFT TOUCH LANCETS</b>	1	100 lancets per 30 days are covered for members who are not on insulin. 200 lancets per 30 days are covered for members who are receiving insulin.; QL (100 EA per 30 days)
<b>ACCU-CHEK SOFTCLIX LANCETS</b>	1	100 lancets per 30 days are covered for members who are not on insulin. 200 lancets per 30 days are covered for members who are receiving insulin.; QL (100 EA per 30 days)
<b>DEXCOM G6 RECEIVER DEVICE</b>	2	PA; QL (1 EA per 365 days)
<b>DEXCOM G6 SENSOR</b>	2	PA; QL (3 EA per 30 days)



Drug Name	Tier	Notes
DEXCOM G6 TRANSMITTER	2	PA; QL (1 EA per 90 days)
FREESTYLE LIBRE 14 DAY READER DEVICE	2	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR	2	PA; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER SYSTM DEVICE	2	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 2 SENSOR SYSTM	2	PA; QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE	2	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE SENSOR SYSTEM	2	PA; QL (3 EA per 30 days)
GUARDIAN LINK 3 TRANSMITTER	3	PA; QL (1 EA per 365 days)
GUARDIAN SENSOR (3)	2	PA; QL (5 EA per 30 days)
<i>guardian sensor 3</i>	2	PA; QL (5 EA per 30 days)
MINIMED GUARDIAN LINK 3	2	PA; QL (1 EA per 365 days)
MINIMED GUARDIAN SENSOR 3	2	PA; QL (5 EA per 30 days)
<b>*INSULIN ADMINISTRATION SUPPLIES***</b>		
MINIMED GUARDIAN LINK 3	2	PA; QL (1 EA per 365 days)
<b>*NEEDLES &amp; SYRINGES***</b>		
NOVOFINE 32G X 6 MM	1	QL (100 EA per 30 days)
<b>*MIGRAINE PRODUCTS*</b>		
<b>*MIGRAINE PRODUCTS***</b>		
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	MB	
<b>*MINERALS &amp; ELECTROLYTES*</b>		
<b>*CALCIUM***</b>		
<i>calcium gluconate intravenous solution 10 %</i>	MB	
<b>CALPHOSAN INJECTION SOLUTION 50-50 MG/10ML</b>	MB	
<b>*FLUORIDE***</b>		
Flura-Drops Oral Solution 0.275 (0.125 F) MG/DROP, 0.55 (0.25 F) MG/DROP	\$0	\$0 Copay PPACA Guidelines.; AG (Max 6 Years)
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	\$0	\$0 copay per PPACA guidelines.; AG (Min 6 Years and Max 5 Years)
sodium fluoride oral tablet 1.1 (0.5 f) mg, 2.2 (1 f) mg	\$0	\$0 Copay per PPACA guidelines.; AG (Min 6 Years and Max 5 Years)
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	\$0	\$0 Copay per PPACA guidelines.; AG (Min 6 Years and Max 5 Years)
<b>*ZINC***</b>		
<i>zinc sulfate intravenous solution 3 mg/ml</i>	MB	
<b>*MISCELLANEOUS THERAPEUTIC CLASSES*</b>		
<b>*B-LYMPHOCYTE STIMULATOR (BLYS)-SPECIFIC INHIBITORS***</b>		

Drug Name	Tier	Notes
<b>BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG, 400 MG</b>	MB	PA
<b>*ENZYMES***</b>		
<b>HYLENEX INJECTION SOLUTION 150 UNIT/ML</b>	MB	PA
<b>*MACROLIDE IMMUNOSUPPRESSANTS***</b>		
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	3	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	1	
<b>ZORTRESS ORAL TABLET 1 MG</b>	4	PA
<b>*MONOCLONAL ANTIBODIES***</b>		
<b>GAMIFANT INTRAVENOUS SOLUTION 10 MG/2ML, 50 MG/10ML</b>	MB	PA
<b>SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG</b>	MB	
<b>*SCLEROSING AGENTS***</b>		
<b>ETHAMOLIN INTRAVENOUS SOLUTION 5 %</b>	MB	
<b>*MULTIVITAMINS*</b>		
<b>*PEDIATRIC VITAMINS A &amp; D W/ C***</b>		
<i>tri-vite pediatric oral solution 750-400-35 unit-mg/ml</i>	\$0	\$0 Copay per PPACA Guidelines.; AG (Max 6 Years)
<b>*PRENATAL MV &amp; MIN W/FE-FA***</b>		
<i>multi prenatal oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<i>pnv prenatal plus multivitamin oral tablet 27-1 mg</i>	2	
<b>PRENATABS RX ORAL TABLET 29-1 MG</b>	2	
<i>prenatal 19 oral tablet chewable , 29-1 mg</i>	2	
<i>prenatal low iron oral tablet 27-0.8 mg, 27-1 mg</i>	2	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<i>prenatal oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<i>prenatal oral tablet 27-1 mg</i>	2	
<i>prenatal plus iron oral tablet 29-1 mg</i>	2	
<i>prenatal plus oral tablet 27-1 mg</i>	2	
<i>prenatal plus/iron oral tablet 27-1 mg</i>	2	
<i>prenatal vitamin oral tablet 27-0.8 mg</i>	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<b>PRENATAL/FOLIC ACID ORAL TABLET</b>	2	
<b>PRENATAL-U ORAL CAPSULE 106.5-1 MG</b>	2	

Drug Name	Tier	Notes
Right Step Prenatal Oral Tablet 27-0.8 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
<b>*MUSCULOSKELETAL THERAPY AGENTS*</b>		
<b>*CENTRAL MUSCLE RELAXANTS***</b>		
LIORESAL INTRATHECAL SOLUTION 0.05 MG/ML	MB	
<b>*VISCOSUPPLEMENTS***</b>		
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML	MB	PA
GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE 30 MG/3ML	MB	PA
<b>*NEUROMUSCULAR AGENTS*</b>		
<b>*DEPOLARIZING MUSCLE RELAXANTS***</b>		
<i>succinylcholine chloride injection solution 20 mg/ml</i>	MB	
<b>*NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS***</b>		
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT, 200 UNIT	MB	PA
DYSPORT INTRAMUSCULAR SOLUTION RECONSTITUTED 300 UNIT, 500 UNIT	MB	PA
MYOBLOC INTRAMUSCULAR SOLUTION 10000 UNIT/2ML, 2500 UNIT/0.5ML, 5000 UNIT/ML	MB	PA
<b>*OPHTHALMIC AGENTS*</b>		
<b>*OPHTHALMIC ANTIBIOTICS***</b>		
erythromycin ophthalmic ointment 5 mg/gm	\$0	\$0 Copay for members 1 year of age or younger per PPACA guidelines; AG (Max 1 Years)
<b>*OPHTHALMIC SURGICAL AIDS - COMBINATIONS***</b>		
OMIDRIA INTRAOCULAR SOLUTION 1-0.3 %	MB	
<b>*VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) ANTAGONISTS***</b>		
EYLEA INTRAVITREAL SOLUTION 2 MG/0.05ML	MB	
EYLEA INTRAVITREAL SOLUTION PREFILLED SYRINGE 2 MG/0.05ML	MB	
LUCENTIS INTRAVITREAL SOLUTION 0.3 MG/0.05ML, 0.5 MG/0.05ML	MB	
<b>*OXYTOCICS*</b>		
<b>*ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS***</b>		

Drug Name	Tier	Notes
<i>carboprost tromethamine intramuscular solution 250 mcg/ml</i>	MB	
<b>*PASSIVE IMMUNIZING AND TREATMENT AGENTS*</b>		
<b>*ANTITOXINS-ANTIVENINS***</b>		
ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
ANAVIP INTRAVENOUS SOLUTION RECONSTITUTED	MB	
CROFAB INTRAVENOUS SOLUTION RECONSTITUTED	MB	
<b>*ANTIVIRAL MONOCLONAL ANTIBODIES***</b>		
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML	MB	PA
<b>*IMMUNE SERUMS***</b>		
CYTOGAM INTRAVENOUS INJECTABLE 50 MG/ML	MB	PA
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 0.5 GM/10ML, 10 GM/100ML, 10 GM/200ML, 2.5 GM/50ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML	MB	PA
GAMUNEX INTRAVENOUS SOLUTION 1 GM/10ML	MB	PA
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
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	MB	PA
<b>*PENICILLINS*</b>		
<b>*AMINOPENICILLINS***</b>		
<i>ampicillin sodium injection solution reconstituted 125 mg</i>	MB	
<b>*NATURAL PENICILLINS***</b>		
BICILLIN L-A INTRAMUSCULAR SUSPENSION 600000 UNIT/ML	MB	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 600000 UNIT/ML	MB	
<b>*PENICILLIN COMBINATIONS***</b>		
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML	MB	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML	MB	

Drug Name	Tier	Notes
UNASYN INJECTION SOLUTION RECONSTITUTED 1.5 (1-0.5) GM	MB	
<b>*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*</b>		
<b>*MULTIPLE SCLEROSIS AGENTS - MONOCLONAL ANTIBODIES***</b>		
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML	MB	PA
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML	MB	PA
<b>*SMALL INTERFERING RIBONUCLEIC ACID (SIRNA) AGENTS***</b>		
ONPATTRO INTRAVENOUS SOLUTION 10 MG/5ML	MB	PA
<b>*SMOKING DETERRENTS***</b>		
apo-varenicline oral tablet 0.5 mg, 1 mg	\$0	ST; \$0 Copay PPACA Guidelines.; QL (360 EA per 365 days)
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	\$0	\$0 Copay per PPACA guidelines. Limited to two 90 day courses per 365 days.; QL (360 EA per 365 days)
Chantix Continuing Month Pak Oral Tablet 1 MG	\$0	ST; To qualify for \$0 copay the step therapy requirement has to be met. The patient must have a claim history of one over-the-counter (OTC) nicotine product and bupropion ER.; QL (360 EA per 365 days)
Chantix Oral Tablet 0.5 MG, 1 MG	\$0	ST; To qualify for \$0 copay the step therapy requirement has to be met. The patient must have a claim history of one over-the-counter (OTC) nicotine product and bupropion ER.; QL (360 EA per 365 days)
Chantix Starting Month Pak Oral Tablet 0.5 MG X 11 & 1 MG X 42	\$0	ST; To qualify for \$0 copay the step therapy requirement has to be met. The patient must have a claim history of one over-the-counter (OTC) nicotine product and bupropion ER.; QL (360 EA per 365 days)
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	\$0	\$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (4300 EA per 365 days)
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	\$0	\$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (3600 EA per 365 days)

Drug Name	Tier	Notes
nicotine transdermal kit 21-14-7 mg/24hr	\$0	\$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr	\$0	\$0 dollar copayment per ACA guidelines. Limited to two 90 courses per 365 days.; QL (182 EA per 365 days)
nicotine transdermal patch 24 hour 7 mg/24hr	\$0	\$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; QL (182 EA per 365 days)
Nicotrol Inhalation Inhaler 10 MG	\$0	ST; \$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; QL (3024 EA per 365 days)
Nicotrol NS Nasal Solution 10 MG/ML	\$0	ST; \$0 dollar copayment per PPACA guidelines. Limited to two 90 courses per 365 days.; QL (720 ML per 365 days)
varenicline tartrate oral tablet 0.5 mg, 1 mg	\$0	ST; \$0 Copay PPACA Guidelines.; QL (360 EA per 365 days)
<b>*TOXOIDS*</b>		
<b>*TOXOID COMBINATIONS***</b>		
Adacel Intramuscular Suspension 5-2-15.5 LF-MCG/0.5	\$0	\$0 Copay for Preventative Services.
Boostrix Intramuscular Suspension 5-2.5-18.5	\$0	\$0 Copay for Preventative Services.
Boostrix Intramuscular Suspension Prefilled Syringe 5-2.5-18.5 LF-MCG/0.5	\$0	\$0 Copay for Preventative Services.
tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml	\$0	\$0 Copay for Preventative Services.
<b>*ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS*</b>		
<b>*ANTISPASMODICS***</b>		
<i>dicyclomine hcl intramuscular solution 10 mg/ml</i>	MB	
<b>*BELLADONNA ALKALOIDS***</b>		
<i>atropine sulfate injection solution 8 mg/20ml</i>	MB	
<i>atropine sulfate injection solution prefilled syringe 1 mg/10ml</i>	MB	
<b>*H-2 ANTAGONISTS***</b>		
<i>ranitidine hcl injection solution 1000 mg/40ml, 150 mg/6ml</i>	MB	
<b>*PROTON PUMP INHIBITORS***</b>		

Drug Name	Tier	Notes
<i>pantoprazole sodium intravenous solution reconstituted 40 mg</i>	MB	
<b>*VACCINES*</b>		
<b>*BACTERIAL VACCINES***</b>		
<b>BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b>	MB	
Menactra Intramuscular Injectable	\$0	\$0 Copay for Preventative Services.
Menactra Intramuscular Solution	\$0	\$0 Copay for Preventative Services.
Menveo Intramuscular Solution Reconstituted	\$0	\$0 Copay for Preventative Services.
Pneumovax 23 Injection Injectable 25 MCG/0.5ML	\$0	\$0 Copay for Preventative Services
Pevnar 13 Intramuscular Suspension	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
<b>*VIRAL VACCINE COMBINATIONS***</b>		
M-M-R II Subcutaneous Injectable	\$0	\$0 copay for Preventative Services.
ProQuad Subcutaneous Injectable	\$0	\$0 copay for Preventative Services.
Twinrix Intramuscular Suspension 720-20	\$0	\$0 Copay for Preventative Services.
Twinrix Intramuscular Suspension Prefilled Syringe 720-20 ELU-MCG/ML	\$0	\$0 Copay PPACA Guidelines.
<b>*VIRAL VACCINES***</b>		
Afluria Intramuscular Suspension	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Afluria Preservative Free Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Afluria Quadrivalent Intramuscular Suspension	\$0	\$0 Copay for Preventative Services.; QL (0.5 ML per 180 days)
Afluria Quadrivalent Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay for Preventative Services.; QL (0.5 ML per 180 days)
astrazeneca covid-19 vaccine intramuscular suspension 0.5 ml	\$0	\$0 Copay PPACA Guidelines.
Comirnaty Intramuscular Suspension 30 MCG/0.3ML	\$0	\$0 Copay PPACA Guidelines.; QL (0.3 ML per 21 days); AG (Min 12 Years)
Engerix-B Injection Suspension 10 MCG/0.5ML, 20 MCG/ML	\$0	\$0 Copay for Preventative Services.
Engerix-B Intramuscular Injectable 10 MCG/0.5ML	\$0	\$0 Copay for Preventative Services
Engerix-B Intramuscular Injectable 20 MCG/ML	\$0	\$0 Copay for Preventative Services.
Fluad Quadrivalent Intramuscular Prefilled Syringe 0.5 ML	\$0	
Fluarix Quadrivalent Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Flublok Quadrivalent Intramuscular Solution Prefilled Syringe 0.5 ML	\$0	PA; \$0 Copay for Preventative Services.; QL (0.5 ML per 180 days)

<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
Flucelvax Quadrivalent Intramuscular Suspension	\$0	\$0 Copay for Preventative Services.; QL (0.5 ML per 180 days)
Flucelvax Quadrivalent Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay for Preventative Services.; QL (0.5 ML per 180 days)
Flulaval Quadrivalent Intramuscular Suspension	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Flulaval Quadrivalent Intramuscular Suspension Prefilled Syringe 0.5 ML	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
FluMist Quadrivalent Nasal Suspension	\$0	\$0 Copay PPACA Guidelines.; QL (1 EA per 180 days); AG (Min 2 Years and Max 49 Years)
Fluzone High-Dose Quadrivalent Intramuscular Suspension Prefilled Syringe 0.7 ML	\$0	\$0 Copay PPACA Guidelines.; QL (0.7 ML per 180 days); AG (Min 65 Years)
Fluzone Quadrivalent Intramuscular Suspension , 0.5 ML	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Fluzone Quadrivalent Intramuscular Suspension Prefilled Syringe 0.25 ML, 0.5 ML	\$0	\$0 Copay for Preventative Services; QL (0.5 ML per 180 days)
Gardasil 9 Intramuscular Suspension	\$0	\$0 Copay PPACA Guidelines.; AG (Min 9 Years and Max 26 Years)
Gardasil 9 Intramuscular Suspension Prefilled Syringe	\$0	\$0 Copay PPACA Guidelines.; AG (Min 9 Years and Max 26 Years)
Havrix Intramuscular Suspension 1440 EL U/ML	\$0	\$0 Copay for Preventative Services.
Havrix Intramuscular Suspension 720 EL U/0.5ML	\$0	\$0 Copay for Preventative Services
Hepilisav-B Intramuscular Solution 20 MCG/0.5ML	\$0	\$0 Copay PPACA Guidelines.; QL (1 ML per 1 day)
janssen covid-19 vaccine intramuscular suspension 0.5 ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.5 ML per 56 days); AG (Min 18 Years)
moderna covid-19 bival booster intramuscular suspension 50 mcg/0.5ml	\$0	\$0 Copay Preventative; QL (0.5 ML per 365 days); AG (Min 18 Years)
moderna covid-19 vac (booster) intramuscular suspension 50 mcg/0.5ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.5 ML per 28 days); AG (Min 6 Years)
moderna covid-19 vac (booster) intramuscular suspension 50 mg/0.5ml	\$0	\$0 Copay PPACA Guidelines.
moderna covid-19 vacc 6-11y intramuscular suspension 50 mcg/0.5ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.5 ML per 28 days); AG (Min 6 Years)
moderna covid-19 vacc 6m-5y intramuscular suspension 25 mcg/0.25ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.25 ML per 28 days); AG (Min 6 Months)
moderna covid-19 vaccine intramuscular suspension 100 mcg/0.5ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.5 ML per 28 days); AG (Min 12 Years)



<b>Drug Name</b>	<b>Tier</b>	<b>Notes</b>
novavax covid-19 vaccine intramuscular suspension 5 mcg/0.5ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.5 ML per 21 days); AG (Min 12 Years)
pfizer covid-19 vac bivalent intramuscular suspension 30 mcg/0.3ml	\$0	\$0 Copay Preventative; QL (0.3 ML per 365 days); AG (Min 12 Years)
pfizer covid-19 vac-tris 5-11y intramuscular suspension 10 mcg/0.2ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.2 ML per 21 days); AG (Min 5 Years)
pfizer covid-19 vac-tris 6m-4y intramuscular suspension 3 mcg/0.2ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.2 ML per 21 days); AG (Min 6 Months)
pfizer-biont covid-19 vac-tris intramuscular suspension 30 mcg/0.3ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.3 ML per 21 days); AG (Min 12 Years)
pfizer-biontech covid-19 vacc intramuscular suspension 30 mcg/0.3ml	\$0	\$0 Copay PPACA Guidelines.; QL (0.3 ML per 21 days); AG (Min 12 Years)
Recombivax HB Injection Suspension 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	\$0	\$0 Copay for Preventative Services.
Spikevax COVID-19 Vaccine Intramuscular Suspension 100 MCG/0.5ML	\$0	\$0 Copay Preventative; QL (0.5 ML per 28 days); AG (Min 12 Years)
Vaqtia Intramuscular Suspension 25 UNIT/0.5ML	\$0	\$0 Copay for Preventative Services
Vaqtia Intramuscular Suspension 50 UNIT/ML	\$0	\$0 Copay for Preventative Services.
Varivax Subcutaneous Injectable 1350 PFU/0.5ML	\$0	\$0 Copay for Preventative Services.
<b>*VAGINAL AND RELATED PRODUCTS*</b>		
<b>*SPERMICIDES***</b>		
Encare Vaginal Suppository 100 MG	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Options Conceptrol Vaginal Gel 4 %	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
Options Gynol II Contraceptive Vaginal Gel 3 %	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)
Shur-Seal Contraceptive Vaginal Gel 2 %	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
Today Sponge Vaginal 1000 MG	\$0	\$0 Copay PPACA Guidelines.
VCF Vaginal Contraceptive Vaginal Film 28 %	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
VCF Vaginal Contraceptive Vaginal Foam 12.5 %	\$0	\$0 Copay per PPACA guidelines.; AG (Max 55 Years)
VCF Vaginal Contraceptive Vaginal Gel 4 %	\$0	\$0 copay per PPACA guidelines.; AG (Max 55 Years)

## Medical Benefit

Drug Name	Tier	Notes
<i>benztropine mesylate injection solution 1 mg/ml</i>	MB	
<i>decitabine intravenous solution reconstituted 50 mg</i>	MB	PA
FemCap Vaginal Device 22 MM, 26 MM, 30 MM	\$0	\$0 copay per PPACA guidelines.
Mirena (52 MG) Intrauterine Intrauterine Device 20 MCG/24HR, 20 MCG/DAY	\$0	\$0 Copay per PPACA guidelines; AG (Max 55 Years)
Nexplanon Subcutaneous Implant 68 MG	\$0	\$0 Copay per PPACA guidelines; QL (1 EA per 3 days); AG (Max 55 Years)
<b>PERJETA INTRAVENOUS SOLUTION 420 MG/14ML</b>	MB	PA
<b>POLIVY INTRAVENOUS SOLUTION RECONSTITUTED 140 MG</b>	MB	PA
Skyla Intrauterine Intrauterine Device 13.5 MG	\$0	\$0 Copay per PPACA guidelines.

## DISCLAIMER

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, please contact the Presbyterian Customer Service Center.

Hours: Monday through Friday from 7:00 a.m. to 6:00 p.m.

Phone: (505) 923-5678 or 1-800-356-2219

TTY: 711

Email: [info@phs.org](mailto:info@phs.org)

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.

- The medications listed on this Formulary/Preferred Drug Listing (PDL) are subject to change pursuant to the Formulary/PDL management activities of Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc.
- This list does not imply a guarantee of coverage.
- 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.
- Non-formulary medications are not considered for coverage unless trial and failure of formulary alternatives are documented.

## Explanation of Terms

1. **Age Limitation (AG)** -- a coverage limits based on minimum or maximum age of the member imposed as a result of safety, efficacy or dosage form considerations.
2. **Drug Efficacy Study Implementation (DESI)** – The FDA’s Drug Efficacy Study Implementation evaluates the effectiveness of those drugs that had been previously approved between 1938 and 1962 on safety grounds alone. Drugs determined through the DESI proceedings to be Less Than Effective (LTE), designation 5 or 6, are not covered and may be excluded from coverage under your plan.
3. **Medical Drugs (MED)** -- **A Medical Drug** is any drug administered by a Health Care Professional and is typically given in the member's home, physician’s office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization and some must be obtained through the specialty network. For a complete list of Medical Drugs to determine which require Prior Authorization please see the Presbyterian Pharmacy website at [www.phs.org](http://www.phs.org).

4. **Medical Exception (ME)** -- A drug that is not on the Plan's formulary. Non-formulary drugs require an Exception to the formulary due to allergy, adverse reactions, or no response to all formulary drugs. An exception may be requested by a prescriber, a member, or their appointed representative. The prescriber must provide information to support the medical exception request by fax, phone or regular mail.
5. **Patient Protection and Affordable Care Act (PPACA)** -- Under the Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act (ACA), certain preventive healthcare is covered with no copayment or coinsurance and is not subject to any deductible or out-of-pocket maximum.
6. **Prior Authorization (PA)** -- a drug that requires prior approval before the Plan will cover it, and when the patient meets the established criteria. The doctor must submit a Pharmacy Prior Authorization Form. The doctor can submit the request by fax, phone, or regular mail.
7. **Quantity Limit (QL)** -- a coverage limit on the medication quantity covered for a defined days' supply (usually 30 or 90 days) based on safety, efficacy and/or dose optimization issues.
8. **Specialty Pharmaceuticals Tier 4 (SP)** -- Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. 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 a 30 day supply. Specialty Pharmaceuticals are not available through the mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill up to a 14-day supply to ensure patients can tolerate the new medication.
9. **Step Edit (ST)** -- a drug that requires a prescription history of specific drugs in the pharmacy claims or data system, and these specific drugs must be taken during a given time frame. After the specific drugs have been taken within the given time frame, online coverage of the newly-prescribed drug occurs at the pharmacy. Step Edits make it easier to access drugs that would normally require a Prior Authorization.

[Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services.](#)