



2024 Formulary (List of Covered Drugs)

Mount Carmel MediGold Health Plan (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on contract renewal. Benefits vary by county. This information is not a complete description of benefits and some benefits are not available on all plans.

For the most updated list of covered drugs, please visit <https://www.thpmedicare.org/mount-carmel/my-medications/formulary>.

This formulary was updated on 11/1/2024. For more recent information or other questions, please contact Member Services at 1-800-240-3851 or, for TTY users, 711, 8 a.m. – 8 p.m., 7 days a week. On certain holidays, your call will be handled by our automated phone system.

Updated 11/2024

2024 Formulary

(List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION
ABOUT THE DRUGS WE COVER IN THIS PLAN**

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary refers to “we,” “us”, or “our,” it means Mount Carmel MediGold Health Plan, Inc. or Mount Carmel Health Insurance Company. When it refers to “plan” or “your plan,” it means Mount Carmel MediGold.

This document includes a list of the drugs (formulary for our plan which is current as of November 1, 2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

What is the Formulary?

A formulary is a list of covered drugs selected by your plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Your plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at your plan's network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but your plan may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary; or add new restrictions to the brand name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, and/or quantity limits on a drug or move a drug

to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of November 1, 2024. To get updated information about the drugs covered by your plan, please contact us. Our contact information appears on the front and back cover pages. In the event of a mid-year non-maintenance formulary change, the Formulary will be updated monthly and posted on our website.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, **CARDIOVASCULAR**. If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 86. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Your plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Your plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from your plan before you fill your prescriptions. If you don't get approval, your plan may not cover the drug.
- **Quantity Limits:** For certain drugs, your plan limits the amount of the drug that your plan will cover. For example, your plan provides 30 tablets per prescription for *rosuvastatin*. This may be in addition to a standard one-month or three-month supply.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explains our prior authorization restriction. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Formulary?" on page iii for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that your plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by your plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by your plan.
- You can ask your plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Formulary?

You can ask your plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- 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 a greater amount.

Generally, your plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary tiering or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Other Transitions: You may have an unplanned transition, such as a move from a hospital to a long-term care facility. If this happens and you need a drug that is not on our formulary, or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover up to a temporary 30-day supply (or 31-day supply if you are a resident of a long-term care facility when you go to a network pharmacy. This gives you time to talk to your doctor about other treatment options. After your first 30-day supply in such situations, you are required to use the plan's formulary exception process.

For more information

For more detailed information about your plan's prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about your plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227 24 hours a day/7 days a week. TTY users should call 1-877-486-2048, or visit <http://www.medicare.gov>.

Our Formulary

The formulary that begins on page 1 provides coverage information about the drugs covered by your plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 86.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., SYNTHROID) and generic drugs are listed in lower-case italics (e.g., *levothyroxine*).

The information in the Requirements/Limits column tells you if your plan has any special requirements for coverage of your drug.

B/D – This drug may be covered under Medicare Part B or Part D, depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

ED – Your plan offers Supplemental Drug Coverage on select plans for some drugs not generally covered by Medicare. This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving Extra Help to pay for your prescriptions, you will not get any Extra Help to pay for this drug. Please refer to our *Evidence of Coverage* for more information.

GC – We provide additional coverage of this prescription drug in the coverage gap. Please refer to our *Evidence of Coverage* for more information about this coverage.

LA – This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call CVS Caremark at 1-866-785-5714, option 2, 24 hours a day, 7 days a week. TTY users should call 711.

NM – Drugs that are not available through mail order service are marked as NM. Generally, the drugs available through mail order are drugs that you take on a regular basis for a chronic or long-term medical condition.

PA – Prior authorization is a utilization tool that helps decide whether or not a prescription is covered before it is filled. The approval or denial is based on plan design, safety and proper medicine use.

QL – For certain drugs, we limit the quantities of the drugs that we will cover. If you need a quantity that exceeds the limit we allow, you may ask us to make an exception to our coverage rules. More information regarding exceptions can be found in your *Evidence of Coverage*.

Mount Carmel MediGold Premier (HMO)
(018-001 serving Central Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$5 copay	\$45 copay	\$75 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$15 copay	\$135 copay	\$225 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$150 copay	Not available

Mount Carmel MediGold Premier (HMO)
(018-002 serving Southwest Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$5 copay	\$45 copay	\$75 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$15 copay	\$135 copay	\$225 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$150 copay	Not available

Mount Carmel MediGold No Premium (HMO)
(019-001 serving Central Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$5 copay	\$45 copay	\$95 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$15 copay	\$135 copay	\$285 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$190 copay	Not available

Mount Carmel MediGold No Premium (HMO)
(019-002 serving Southwest Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$5 copay	\$45 copay	\$95 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$15 copay	\$135 copay	\$285 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$190 copay	Not available

Mount Carmel MediGold No Premium (HMO)
(020 serving Northwest Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$10 copay	\$45 copay	\$75 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$30 copay	\$135 copay	\$225 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$150 copay	Not available

Mount Carmel MediGold Plus (HMO)
(022 serving Central Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non- Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$10 copay	\$45 copay	\$75 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$30 copay	\$135 copay	\$225 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$150 copay	Not available

Mount Carmel MediGold Plus (HMO)

(023 serving Southwest Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
Up to a 30-day supply retail	\$0 copay	\$10 copay	\$45 copay	\$75 copay	33% coinsurance
Up to a 90-day supply retail	\$0 copay	\$30 copay	\$135 copay	\$225 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$150 copay	Not available

Mount Carmel MediGold Cash Back No Premium (HMO)

(030 serving Central, Southwest and Northwest Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
*\$150 Part D deductible; applies to Tier 3, Tier 4 and Tier 5 only					
Up to a 30-day supply retail	\$0 copay	\$10 copay	\$47 copay	\$100 copay	30% coinsurance
Up to a 90-day supply retail	\$0 copay	\$30 copay	\$141 copay	\$300 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$94 copay	\$200 copay	Not available

Mount Carmel MediGold Choice (PPO)

(004 serving Select Counties in Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
*\$150 Part D deductible; applies to Tier 3, Tier 4 and Tier 5 only					
Up to a 30-day supply retail	\$2 copay	\$10 copay	\$47 copay	\$100 copay	30% Coinsurance
Up to a 90-day supply retail	\$6 copay	\$30 copay	\$141 copay	\$300 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$94 copay	\$200 copay	Not available

Mount Carmel MediGold No Premium Choice (PPO)

(005 serving Central and Southwest Counties in Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
*\$150 Part D deductible; applies to Tier 3, Tier 4 and Tier 5 only					
Up to a 30-day supply retail	\$0 copay	\$5 copay	\$47 copay	\$100 copay	30% coinsurance
Up to a 90-day supply retail	\$0 copay	\$15 copay	\$141 copay	\$300 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$94 copay	\$200 copay	Not available

Mount Carmel MediGold No Premium Choice (PPO)

(006 serving Northwest Counties in Ohio)

*Plan includes Tier 1 drugs covered in the gap

	Tier 1 Preferred Generic	Tier 2 Generic	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drug	Tier 5 Specialty Tier
*\$150 Part D deductible; applies to Tier 3, Tier 4 and Tier 5 only					
Up to a 30-day supply retail	\$0 copay	\$10 copay	\$45 copay	\$95 copay	30% coinsurance
Up to a 90-day supply retail	\$0 copay	\$30 copay	\$135 copay	\$285 copay	Not available
Up to a 90-day supply mail¹	\$0 copay	\$0 copay	\$90 copay	\$190 copay	Not available

Mount Carmel MediGold Cash Back No Premium MA Only (HMO) does not include Part D prescription drug coverage. It does, however, cover Part B drugs.

Note: If you have coverage through an Employer Group Health Plan, please refer to your *Evidence of Coverage* for specific copay and coverage information.

¹You may receive prescription drugs at home when using our network mail order program, generally within 10 calendar days of when your order is received. For questions about mail order medication, call 1-866-785-5714, option 2 (TTY 711). Our mail order pharmacy is to obtain consent prior to shipping or delivering any prescriptions that the beneficiary did not personally initiate unless there are mail order prescriptions for the beneficiary in the last 12 months.

Mount Carmel MediGold is a Medicare Advantage organizations with a Medicare contract. Enrollment in one of our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Copayments/coinsurance may change on January 1 of each year. The formulary may change at any time. You will receive notice when necessary.

For the most updated list of covered drugs, please visit <https://www.thpmedicare.org/mount-carmel/my-medications/formulary>.

Y0164_OHForm24_C

MOUNT_CARMEL_CY24_5T_GS_CORE eff 11/01/2024

Drug Name Drug Tier Requirements/Limits

ANALGESICS

GOUT

<i>allopurinol</i> TABS 100mg, 300mg	1	GC
<i>colchicine</i> TABS .6mg	3	QL (120 tabs / 30 days)
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	3	
<i>febuxostat</i> TABS 40mg, 80mg	4	PA
MITIGARE CAPS .6mg	3	QL (60 caps / 30 days)
<i>probenecid</i> TABS 500mg	3	

NSAIDS

<i>celecoxib</i> CAPS 50mg, 100mg, 200mg	3	QL (60 caps / 30 days)
<i>celecoxib</i> CAPS 400mg	3	QL (30 caps / 30 days)
<i>diclofenac potassium</i> TABS 50mg	3	QL (120 tabs / 30 days)
<i>diclofenac sodium</i> TB24 100mg	3	
<i>diclofenac sodium</i> TBEC 25mg, 50mg, 75mg	2	
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i>	4	
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i>	4	
<i>diflunisal</i> TABS 500mg	3	
<i>ec-naproxen</i> TBEC 375mg	2	QL (120 tabs / 30 days)
<i>ec-naproxen</i> TBEC 500mg	4	QL (90 tabs / 30 days)
<i>etodolac</i> CAPS 200mg, 300mg; TABS 400mg, 500mg; TB24 400mg, 500mg, 600mg	3	
<i>flurbiprofen</i> TABS 100mg	3	
<i>ibu</i> TABS 400mg, 600mg, 800mg	1	GC
<i>ibuprofen</i> SUSP 100mg/5ml	3	
<i>ibuprofen</i> TABS 400mg, 600mg, 800mg	1	GC
<i>meloxicam</i> TABS 7.5mg, 15mg	1	GC
<i>nabumetone</i> TABS 500mg, 750mg	2	
<i>naproxen</i> TABS 250mg, 375mg, 500mg	1	GC
<i>naproxen</i> TBEC 375mg	2	QL (120 tabs / 30 days)
<i>naproxen dr</i> TBEC 500mg	4	QL (90 tabs / 30 days)
<i>naproxen sodium</i> TABS 275mg, 550mg	3	
<i>oxaprozin</i> TABS 600mg	4	
<i>piroxicam</i> CAPS 10mg, 20mg	3	
<i>sulindac</i> TABS 150mg, 200mg	2	

OPIOID ANALGESICS, LONG-ACTING

<i>fentanyl</i> PT72 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr	4	QL (10 patches / 30 days), PA
--	---	-------------------------------

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocodone bitartrate</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA
<i>HYSINGLA ER</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	3	QL (450 mL / 30 days), PA
<i>methadone hcl</i> TABS 5mg, 10mg	3	QL (90 tabs / 30 days), PA
<i>methadone hydrochloride i</i> CONC 10mg/ml	3	QL (90 mL / 30 days), PA
<i>morphine sulfate</i> TBCR 15mg, 30mg, 60mg, 100mg, 200mg	3	QL (90 tabs / 30 days), PA
OPIOID ANALGESICS, SHORT-ACTING		
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	2	QL (2700 mL / 30 days)
<i>acetaminophen w/ codeine tab 300-15 mg</i>	2	QL (400 tabs / 30 days)
<i>acetaminophen w/ codeine tab 300-30 mg</i>	2	QL (360 tabs / 30 days)
<i>acetaminophen w/ codeine tab 300-60 mg</i>	2	QL (180 tabs / 30 days)
<i>butorphanol tartrate</i> SOLN 1mg/ml, 2mg/ml	4	
<i>butorphanol tartrate</i> SOLN 10mg/ml	3	QL (10 mL / 30 days)
<i>endocet tab 2.5-325mg</i>	3	QL (360 tabs / 30 days)
<i>endocet tab 5-325mg</i>	3	QL (360 tabs / 30 days)
<i>endocet tab 7.5-325mg</i>	3	QL (240 tabs / 30 days)
<i>endocet tab 10-325mg</i>	3	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP 200mcg	4	QL (120 lozenges / 30 days), PA
<i>fentanyl citrate</i> LPOP 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	5	QL (120 lozenges / 30 days), PA
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	4	QL (2700 mL / 30 days)
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	3	QL (240 tabs / 30 days)
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	3	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	3	QL (180 tabs / 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	3	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD 1mg/ml	4	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> TABS 2mg, 4mg, 8mg	3	QL (180 tabs / 30 days)
<i>MORPHINE SULFATE</i> SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml, 50mg/ml	4	B/D
<i>morphine sulfate</i> SOLN 4mg/ml, 8mg/ml, 10mg/ml	4	B/D

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>morphine sulfate</i> SOLN 10mg/5ml, 20mg/5ml	3	QL (900 mL / 30 days)
<i>morphine sulfate</i> SOLN 100mg/5ml	3	QL (180 mL / 30 days)
<i>morphine sulfate</i> TABS 15mg, 30mg	3	QL (180 tabs / 30 days)
MORPHINE SULFATE/SODIUM C SOLN 1mg/ml	4	B/D
<i>nalbuphine hcl</i> SOLN 10mg/ml, 20mg/ml	4	
<i>oxycodone hcl</i> CAPS 5mg	4	QL (180 caps / 30 days)
<i>oxycodone hcl</i> CONC 100mg/5ml	4	QL (180 mL / 30 days)
<i>oxycodone hcl</i> SOLN 5mg/5ml	4	QL (900 mL / 30 days)
<i>oxycodone hcl</i> TABS 5mg, 10mg, 15mg, 20mg, 30mg	3	QL (180 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	3	QL (240 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	3	QL (180 tabs / 30 days)
<i>tramadol hcl</i> TABS 50mg	2	QL (240 tabs / 30 days)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	3	QL (240 tabs / 30 days)

ANESTHETICS

LOCAL ANESTHETICS

<i>lidocaine hcl (local anesth.)</i> SOLN .5%, 1%, 1.5%, 2%	3	B/D
---	---	-----

ANTI-INFECTIVES

ANTI-INFECTIVES - MISCELLANEOUS

<i>albendazole</i> TABS 200mg	5	QL (672 tabs / year), PA
<i>amikacin sulfate</i> SOLN 1gm/4ml, 500mg/2ml	4	
<i>atovaquone</i> SUSP 750mg/5ml	4	
<i>aztreonam</i> SOLR 1gm, 2gm	4	
CAYSTON SOLR 75mg	5	NM, LA, PA
<i>clindamycin hcl</i> CAPS 75mg, 150mg, 300mg	2	
<i>clindamycin palmitate hydrochloride</i> SOLR 75mg/5ml	4	
<i>clindamycin phosphate</i> SOLN 600mg/4ml, 900mg/6ml, 9000mg/60ml	3	
<i>clindamycin phosphate in d5w iv soln 300 mg/50ml</i>	4	
<i>clindamycin phosphate in d5w iv soln 600 mg/50ml</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate in d5w iv soln 900 mg/50ml</i>	4	
CLINDMYC/NAC INJ 300/50ML	4	
CLINDMYC/NAC INJ 600/50ML	4	
CLINDMYC/NAC INJ 900/50ML	4	
<i>colistimethate sodium SOLR 150mg</i>	4	
<i>dapsone TABS 25mg, 100mg</i>	3	
DAPTOMYCIN SOLR 350mg	5	
<i>daptomycin SOLR 350mg, 500mg</i>	5	
EMVERM CHEW 100mg	5	QL (12 tabs / year)
<i>ertapenem sodium SOLR 1gm</i>	4	
<i>gentamicin in saline inj 0.8 mg/ml</i>	3	
<i>gentamicin in saline inj 1 mg/ml</i>	3	
<i>gentamicin in saline inj 1.2 mg/ml</i>	3	
<i>gentamicin in saline inj 1.6 mg/ml</i>	3	
<i>gentamicin in saline inj 2 mg/ml</i>	3	
<i>gentamicin sulfate SOLN 10mg/ml, 40mg/ml</i>	3	
<i>imipenem-cilastatin intravenous for soln 250 mg</i>	4	
<i>imipenem-cilastatin intravenous for soln 500 mg</i>	4	
<i>ivermectin TABS 3mg</i>	3	QL (12 tabs / 90 days), PA
<i>linezolid SOLN 600mg/300ml</i>	4	
<i>linezolid SUSR 100mg/5ml</i>	5	QL (1800 mL / 30 days)
<i>linezolid TABS 600mg</i>	4	QL (60 tabs / 30 days)
LINEZOLID INJ 2MG/ML	4	
<i>meropenem SOLR 1gm, 500mg</i>	4	
<i>methenamine hippurate TABS 1gm</i>	4	
<i>metronidazole SOLN 500mg/100ml</i>	3	
<i>metronidazole TABS 250mg, 500mg</i>	1	GC
<i>neomycin sulfate TABS 500mg</i>	2	
<i>nitazoxanide TABS 500mg</i>	5	QL (6 tabs / 30 days)
<i>nitrofurantoin macrocrystal CAPS 50mg, 100mg</i>	3	
<i>nitrofurantoin monohyd macro CAPS 100mg</i>	3	
<i>pentamidine isethionate inh SOLR 300mg</i>	4	B/D
<i>pentamidine isethionate inj SOLR 300mg</i>	4	
<i>praziquantel TABS 600mg</i>	4	
SIVEXTRO SOLR 200mg; TABS 200mg	5	
<i>streptomycin sulfate SOLR 1gm</i>	5	
<i>sulfadiazine TABS 500mg</i>	5	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml</i>	4	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	3	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	GC
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	GC
<i>tinidazole TABS 250mg, 500mg</i>	3	
<i>tobramycin NEBU 300mg/5ml</i>	5	NM, PA
<i>tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml</i>	3	
<i>trimethoprim TABS 100mg</i>	3	
<i>vancomycin hcl CAPS 125mg</i>	4	QL (80 caps / 180 days)
<i>vancomycin hcl CAPS 250mg</i>	4	QL (160 caps / 180 days)
<i>vancomycin hcl SOLR 1gm, 1.25gm, 1.5gm, 5gm, 10gm, 500mg, 750mg</i>	4	
<i>VANCOMYCIN HYDROCHLORIDE SOLR 1gm, 5gm, 10gm, 500mg</i>	4	
<i>VANCOMYCIN INJ 1 GM</i>	4	
<i>VANCOMYCIN INJ 500MG</i>	4	
<i>VANCOMYCIN INJ 750MG</i>	4	

ANTIFUNGALS

<i>ABELCET SUSP 5mg/ml</i>	4	B/D
<i>amphotericin b SOLR 50mg</i>	4	B/D
<i>amphotericin b liposome SUSR 50mg</i>	5	B/D
<i>caspofungin acetate SOLR 50mg, 70mg</i>	4	
<i>fluconazole SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 200mg</i>	3	
<i>fluconazole TABS 150mg</i>	2	
<i>fluconazole in nacl 0.9% inj 200 mg/100ml</i>	3	
<i>fluconazole in nacl 0.9% inj 400 mg/200ml</i>	3	
<i>flucytosine CAPS 250mg, 500mg</i>	5	PA
<i>griseofulvin microsize SUSP 125mg/5ml; TABS 500mg</i>	4	
<i>griseofulvin ultramicrosize TABS 125mg, 250mg</i>	4	
<i>itraconazole CAPS 100mg</i>	4	PA
<i>ketoconazole TABS 200mg</i>	3	PA
<i>miconazole sodium SOLR 50mg, 100mg</i>	5	
<i>nystatin TABS 500000unit</i>	3	
<i>posaconazole SUSP 40mg/ml</i>	5	QL (630 mL / 30 days), PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>posaconazole</i> TBEC 100mg	5	QL (93 tabs / 30 days), PA
<i>terbinafine hcl</i> TABS 250mg	1	GC, QL (90 tabs / year)
<i>voriconazole</i> SOLR 200mg	4	PA
<i>voriconazole</i> SUSR 40mg/ml	5	PA
<i>voriconazole</i> TABS 50mg	4	QL (480 tabs / 30 days), PA
<i>voriconazole</i> TABS 200mg	4	QL (120 tabs / 30 days), PA

ANTIMALARIALS

<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	4	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	4	
<i>chloroquine phosphate</i> TABS 250mg, 500mg	4	
COARTEM TAB 20-120MG	4	
<i>mefloquine hcl</i> TABS 250mg	3	
<i>primaquine phosphate</i> TABS 26.3mg	3	
PRIMAQUINE PHOSPHATE TABS 26.3mg	3	
<i>quinine sulfate</i> CAPS 324mg	4	PA

ANTIRETROVIRAL AGENTS

<i>abacavir sulfate</i> SOLN 20mg/ml	4	
<i>abacavir sulfate</i> TABS 300mg	3	
APTIVUS CAPS 250mg	5	
<i>atazanavir sulfate</i> CAPS 150mg, 200mg, 300mg	4	
<i>darunavir</i> TABS 600mg	5	QL (60 tabs / 30 days)
<i>darunavir</i> TABS 800mg	5	QL (30 tabs / 30 days)
EDURANT TABS 25mg	5	
<i>efavirenz</i> TABS 600mg	4	
<i>emtricitabine</i> CAPS 200mg	3	
EMTRIVA SOLN 10mg/ml	4	
<i>etravirine</i> TABS 100mg, 200mg	5	
<i>fosamprenavir calcium</i> TABS 700mg	5	
FUZEON SOLR 90mg	5	LA
INTELENCE TABS 25mg	4	
ISENTRESS CHEW 25mg	4	
ISENTRESS CHEW 100mg; PACK 100mg; TABS 400mg	5	
ISENTRESS HD TABS 600mg	5	
<i>lamivudine</i> SOLN 10mg/ml; TABS 150mg, 300mg	3	
<i>maraviroc</i> TABS 150mg, 300mg	5	
<i>nevirapine</i> SUSP 50mg/5ml; TB24 400mg	4	
<i>nevirapine</i> TABS 200mg	2	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
NORVIR PACK 100mg	4	
PIFELTRO TABS 100mg	5	
PREZISTA SUSP 100mg/ml	5	QL (400 mL / 30 days)
PREZISTA TABS 75mg	4	QL (480 tabs / 30 days)
PREZISTA TABS 150mg	5	QL (240 tabs / 30 days)
REYATAZ PACK 50mg	5	
<i>ritonavir</i> TABS 100mg	3	
RUKOBIA TB12 600mg	5	
SELZENTRY SOLN 20mg/ml; TABS 75mg	5	
SELZENTRY TABS 25mg	4	
SUNLENCA TBPK 300mg	5	LA
<i>tenofovir disoproxil fumarate</i> TABS 300mg	3	
TIVICAY TABS 10mg	3	
TIVICAY TABS 25mg, 50mg	5	
TIVICAY PD TBSO 5mg	5	
TROGARZO SOLN 200mg/1.33ml	5	LA
TYBOST TABS 150mg	3	
VIRACEPT TABS 250mg, 625mg	5	
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	5	
<i>zidovudine</i> CAPS 100mg; SYRP 50mg/5ml	4	
<i>zidovudine</i> TABS 300mg	3	
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	3	
BIKTARVY TAB 30-120-15 MG	5	
BIKTARVY TAB 50-200-25 MG	5	
CIMDUO TAB 300-300	5	
COMPLERA TAB	5	
DELSTRIGO TAB	5	
DESCOVY TAB 120-15MG	5	
DESCOVY TAB 200/25MG	5	
DOVATO TAB 50-300MG	5	
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	5	
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	5	
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	5	

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	4	
EVOTAZ TAB 300-150	5	
GENVOYA TAB	5	
JULUCA TAB 50-25MG	5	
<i>lamivudine-zidovudine tab 150-300 mg</i>	4	
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	4	
<i>lopinavir-ritonavir tab 100-25 mg</i>	4	
<i>lopinavir-ritonavir tab 200-50 mg</i>	4	
ODEFSEY TAB	5	
PREZCOBIX TAB 800-150	5	
STRIBILD TAB	5	
SYMTUZA TAB	5	
TRIUMEQ PD TAB	5	
TRIUMEQ TAB	5	
TRIZIVIR TAB	5	
ANTITUBERCULAR AGENTS		
<i>cycloserine CAPS 250mg</i>	5	
<i>ethambutol hcl TABS 100mg, 400mg</i>	3	
<i>isoniazid SYRP 50mg/5ml</i>	4	
<i>isoniazid TABS 100mg, 300mg</i>	1	GC
PRIFTIN TABS 150mg	4	
<i>pyrazinamide TABS 500mg</i>	4	
<i>rifabutin CAPS 150mg</i>	4	
<i>rifampin CAPS 150mg, 300mg</i>	3	
<i>rifampin SOLR 600mg</i>	4	
SIRTURO TABS 20mg, 100mg	5	NM, LA, PA
TRECTOR TABS 250mg	4	
ANTIVIRALS		
<i>acyclovir CAPS 200mg; TABS 400mg, 800mg</i>	2	
<i>acyclovir SUSP 200mg/5ml</i>	4	
<i>acyclovir sodium SOLN 50mg/ml</i>	4	B/D
<i>adefovir dipivoxil TABS 10mg</i>	4	
BARACLUDE SOLN .05mg/ml	5	
<i>entecavir TABS .5mg, 1mg</i>	4	
EPCLUSA PAK 150-37.5	5	NM, PA
EPCLUSA PAK 200-50MG	5	NM, PA
EPCLUSA TAB 200-50MG	5	NM, PA
EPCLUSA TAB 400-100	5	NM, PA

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>famciclovir</i> TABS 125mg, 250mg, 500mg	3	
<i>ganciclovir sodium</i> SOLR 500mg	4	B/D
HARVONI PAK 33.75-150MG	5	NM, PA
HARVONI PAK 45-200MG	5	NM, PA
HARVONI TAB 45-200MG	5	NM, PA
HARVONI TAB 90-400MG	5	NM, PA
<i>lamivudine (hbv)</i> TABS 100mg	4	
MAVYRET PAK 50-20MG	5	NM, PA
MAVYRET TAB 100-40MG	5	NM, PA
<i>oseltamivir phosphate</i> CAPS 30mg	3	QL (168 caps / year)
<i>oseltamivir phosphate</i> CAPS 45mg, 75mg	3	QL (84 caps / year)
<i>oseltamivir phosphate</i> SUSR 6mg/ml	3	QL (1080 mL / year)
PAXLOVID TAB 150-100	3	QL (40 tabs / 30 days); \$0 Cost Share
PAXLOVID TAB 300-100	3	QL (60 tabs / 30 days); \$0 Cost Share
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	5	NM, PA
PREVYMIS TABS 240mg, 480mg	5	QL (28 tabs / 28 days), PA
RELENZA DISKHALER AEPB 5mg/blister	3	QL (6 inhalers / year)
<i>ribavirin (hepatitis c)</i> CAPS 200mg	3	NM
<i>ribavirin (hepatitis c)</i> TABS 200mg	4	NM
<i>rimantadine hydrochloride</i> TABS 100mg	4	
<i>valacyclovir hcl</i> TABS 1gm, 500mg	3	
<i>valganciclovir hcl</i> SOLR 50mg/ml	5	
<i>valganciclovir hcl</i> TABS 450mg	3	
VEMLIDY TABS 25mg	5	
VOSEVI TAB	5	NM, PA
CEPHALOSPORINS		
<i>cefaclor</i> CAPS 250mg, 500mg	3	
<i>cefaclor</i> SUSR 250mg/5ml	4	
CEFAZOLIN ER TB12 500mg	4	
<i>cefadroxil</i> CAPS 500mg	2	
<i>cefadroxil</i> SUSR 250mg/5ml, 500mg/5ml	3	
CEFAZOLIN SOLR 2gm, 3gm	4	
CEFAZOLIN INJ 1GM/50ML	4	
<i>cefazolin sodium</i> SOLR 1gm, 2gm, 3gm, 10gm, 500mg	3	
CEFAZOLIN SOLN 2GM/100ML-4%	4	
<i>cefdinir</i> CAPS 300mg	2	
<i>cefdinir</i> SUSR 125mg/5ml, 250mg/5ml	3	
<i>cefepime hcl</i> SOLR 1gm, 2gm	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>cefixime</i> CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	4	
<i>cefoxitin sodium</i> SOLR 1gm, 2gm, 10gm	4	
<i>cefpodoxime proxetil</i> SUSR 50mg/5ml, 100mg/5ml	4	
<i>cefpodoxime proxetil</i> TABS 100mg, 200mg	3	
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	3	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	4	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	4	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	3	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	3	
<i>cephalexin</i> CAPS 250mg, 500mg	1	GC
<i>cephalexin</i> SUSR 125mg/5ml, 250mg/5ml	3	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	4	
TEFLARO SOLR 400mg, 600mg	5	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i> PACK 1gm; SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml	3	
<i>azithromycin</i> TABS 250mg, 500mg, 600mg	1	GC
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml; TB24 500mg	4	
<i>clarithromycin</i> TABS 250mg, 500mg	3	
DIFICID SUSR 40mg/ml; TABS 200mg	5	
<i>e.e.s. 400</i> TABS 400mg	4	
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	4	
ERYTHROCIN LACTOBIONATE SOLR 500mg	4	
<i>erythromycin base</i> CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	4	
<i>erythromycin ethylsuccinate</i> TABS 400mg	4	
<i>erythromycin lactobionate</i> SOLR 500mg	4	
FLUOROQUINOLONES		
CIPRO SUSR 500mg/5ml	4	
<i>ciprofloxacin 200 mg/100ml in d5w</i>	3	
<i>ciprofloxacin 400 mg/200ml in d5w</i>	3	
<i>ciprofloxacin hcl</i> TABS 250mg, 500mg, 750mg	1	GC
<i>levofloxacin</i> SOLN 25mg/ml	4	
<i>levofloxacin</i> TABS 250mg, 500mg, 750mg	1	GC
<i>levofloxacin in d5w iv soln 250 mg/50ml</i>	3	

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>levofloxacin in d5w iv soln 500 mg/100ml</i>	3	
<i>levofloxacin in d5w iv soln 750 mg/150ml</i>	3	
<i>moxifloxacin hcl TABS 400mg</i>	4	
<i>moxifloxacin hcl 400 mg/250ml in sodium chloride 0.8% inj</i>	4	

PENICILLINS

<i>amoxicillin CAPS 250mg, 500mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg</i>	1	GC
<i>amoxicillin CHEW 125mg, 250mg</i>	2	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	4	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	3	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	4	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	3	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	3	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	3	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	2	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	2	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	4	
<i>ampicillin CAPS 500mg</i>	2	
<i>ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm</i>	4	
<i>ampicillin & sulbactam sodium for inj 3 (2-1) gm</i>	4	
<i>ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm</i>	4	
<i>ampicillin & sulbactam sodium for iv soln 3 (2-1) gm</i>	4	
<i>ampicillin & sulbactam sodium for iv soln 15 (10-5) gm</i>	4	
<i>ampicillin sodium SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg</i>	4	
<i>BICILLIN L-A SUSY 600000unit/ml, 1200000unit/2ml, 2400000unit/4ml</i>	4	
<i>dicloxacillin sodium CAPS 250mg, 500mg</i>	3	
<i>nafcillin sodium SOLR 1gm, 2gm</i>	4	
<i>nafcillin sodium SOLR 10gm</i>	5	
<i>oxacillin sodium SOLR 1gm, 2gm, 10gm</i>	4	
<i>PEN GK/DEXTR INJ 40000/ML</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
PEN GK/DEXTR INJ 60000/ML	4	
<i>penicillin g potassium</i> SOLR 5000000unit, 20000000unit	4	
<i>penicillin g sodium</i> SOLR 5000000unit	4	
<i>penicillin v potassium</i> SOLR 125mg/5ml, 250mg/5ml	2	
<i>penicillin v potassium</i> TABS 250mg, 500mg	1	GC
<i>pfizerpen</i> SOLR 5000000unit, 20000000unit	4	
<i>piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)</i>	4	

TETRACYCLINES

<i>doxy 100</i> SOLR 100mg	4	
<i>doxycycline (monohydrate)</i> CAPS 50mg, 100mg	2	
<i>doxycycline (monohydrate)</i> SUSR 25mg/5ml; TABS 50mg, 75mg, 100mg	3	
<i>doxycycline hyclate</i> CAPS 50mg, 100mg; TABS 20mg, 100mg	3	
<i>doxycycline hyclate</i> SOLR 100mg	4	
<i>minocycline hcl</i> CAPS 50mg, 75mg, 100mg	3	
NUZYRA SOLR 100mg; TABS 150mg	5	NM, LA
<i>tetracycline hcl</i> CAPS 250mg, 500mg	4	PA
<i>tigecycline</i> SOLR 50mg	5	

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

BENDAMUSTINE HYDROCHLORID SOLN 100mg/4ml	5	B/D, NM
BENDEKA SOLN 100mg/4ml	5	B/D, NM, LA
<i>carboplatin</i> SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	3	B/D
<i>cisplatin</i> SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	3	B/D
<i>cyclophosphamide</i> CAPS 25mg, 50mg	3	B/D

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml, 500mg/5ml, 1000mg/10ml, 2000mg/20ml	5	B/D
<i>cyclophosphamide</i> SOLR 1gm, 500mg	4	B/D
<i>cyclophosphamide</i> SOLR 2gm	5	B/D
CYCLOPHOSPHAMIDE TABS 25mg, 50mg	4	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	5	B/D
GLEOSTINE CAPS 10mg, 40mg	4	NM
GLEOSTINE CAPS 100mg	5	NM
LEUKERAN TABS 2mg	5	
<i>oxaliplatin</i> SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml; SOLR 50mg	4	B/D
<i>oxaliplatin</i> SOLR 100mg	5	B/D
<i>paraplatin</i> SOLN 1000mg/100ml	3	B/D
ANTIBIOTICS		
<i>doxorubicin hcl</i> SOLN 2mg/ml	4	B/D
<i>doxorubicin hcl liposomal</i> SUSP 2mg/ml	5	B/D
DOXORUBICIN HYDROCHLORIDE SOLN 2mg/ml	4	B/D
ELLECE SOLN 50mg/25ml, 200mg/100ml	4	B/D
ANTIMETABOLITES		
<i>azacitidine</i> SUSR 100mg	5	B/D, NM
<i>cytarabine</i> SOLN 20mg/ml	3	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	3	B/D
<i>gemcitabine hcl</i> SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	4	B/D
INQOVI TAB 35-100MG	5	QL (5 tabs / 28 days), NM, LA, PA
LONSURF TAB 15-6.14	5	QL (100 tabs / 28 days), NM, LA, PA
LONSURF TAB 20-8.19	5	QL (80 tabs / 28 days), NM, LA, PA
<i>mercaptopurine</i> TABS 50mg	3	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	2	B/D
ONUREG TABS 200mg, 300mg	5	QL (14 tabs / 28 days), NM, LA, PA
<i>pemetrexed disodium</i> SOLR 100mg, 500mg, 750mg, 1000mg	5	B/D
PURIXAN SUSP 2000mg/100ml	5	NM, LA
TABLOID TABS 40mg	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i> TABS 250mg	5	QL (120 tabs / 30 days), NM, PA
<i>abiraterone acetate</i> TABS 500mg	5	QL (60 tabs / 30 days), NM, PA
AKEEGA TAB 50/500MG	5	QL (60 tabs / 30 days), NM, LA, PA
AKEEGA TAB 100/500	5	QL (60 tabs / 30 days), NM, LA, PA
<i>anastrozole</i> TABS 1mg	2	
<i>bicalutamide</i> TABS 50mg	2	
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	4	NM, PA
ERLEADA TABS 60mg	5	QL (120 tabs / 30 days), NM, LA, PA
ERLEADA TABS 240mg	5	QL (30 tabs / 30 days), NM, LA, PA
EULEXIN CAPS 125mg	5	
<i>exemestane</i> TABS 25mg	4	
FIRMAGON SOLR 80mg	4	NM, PA
FIRMAGON SOLR 120mg/vial	5	NM, PA
<i>fulvestrant</i> SOSY 250mg/5ml	5	B/D
<i>letrozole</i> TABS 2.5mg	2	
<i>leuprolide acetate</i> KIT 1mg/0.2ml	4	NM, PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	5	NM, PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	5	NM, PA
LYSODREN TABS 500mg	5	NM, LA
<i>megestrol acetate</i> TABS 20mg, 40mg	3	
<i>nilutamide</i> TABS 150mg	5	
NUBEQA TABS 300mg	5	QL (120 tabs / 30 days), NM, LA, PA
ORGOVYX TABS 120mg	5	NM, LA, PA
ORSERDU TABS 86mg	5	QL (90 tabs / 30 days), NM, LA, PA
ORSERDU TABS 345mg	5	QL (30 tabs / 30 days), NM, LA, PA
SOLTAMOX SOLN 10mg/5ml	5	
<i>tamoxifen citrate</i> TABS 10mg, 20mg	2	
<i>toremifene citrate</i> TABS 60mg	4	
XTANDI CAPS 40mg	5	QL (120 caps / 30 days), NM, LA, PA
XTANDI TABS 40mg	5	QL (120 tabs / 30 days), NM, LA, PA
XTANDI TABS 80mg	5	QL (60 tabs / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
IMMUNOMODULATORS		
<i>lenalidomide</i> CAPS 2.5mg, 5mg, 10mg, 15mg	5	QL (28 caps / 28 days), NM, LA, PA
<i>lenalidomide</i> CAPS 20mg, 25mg	5	QL (21 caps / 28 days), NM, LA, PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg	5	QL (21 caps / 28 days), NM, LA, PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg	5	QL (28 caps / 28 days), NM, LA, PA
REVLIMID CAPS 20mg, 25mg	5	QL (21 caps / 28 days), NM, LA, PA
THALOMID CAPS 50mg	5	QL (84 caps / 28 days), NM, LA, PA
THALOMID CAPS 100mg	5	QL (112 caps / 28 days), NM, LA, PA
THALOMID CAPS 150mg, 200mg	5	QL (56 caps / 28 days), NM, LA, PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml	5	QL (2 syringes / 28 days), NM, LA, PA
<i>bexarotene</i> CAPS 75mg	5	QL (300 caps / 30 days), NM, PA
<i>hydroxyurea</i> CAPS 500mg	2	
<i>irinotecan hcl</i> SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	4	B/D
IWILFIN TABS 192mg	5	QL (240 tabs / 30 days), NM, LA, PA
KISQALI 200 PAK FEMARA	5	QL (49 tabs / 28 days), NM, PA
KISQALI 400 PAK FEMARA	5	QL (70 tabs / 28 days), NM, PA
KISQALI 600 PAK FEMARA	5	QL (91 tabs / 28 days), NM, PA
MATULANE CAPS 50mg	5	NM, LA
<i>tretinoin (chemotherapy)</i> CAPS 10mg	5	
WELIREG TABS 40mg	5	QL (90 tabs / 30 days), NM, LA, PA
MITOTIC INHIBITORS		
<i>docetaxel</i> CONC 20mg/ml	4	B/D
<i>docetaxel</i> CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>etoposide</i> SOLN 1gm/50ml, 100mg/5ml, 500mg/25ml	3	B/D
<i>paclitaxel</i> CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	4	B/D
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	5	B/D, NM
<i>vincristine sulfate</i> SOLN 1mg/ml	2	B/D
<i>vinorelbine tartrate</i> SOLN 10mg/ml, 50mg/5ml	4	B/D

MOLECULAR TARGET AGENTS

ALECENSA CAPS 150mg	5	QL (240 caps / 30 days), NM, LA, PA
ALUNBRIG TABS 30mg	5	QL (120 tabs / 30 days), NM, LA, PA
ALUNBRIG TABS 90mg, 180mg	5	QL (30 tabs / 30 days), NM, LA, PA
ALUNBRIG PAK	5	QL (30 tabs / 30 days), NM, LA, PA
AUGTYRO CAPS 40mg	5	QL (240 caps / 30 days), NM, LA, PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg	5	QL (30 tabs / 30 days), NM, LA, PA
BALVERSA TABS 3mg	5	QL (84 tabs / 28 days), NM, LA, PA
BALVERSA TABS 4mg	5	QL (56 tabs / 28 days), NM, LA, PA
BALVERSA TABS 5mg	5	QL (28 tabs / 28 days), NM, LA, PA
BORTEZOMIB SOLR 1mg, 2.5mg	5	NM, PA
<i>bortezomib</i> SOLR 3.5mg	5	NM, PA
BOSULIF CAPS 50mg	5	QL (360 caps / 30 days), NM, PA
BOSULIF CAPS 100mg	5	QL (150 caps / 25 days), NM, PA
BOSULIF TABS 100mg	5	QL (180 tabs / 30 days), NM, PA
BOSULIF TABS 400mg, 500mg	5	QL (30 tabs / 30 days), NM, PA
BRAFTOVI CAPS 75mg	5	QL (180 caps / 30 days), NM, LA, PA
BRUKINSA CAPS 80mg	5	QL (120 caps / 30 days), NM, LA, PA
CABOMETYX TABS 20mg, 40mg, 60mg	5	QL (30 tabs / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
CALQUENCE CAPS 100mg	5	QL (60 caps / 30 days), NM, LA, PA
CALQUENCE TABS 100mg	5	QL (60 tabs / 30 days), NM, LA, PA
CAPRELSA TABS 100mg	5	QL (60 tabs / 30 days), NM, LA, PA
CAPRELSA TABS 300mg	5	QL (30 tabs / 30 days), NM, LA, PA
COMETRIQ (60MG DOSE) KIT 20mg	5	QL (84 caps / 28 days), NM, LA, PA
COMETRIQ KIT 100MG	5	QL (56 caps / 28 days), NM, LA, PA
COMETRIQ KIT 140MG	5	QL (112 caps / 28 days), NM, LA, PA
COPIKTRA CAPS 15mg, 25mg	5	QL (56 caps / 28 days), NM, LA, PA
COTELLIC TABS 20mg	5	QL (63 tabs / 28 days), NM, LA, PA
<i>dasatinib</i> TABS 20mg	5	QL (90 tabs / 30 days), NM, PA
<i>dasatinib</i> TABS 50mg, 70mg, 80mg, 100mg, 140mg	5	QL (30 tabs / 30 days), NM, PA
DAURISMO TABS 25mg	5	QL (60 tabs / 30 days), NM, LA, PA
DAURISMO TABS 100mg	5	QL (30 tabs / 30 days), NM, LA, PA
ERIVEDGE CAPS 150mg	5	QL (30 caps / 30 days), NM, LA, PA
<i>erlotinib hcl</i> TABS 25mg	5	QL (90 tabs / 30 days), NM, PA
<i>erlotinib hcl</i> TABS 100mg, 150mg	5	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TABS 2.5mg, 5mg, 7.5mg, 10mg	5	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 2mg	5	QL (150 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 3mg	5	QL (90 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 5mg	5	QL (60 tabs / 30 days), NM, PA
FOTIVDA CAPS .89mg, 1.34mg	5	QL (21 caps / 28 days), NM, LA, PA
FRUZAQLA CAPS 1mg	5	QL (84 caps / 28 days), NM, LA, PA
FRUZAQLA CAPS 5mg	5	QL (21 caps / 28 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
GAVRETO CAPS 100mg	5	QL (120 caps / 30 days), NM, LA, PA
<i>gefitinib</i> TABS 250mg	5	QL (30 tabs / 30 days), NM, PA
GILOTRIF TABS 20mg, 30mg, 40mg	5	QL (30 tabs / 30 days), NM, LA, PA
HERCEP HYLEC SOL 60-10000	5	NM, LA, PA
HERCEPTIN SOLR 150mg	5	NM, LA, PA
HERZUMA SOLR 150mg, 420mg	5	NM, PA
IBRANCE CAPS 75mg, 100mg, 125mg	5	QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS 75mg, 100mg, 125mg	5	QL (21 tabs / 28 days), NM, LA, PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg	5	QL (30 tabs / 30 days), NM, LA, PA
IDHIFA TABS 50mg, 100mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>imatinib mesylate</i> TABS 100mg	5	QL (90 tabs / 30 days), NM, PA
<i>imatinib mesylate</i> TABS 400mg	5	QL (60 tabs / 30 days), NM, PA
IMBRUVICA CAPS 70mg	5	QL (30 caps / 30 days), NM, LA, PA
IMBRUVICA CAPS 140mg	5	QL (120 caps / 30 days), NM, LA, PA
IMBRUVICA SUSP 70mg/ml	5	QL (216 mL / 27 days), NM, LA, PA
IMBRUVICA TABS 140mg, 280mg, 420mg	5	QL (30 tabs / 30 days), NM, LA, PA
INLYTA TABS 1mg	5	QL (180 tabs / 30 days), NM, LA, PA
INLYTA TABS 5mg	5	QL (120 tabs / 30 days), NM, LA, PA
INREBIC CAPS 100mg	5	QL (120 caps / 30 days), NM, LA, PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg	5	QL (60 tabs / 30 days), NM, LA, PA
JAYPIRCA TABS 50mg	5	QL (30 tabs / 30 days), NM, LA, PA
JAYPIRCA TABS 100mg	5	QL (60 tabs / 30 days), NM, LA, PA
KADCYLA SOLR 100mg, 160mg	5	B/D, NM, LA
KANJINTI SOLR 150mg, 420mg	5	NM, LA, PA
KEYTRUDA SOLN 100mg/4ml	5	NM, LA, PA
KISQALI 200 DOSE TBPK 200mg	5	QL (21 tabs / 28 days), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
KISQALI 400 DOSE TBPK 200mg	5	QL (42 tabs / 28 days), NM, PA
KISQALI 600 DOSE TBPK 200mg	5	QL (63 tabs / 28 days), NM, PA
KOSELUGO CAPS 10mg	5	QL (240 caps / 30 days), NM, LA, PA
KOSELUGO CAPS 25mg	5	QL (120 caps / 30 days), NM, LA, PA
KRAZATI TABS 200mg	5	QL (180 tabs / 30 days), NM, LA, PA
<i>lapatinib ditosylate</i> TABS 250mg	5	QL (180 tabs / 30 days), NM, PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg	5	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg	5	QL (60 caps / 30 days), NM, LA, PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg	5	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 12MG DAILY DOSE CPPK 4mg	5	QL (90 caps / 30 days), NM, LA, PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg	5	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 14 MG	5	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 18 MG	5	QL (90 caps / 30 days), NM, LA, PA
LENVIMA CAP 24 MG	5	QL (90 caps / 30 days), NM, LA, PA
LORBRENA TABS 25mg	5	QL (90 tabs / 30 days), NM, LA, PA
LORBRENA TABS 100mg	5	QL (30 tabs / 30 days), NM, LA, PA
LUMAKRAS TABS 120mg	5	QL (240 tabs / 30 days), NM, LA, PA
LUMAKRAS TABS 320mg	5	QL (90 tabs / 30 days), NM, LA, PA
LYNPARZA TABS 100mg, 150mg	5	QL (120 tabs / 30 days), NM, LA, PA
LYTGOBI (12 MG DAILY DOSE) TBPK 4mg	5	QL (84 tabs / 28 days), NM, LA, PA
LYTGOBI (16 MG DAILY DOSE) TBPK 4mg	5	QL (112 tabs / 28 days), NM, LA, PA
LYTGOBI (20 MG DAILY DOSE) TBPK 4mg	5	QL (140 tabs / 28 days), NM, LA, PA
MEKINIST SOLR .05mg/ml	5	QL (1260 mL / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
MEKINIST TABS 2mg	5	QL (30 tabs / 30 days), NM, LA, PA
MEKINIST TABS .5mg	5	QL (90 tabs / 30 days), NM, LA, PA
MEKTOVI TABS 15mg	5	QL (180 tabs / 30 days), NM, LA, PA
MONJUVI SOLR 200mg	5	NM, LA, PA
NERLYNX TABS 40mg	5	QL (180 tabs / 30 days), NM, LA, PA
NEXAVAR TABS 200mg	5	QL (120 tabs / 30 days), NM, LA, PA
NINLARO CAPS 2.3mg, 3mg, 4mg	5	QL (3 caps / 28 days), NM, PA
ODOMZO CAPS 200mg	5	QL (30 caps / 30 days), NM, LA, PA
OGIVRI SOLR 150mg, 420mg	5	NM, LA, PA
OGSIVEO TABS 50mg	5	QL (180 tabs / 30 days), NM, LA, PA
OGSIVEO TABS 100mg, 150mg	5	QL (56 tabs / 28 days), NM, LA, PA
OJEMDA SUSR 25mg/ml	5	QL (96 mL / 28 days), NM, LA, PA
OJEMDA TABS 100mg	5	QL (24 tabs / 28 days), NM, LA, PA
OJJAARA TABS 100mg, 150mg, 200mg	5	QL (30 tabs / 30 days), NM, LA, PA
ONTRUZANT SOLR 150mg, 420mg	5	NM, LA, PA
<i>pazopanib hcl</i> TABS 200mg	5	QL (120 tabs / 30 days), NM, PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	5	QL (28 tabs / 28 days), NM, LA, PA
PHESGO SOL	5	NM, LA, PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	5	QL (28 tabs / 28 days), NM, PA
PIQRAY 250MG TAB DOSE	5	QL (56 tabs / 28 days), NM, PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	5	QL (56 tabs / 28 days), NM, PA
QINLOCK TABS 50mg	5	QL (90 tabs / 30 days), NM, LA, PA
RETEVMO CAPS 40mg	5	QL (180 caps / 30 days), NM, LA, PA
RETEVMO CAPS 80mg	5	QL (120 caps / 30 days), NM, LA, PA
RETEVMO TABS 40mg	5	QL (90 tabs / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

20

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
RETEVMO TABS 80mg, 120mg, 160mg	5	QL (60 tabs / 30 days), NM, LA, PA
REZLIDHIA CAPS 150mg	5	QL (60 caps / 30 days), NM, LA, PA
ROZLYTREK CAPS 100mg	5	QL (150 caps / 30 days), NM, LA, PA
ROZLYTREK CAPS 200mg	5	QL (90 caps / 30 days), NM, LA, PA
ROZLYTREK PACK 50mg	5	QL (336 packets / 28 days), NM, LA, PA
RUBRACA TABS 200mg, 250mg, 300mg	5	QL (120 tabs / 30 days), NM, LA, PA
RYDAPT CAPS 25mg	5	QL (224 caps / 28 days), NM, PA
SCEMBLIX TABS 20mg	5	QL (60 tabs / 30 days), NM, PA
SCEMBLIX TABS 40mg	5	QL (300 tabs / 30 days), NM, PA
SCEMBLIX TABS 100mg	5	QL (120 tabs / 30 days), NM, PA
<i>sorafenib tosylate</i> TABS 200mg	5	QL (120 tabs / 30 days), NM, PA
SPRYCEL TABS 20mg	5	QL (90 tabs / 30 days), NM, PA
SPRYCEL TABS 50mg, 70mg, 80mg, 100mg, 140mg	5	QL (30 tabs / 30 days), NM, PA
STIVARGA TABS 40mg	5	QL (84 tabs / 28 days), NM, LA, PA
<i>sunitinib malate</i> CAPS 12.5mg, 25mg, 37.5mg, 50mg	5	QL (30 caps / 30 days), NM, PA
TABRECTA TABS 150mg, 200mg	5	QL (112 tabs / 28 days), NM, PA
TAFINLAR CAPS 50mg, 75mg	5	QL (120 caps / 30 days), NM, LA, PA
TAFINLAR TBSO 10mg	5	QL (900 tabs / 30 days), NM, LA, PA
TAGRISSE TABS 40mg, 80mg	5	QL (30 tabs / 30 days), NM, LA, PA
TALZENNA CAPS .1mg, .35mg, .5mg, .75mg, 1mg	5	QL (30 caps / 30 days), NM, LA, PA
TALZENNA CAPS .25mg	5	QL (90 caps / 30 days), NM, LA, PA
TASIGNA CAPS 50mg	5	QL (120 caps / 30 days), NM, PA
TASIGNA CAPS 150mg, 200mg	5	QL (112 caps / 28 days), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
TAZVERIK TABS 200mg	5	QL (240 tabs / 30 days), NM, LA, PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	5	NM, LA, PA
TEPMETKO TABS 225mg	5	QL (60 tabs / 30 days), NM, LA, PA
TIBSOVO TABS 250mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>torpenz</i> TABS 2.5mg, 5mg, 7.5mg, 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
TRAZIMERA SOLR 150mg, 420mg	5	NM, PA
TRUQAP TABS 160mg, 200mg	5	QL (64 tabs / 28 days), NM, LA, PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	5	NM, PA
TUKYSA TABS 50mg, 150mg	5	QL (120 tabs / 30 days), NM, LA, PA
TURALIO CAPS 125mg	5	QL (120 caps / 30 days), NM, LA, PA
VANFLYTA TABS 17.7mg, 26.5mg	5	QL (56 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 10mg	4	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 50mg	5	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 100mg	5	QL (180 tabs / 30 days), NM, LA, PA
VENCLEXTA TAB START PK	5	QL (42 tabs / 28 days), NM, LA, PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg	5	QL (56 tabs / 28 days), NM, LA, PA
VITRAKVI CAPS 25mg	5	QL (180 caps / 30 days), NM, LA, PA
VITRAKVI CAPS 100mg	5	QL (60 caps / 30 days), NM, LA, PA
VITRAKVI SOLN 20mg/ml	5	QL (300 mL / 30 days), NM, LA, PA
VIZIMPRO TABS 15mg, 30mg, 45mg	5	QL (30 tabs / 30 days), NM, LA, PA
VONJO CAPS 100mg	5	QL (120 caps / 30 days), NM, LA, PA
XALKORI CAPS 200mg, 250mg; CPSP 50mg	5	QL (120 caps / 30 days), NM, LA, PA
XALKORI CPSP 20mg	5	QL (240 caps / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
XALKORI CPSP 150mg	5	QL (180 caps / 30 days), NM, LA, PA
XOSPATA TABS 40mg	5	QL (90 tabs / 30 days), NM, LA, PA
XPOVIO 40 MG ONCE WEEKLY TBPk 40mg	5	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY TBPk 40mg	5	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY TBPk 60mg	5	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY TBPk 20mg	5	QL (24 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY TBPk 40mg	5	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY TBPk 20mg	5	QL (32 tabs / 28 days), NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY TBPk 50mg	5	QL (8 tabs / 28 days), NM, LA, PA
ZEJULA TABS 100mg, 200mg, 300mg	5	QL (30 tabs / 30 days), NM, LA, PA
ZELBORAF TABS 240mg	5	QL (240 tabs / 30 days), NM, LA, PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	5	NM, LA, PA
ZOLINZA CAPS 100mg	5	QL (120 caps / 30 days), NM, PA
ZYDELIG TABS 100mg, 150mg	5	QL (60 tabs / 30 days), NM, LA, PA
ZYKADIA TABS 150mg	5	QL (84 tabs / 28 days), NM, LA, PA

PROTECTIVE AGENTS

<i>leucovorin calcium</i> SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	4	B/D
<i>leucovorin calcium</i> TABS 5mg, 10mg, 15mg, 25mg	3	
MESNEX TABS 400mg	5	

CARDIOVASCULAR

ACE INHIBITOR COMBINATIONS

<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	GC, QL (30 caps / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	GC, QL (30 caps / 30 days)
<i>benazepril & hydrochlorothiazide tab 5-6.25mg</i>	1	GC
<i>benazepril & hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>benazepril & hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	1	GC
<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	1	GC
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	1	GC
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	1	GC
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	1	GC
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	GC
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	GC
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	GC
ACE INHIBITORS		
<i>benazepril hcl TABS 5mg, 10mg, 20mg, 40mg</i>	1	GC
<i>captopril TABS 12.5mg, 25mg, 50mg, 100mg</i>	1	GC
<i>enalapril maleate TABS 2.5mg, 5mg, 10mg, 20mg</i>	1	GC
<i>fosinopril sodium TABS 10mg, 20mg, 40mg</i>	1	GC

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>lisinopril</i> TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	GC
<i>moexipril hcl</i> TABS 7.5mg, 15mg	1	GC
<i>perindopril erbumine</i> TABS 2mg, 4mg, 8mg	1	GC
<i>quinapril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>ramipril</i> CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	GC
<i>trandolapril</i> TABS 1mg, 2mg, 4mg	1	GC

ALDOSTERONE RECEPTOR ANTAGONISTS

<i>eplerenone</i> TABS 25mg, 50mg	3	
KERENDIA TABS 10mg, 20mg	3	QL (30 tabs / 30 days)
<i>spironolactone</i> TABS 25mg, 50mg, 100mg	1	GC

ALPHA BLOCKERS

<i>doxazosin mesylate</i> TABS 1mg, 2mg, 4mg, 8mg	2	
<i>prazosin hcl</i> CAPS 1mg, 2mg, 5mg	3	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	1	GC

ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS

<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	1	GC, QL (60 tabs / 30 days)
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	GC, QL (30 tabs / 30 days)
EDARBYCLOR TAB 40-12.5	4	QL (30 tabs / 30 days)
EDARBYCLOR TAB 40-25MG	4	QL (30 tabs / 30 days)
ENTRESTO CAP 6-6MG	3	QL (240 caps / 30 days)
ENTRESTO CAP 15-16MG	3	QL (240 caps / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

25

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
ENTRESTO TAB 24-26MG	3	QL (60 tabs / 30 days)
ENTRESTO TAB 49-51MG	3	QL (60 tabs / 30 days)
ENTRESTO TAB 97-103MG	3	QL (60 tabs / 30 days)
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	GC, QL (60 tabs / 30 days)
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	GC
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	GC
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	GC
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 40-5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 40-10 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 80-5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 80-10 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan-hydrochlorothiazide tab 40-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	GC, QL (60 tabs / 30 days)
<i>telmisartan-hydrochlorothiazide tab 80-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	GC, QL (30 tabs / 30 days)

ANGIOTENSIN II RECEPTOR ANTAGONISTS

<i>candesartan cilexetil TABS 4mg, 8mg, 16mg</i>	1	GC, QL (60 tabs / 30 days)
<i>candesartan cilexetil TABS 32mg</i>	1	GC, QL (30 tabs / 30 days)
<i>EDARBI TABS 40mg, 80mg</i>	4	QL (30 tabs / 30 days)
<i>irbesartan TABS 75mg, 150mg, 300mg</i>	1	GC, QL (30 tabs / 30 days)
<i>losartan potassium TABS 25mg, 50mg, 100mg</i>	1	GC
<i>olmesartan medoxomil TABS 5mg</i>	1	GC, QL (60 tabs / 30 days)
<i>olmesartan medoxomil TABS 20mg, 40mg</i>	1	GC, QL (30 tabs / 30 days)
<i>telmisartan TABS 20mg, 40mg, 80mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan TABS 40mg, 80mg, 160mg</i>	1	GC, QL (60 tabs / 30 days)
<i>valsartan TABS 320mg</i>	1	GC, QL (30 tabs / 30 days)

ANTIARRHYTHMICS

<i>amiodarone hcl SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 400mg</i>	4	
<i>amiodarone hcl TABS 200mg</i>	1	GC
<i>disopyramide phosphate CAPS 100mg, 150mg</i>	4	
<i>dofetilide CAPS 125mcg, 250mcg, 500mcg</i>	4	
<i>flecainide acetate TABS 50mg, 100mg, 150mg</i>	3	
<i>MULTAQ TABS 400mg</i>	4	
<i>NORPACE CR CP12 100mg, 150mg</i>	4	
<i>pacerone TABS 100mg, 400mg</i>	4	
<i>pacerone TABS 200mg</i>	1	GC
<i>propafenone hcl CP12 225mg, 325mg, 425mg</i>	4	
<i>propafenone hcl TABS 150mg, 225mg, 300mg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>quinidine sulfate</i> TABS 200mg, 300mg	3	
<i>sorine</i> TABS 80mg, 120mg, 160mg, 240mg	2	
<i>sotalol hcl</i> TABS 80mg, 120mg, 160mg, 240mg	2	
<i>sotalol hcl (afib/af)</i> TABS 80mg, 120mg, 160mg	3	

ANTILIPEMICS, FIBRATES

<i>choline fenofibrate</i> CPDR 45mg, 135mg	3	
<i>fenofibrate</i> TABS 48mg, 54mg, 145mg, 160mg	2	
<i>fenofibrate micronized</i> CAPS 67mg, 134mg, 200mg	3	
<i>gemfibrozil</i> TABS 600mg	1	GC

ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS

ALTOPREV TB24 20mg, 40mg, 60mg	5	QL (30 tabs / 30 days)
<i>atorvastatin calcium</i> TABS 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
EZALLOR SPRINKLE CPSP 5mg, 10mg, 20mg, 40mg	4	QL (30 caps / 30 days)
<i>fluvastatin sodium</i> CAPS 20mg, 40mg	1	GC, QL (60 caps / 30 days)
<i>fluvastatin sodium</i> TB24 80mg	1	GC, QL (30 tabs / 30 days)
<i>lovastatin</i> TABS 10mg, 20mg, 40mg	1	GC, QL (60 tabs / 30 days)
<i>pitavastatin calcium</i> TABS 1mg, 2mg, 4mg	1	GC, QL (30 tabs / 30 days)
<i>pravastatin sodium</i> TABS 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
<i>rosuvastatin calcium</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC, QL (30 tabs / 30 days)
<i>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
ZYPITAMAG TABS 2mg, 4mg	4	QL (30 tabs / 30 days)

ANTILIPEMICS, MISCELLANEOUS

<i>cholestyramine</i> PACK 4gm; POWD 4gm/dose	3	
<i>cholestyramine light</i> PACK 4gm; POWD 4gm/dose	3	
<i>colesevelam hcl</i> PACK 3.75gm; TABS 625mg	4	
<i>colestipol hcl</i> GRAN 5gm; PACK 5gm	4	
<i>colestipol hcl</i> TABS 1gm	3	
<i>ezetimibe</i> TABS 10mg	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	GC, QL (30 tabs / 30 days)
NEXLETOL TABS 180mg	3	QL (30 tabs / 30 days)
NEXLIZET TAB 180/10MG	3	QL (30 tabs / 30 days)
<i>niacin (antihyperlipidemic) TBCR 500mg, 750mg, 1000mg</i>	3	QL (60 tabs / 30 days)
<i>omega-3-acid ethyl esters cap 1 gm</i>	3	PA
<i>prevalite PACK 4gm; POWD 4gm/dose</i>	3	
REPATHA SOSY 140mg/ml	3	NM, PA
REPATHA PUSHTRONEX SYSTEM SOCT 420mg/3.5ml	3	NM, PA
REPATHA SURECLICK SOAJ 140mg/ml	3	NM, PA
VASCEPA CAPS .5gm, 1gm	3	

BETA-BLOCKER/DIURETIC COMBINATIONS

<i>atenolol & chlorthalidone tab 50-25 mg</i>	2	
<i>atenolol & chlorthalidone tab 100-25 mg</i>	2	
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	2	
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	2	
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	2	
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	3	
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	3	
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	3	

BETA-BLOCKERS

<i>acebutolol hcl CAPS 200mg, 400mg</i>	3	
<i>atenolol TABS 25mg, 50mg, 100mg</i>	1	GC
<i>bisoprolol fumarate TABS 5mg, 10mg</i>	2	
<i>carvedilol TABS 3.125mg, 6.25mg, 12.5mg, 25mg</i>	1	GC
<i>labetalol hcl TABS 100mg, 200mg, 300mg</i>	3	
<i>metoprolol succinate TB24 25mg, 50mg, 100mg, 200mg</i>	1	GC
<i>metoprolol tartrate SOLN 5mg/5ml</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>metoprolol tartrate</i> TABS 25mg, 50mg, 100mg	1	GC
<i>nadolol</i> TABS 20mg, 40mg, 80mg	3	
<i>nebivolol hcl</i> TABS 2.5mg, 5mg, 10mg	3	QL (30 tabs / 30 days)
<i>nebivolol hcl</i> TABS 20mg	3	QL (60 tabs / 30 days)
<i>pindolol</i> TABS 5mg, 10mg	3	
<i>propranolol hcl</i> CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml	3	
<i>propranolol hcl</i> TABS 10mg, 20mg, 40mg, 60mg, 80mg	2	
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	3	

CALCIUM CHANNEL BLOCKERS

<i>amlodipine besylate</i> TABS 2.5mg, 5mg, 10mg	1	GC
<i>cartia xt</i> CP24 120mg, 180mg, 240mg, 300mg	2	
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	2	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg; TB24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	4	
<i>diltiazem hcl</i> SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml	3	
<i>diltiazem hcl</i> TABS 30mg, 60mg, 90mg, 120mg	2	
<i>diltiazem hcl coated beads</i> CP24 120mg, 180mg, 240mg, 300mg	2	
<i>diltiazem hcl coated beads</i> CP24 360mg	4	
<i>diltiazem hcl extended release beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	2	
<i>isradipine</i> CAPS 2.5mg, 5mg	4	
<i>matzim la</i> TB24 180mg, 240mg, 300mg, 360mg, 420mg	4	
<i>nicardipine hcl</i> CAPS 20mg, 30mg	4	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	3	
<i>nimodipine</i> CAPS 30mg	4	
<i>nisoldipine</i> TB24 8.5mg, 17mg, 20mg, 25.5mg, 30mg, 34mg, 40mg	4	
NYMALIZE SOLN 6mg/ml	5	
<i>tiadylt er</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
<i>verapamil hcl</i> CP24 100mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>verapamil hcl</i> CP24 120mg, 180mg, 240mg	3	
<i>verapamil hcl</i> TABS 40mg, 80mg, 120mg	1	GC
<i>verapamil hcl</i> TBCR 120mg, 180mg, 240mg	2	

DIURETICS

<i>acetazolamide</i> CP12 500mg	4	
<i>acetazolamide</i> TABS 125mg, 250mg	3	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	2	
<i>amiloride hcl</i> TABS 5mg	2	
<i>bumetanide</i> SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	3	
<i>chlorthalidone</i> TABS 25mg, 50mg	2	
<i>furosemide</i> SOLN 10mg/ml, 40mg/5ml	2	
<i>furosemide</i> TABS 20mg, 40mg, 80mg	1	GC
<i>furosemide inj</i> SOLN 10mg/ml	3	
<i>hydrochlorothiazide</i> CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	GC
<i>indapamide</i> TABS 1.25mg, 2.5mg	1	GC
<i>methazolamide</i> TABS 25mg, 50mg	4	
<i>metolazone</i> TABS 2.5mg, 5mg, 10mg	3	
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	3	
<i>toremide</i> TABS 5mg, 10mg, 20mg, 100mg	2	
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	GC
<i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	1	GC
<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	1	GC

MISCELLANEOUS

<i>aliskiren fumarate</i> TABS 150mg, 300mg	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	1	GC

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	1	GC
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	1	GC
<i>clonidine</i> PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	3	
<i>clonidine hcl</i> TABS .1mg, .2mg, .3mg	1	GC
CORLANOR SOLN 5mg/5ml	4	QL (450 mL / 30 days)
CORLANOR TABS 5mg, 7.5mg	4	QL (60 tabs / 30 days)
<i>digoxin</i> SOLN .05mg/ml, .25mg/ml	4	
<i>digoxin</i> TABS 125mcg, 250mcg	2	QL (30 tabs / 30 days)
<i>droxidopa</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA
<i>droxidopa</i> CAPS 200mg, 300mg	5	QL (180 caps / 30 days), NM, PA
<i>epinephrine (anaphylaxis)</i> SOLN 1mg/ml	4	
<i>guanfacine hcl</i> TABS 1mg, 2mg	3	PA; PA if 70 years and older
<i>hydralazine hcl</i> SOLN 20mg/ml	4	
<i>hydralazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	2	
<i>ivabradine hcl</i> TABS 5mg, 7.5mg	4	QL (60 tabs / 30 days)
<i>metyrosine</i> CAPS 250mg	5	NM, PA
<i>midodrine hcl</i> TABS 2.5mg, 5mg	3	
<i>midodrine hcl</i> TABS 10mg	4	
<i>minoxidil</i> TABS 2.5mg, 10mg	2	
<i>ranolazine</i> TB12 500mg, 1000mg	4	
VERQUVO TABS 2.5mg, 5mg, 10mg	3	QL (30 tabs / 30 days)

NITRATES

<i>isosorbide dinitrate</i> TABS 5mg, 10mg, 20mg, 30mg	3	
<i>isosorbide mononitrate</i> TABS 10mg, 20mg	2	
<i>isosorbide mononitrate</i> TB24 30mg, 60mg, 120mg	1	GC
NITRO-BID OINT 2%	3	
<i>nitroglycerin</i> PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SUBL .3mg, .6mg	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>nitroglycerin</i> SUBL .4mg	2	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	5	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i> TABS 5mg, 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan</i> TABS 62.5mg, 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT TABS 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>sildenafil citrate (pulmonary hypertension)</i> TABS 20mg	3	QL (360 tabs / 30 days), NM, PA
<i>treprostinil</i> SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	5	NM, LA, PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	5	NM, LA, PA
CENTRAL NERVOUS SYSTEM		
ANTI-ANXIETY		
<i>alprazolam</i> TABS .25mg, .5mg, 1mg, 2mg	2	QL (150 tabs / 30 days)
<i>bupirone hcl</i> TABS 5mg, 10mg, 15mg	1	GC
<i>bupirone hcl</i> TABS 7.5mg, 30mg	3	
<i>fluvoxamine maleate</i> TABS 25mg, 50mg, 100mg	3	
<i>lorazepam</i> CONC 2mg/ml	3	QL (150 mL / 30 days)
<i>lorazepam</i> SOLN 2mg/ml, 4mg/ml	2	
<i>lorazepam</i> TABS .5mg, 1mg, 2mg	2	QL (150 tabs / 30 days)
<i>lorazepam intensol</i> CONC 2mg/ml	3	QL (150 mL / 30 days)
ANTIDEMENTIA		
<i>donepezil hydrochloride</i> TABS 5mg; TBP 5mg	2	QL (30 tabs / 30 days)
<i>donepezil hydrochloride</i> TABS 10mg; TBP 10mg	2	
<i>galantamine hydrobromide</i> CP24 8mg, 16mg, 24mg	3	QL (30 caps / 30 days)
<i>galantamine hydrobromide</i> SOLN 4mg/ml	4	QL (200 mL / 30 days)
<i>galantamine hydrobromide</i> TABS 4mg, 8mg, 12mg	3	QL (60 tabs / 30 days)
<i>memantine hcl</i> CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml	4	PA; PA applies if 29 years and younger
<i>memantine hcl</i> TABS 5mg, 10mg	2	PA; PA applies if 29 years and younger
NAMZARIC CAP 7-10MG	4	
NAMZARIC CAP 14-10MG	4	
NAMZARIC CAP 21-10MG	4	
NAMZARIC CAP 28-10MG	4	

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
NAMZARIC CAP PACK	4	
<i>rivastigmine</i> PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	4	QL (30 patches / 30 days)
<i>rivastigmine tartrate</i> CAPS 1.5mg, 3mg, 4.5mg, 6mg	3	QL (60 caps / 30 days)

ANTIDEPRESSANTS

<i>amitriptyline hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	3	
<i>amoxapine</i> TABS 25mg, 50mg, 100mg, 150mg	3	
AUVELITY TAB 45-105MG	4	QL (60 tabs / 30 days), PA
<i>bupropion hcl</i> TABS 75mg, 100mg	3	
<i>bupropion hcl</i> TB12 100mg, 150mg, 200mg	1	GC, QL (60 tabs / 30 days)
<i>bupropion hcl</i> TB24 150mg	2	QL (60 tabs / 30 days)
<i>bupropion hcl</i> TB24 300mg	2	QL (30 tabs / 30 days)
<i>citalopram hydrobromide</i> SOLN 10mg/5ml	3	
<i>citalopram hydrobromide</i> TABS 10mg, 20mg, 40mg	1	GC
<i>clomipramine hcl</i> CAPS 25mg, 50mg, 75mg	4	PA
<i>desipramine hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	4	
<i>desvenlafaxine succinate</i> TB24 25mg, 50mg, 100mg	4	QL (30 tabs / 30 days), PA
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	3	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg	4	QL (60 caps / 30 days), PA
<i>duloxetine hcl</i> CPEP 20mg, 30mg, 60mg	2	QL (60 caps / 30 days)
<i>duloxetine hcl</i> CPEP 40mg	4	QL (60 caps / 30 days)
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr	5	QL (30 patches / 30 days), PA
<i>escitalopram oxalate</i> SOLN 5mg/5ml	4	
<i>escitalopram oxalate</i> TABS 5mg, 10mg, 20mg	1	GC
FETZIMA CP24 20mg, 40mg	4	QL (60 caps / 30 days), PA
FETZIMA CP24 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA CAP TITRATIO	4	QL (2 packs / year), PA
<i>fluoxetine hcl</i> CAPS 10mg, 20mg	1	GC
<i>fluoxetine hcl</i> CAPS 40mg	2	
<i>fluoxetine hcl</i> SOLN 20mg/5ml	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	2	
MARPLAN TABS 10mg	4	QL (180 tabs / 30 days)
<i>mirtazapine</i> TABS 7.5mg; TBDP 15mg, 30mg, 45mg	3	
<i>mirtazapine</i> TABS 15mg, 30mg, 45mg	2	
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	4	
<i>nortriptyline hcl</i> CAPS 10mg, 25mg, 50mg, 75mg	2	
<i>nortriptyline hcl</i> SOLN 10mg/5ml	4	
<i>paroxetine hcl</i> SUSP 10mg/5ml	4	QL (900 mL / 30 days), PA
<i>paroxetine hcl</i> TABS 10mg, 20mg, 30mg, 40mg	2	
<i>paroxetine hcl</i> TB24 12.5mg, 25mg, 37.5mg	4	QL (60 tabs / 30 days)
<i>phenelzine sulfate</i> TABS 15mg	3	
<i>protriptyline hcl</i> TABS 5mg, 10mg	4	
<i>sertraline hcl</i> CONC 20mg/ml	3	
<i>sertraline hcl</i> TABS 25mg, 50mg, 100mg	1	GC
<i>tranylcypromine sulfate</i> TABS 10mg	4	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	GC
<i>trimipramine maleate</i> CAPS 25mg, 50mg	4	QL (120 caps / 30 days)
<i>trimipramine maleate</i> CAPS 100mg	4	QL (60 caps / 30 days)
TRINTELLIX TABS 5mg, 10mg, 20mg	4	QL (30 tabs / 30 days)
<i>venlafaxine hcl</i> CP24 37.5mg, 75mg, 150mg	1	GC
<i>venlafaxine hcl</i> TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	2	
<i>vilazodone hcl</i> TABS 10mg, 20mg, 40mg	4	QL (30 tabs / 30 days)
ZURZUVAE CAPS 20mg, 25mg	5	QL (28 caps / 14 days), LA, PA
ZURZUVAE CAPS 30mg	5	QL (14 caps / 14 days), LA, PA

ANTIPARKINSONIAN AGENTS

<i>amantadine hcl</i> CAPS 100mg	3	QL (120 caps / 30 days)
<i>amantadine hcl</i> SOLN 50mg/5ml	3	
<i>amantadine hcl</i> TABS 100mg	4	
<i>benztropine mesylate</i> SOLN 1mg/ml	4	
<i>benztropine mesylate</i> TABS .5mg, 1mg, 2mg	2	PA; PA if 70 years and older
<i>bromocriptine mesylate</i> CAPS 5mg; TABS 2.5mg	4	
<i>carb/levo orally disintegrating tab 10-100mg</i>	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>carb/levo orally disintegrating tab 25-100mg</i>	4	
<i>carb/levo orally disintegrating tab 25-250mg</i>	4	
<i>carbidopa TABS 25mg</i>	4	
<i>carbidopa & levodopa tab 10-100 mg</i>	2	
<i>carbidopa & levodopa tab 25-100 mg</i>	2	
<i>carbidopa & levodopa tab 25-250 mg</i>	2	
<i>carbidopa & levodopa tab er 25-100 mg</i>	3	
<i>carbidopa & levodopa tab er 50-200 mg</i>	3	
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	4	
<i>entacapone TABS 200mg</i>	4	
INBRIJA CAPS 42mg	5	QL (300 caps / 30 days), NM, LA, PA
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	4	
<i>pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg</i>	2	
<i>pramipexole dihydrochloride TB24 .375mg, .75mg, 1.5mg, 2.25mg, 3mg, 3.75mg, 4.5mg</i>	4	
<i>rasagiline mesylate TABS .5mg, 1mg</i>	4	QL (30 tabs / 30 days)
<i>ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg</i>	2	
<i>ropinirole hydrochloride TB24 2mg, 4mg, 6mg, 8mg, 12mg</i>	4	
<i>selegiline hcl CAPS 5mg; TABS 5mg</i>	3	
<i>trihexyphenidyl hcl SOLN .4mg/ml</i>	3	PA; PA if 70 years and older
<i>trihexyphenidyl hcl TABS 2mg, 5mg</i>	2	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA PRSY 300mg, 400mg	5	QL (1 syringe / 28 days)

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
ABILIFY MAINTENA SRER 300mg, 400mg	5	QL (1 injection / 28 days)
<i>aripiprazole</i> SOLN 1mg/ml	4	QL (900 mL / 30 days)
<i>aripiprazole</i> TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg	4	QL (30 tabs / 30 days)
<i>aripiprazole</i> TBDP 10mg, 15mg	4	QL (60 tabs / 30 days)
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	5	QL (1 syringe / 28 days)
ARISTADA PRSY 1064mg/3.9ml	5	QL (1 syringe / 56 days)
ARISTADA INITIO PRSY 675mg/2.4ml	5	
<i>asenapine maleate</i> SUBL 2.5mg, 5mg, 10mg	4	QL (60 tabs / 30 days)
CAPLYTA CAPS 10.5mg, 21mg, 42mg	4	QL (30 caps / 30 days)
<i>chlorpromazine hcl</i> CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	4	
<i>clozapine</i> TABS 25mg, 50mg	3	
<i>clozapine</i> TABS 100mg	4	QL (270 tabs / 30 days)
<i>clozapine</i> TABS 200mg	4	QL (120 tabs / 30 days)
<i>clozapine</i> TBDP 12.5mg, 25mg	4	PA
<i>clozapine</i> TBDP 100mg	4	QL (270 tabs / 30 days), PA
<i>clozapine</i> TBDP 150mg	4	QL (180 tabs / 30 days), PA
<i>clozapine</i> TBDP 200mg	5	QL (120 tabs / 30 days), PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg	4	QL (60 tabs / 30 days), PA
FANAPT PAK	4	QL (2 packs / year), PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	4	
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	4	
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	2	
<i>haloperidol decanoate</i> SOLN 50mg/ml, 100mg/ml	3	
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	3	
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml	5	QL (1 injection / 180 days)
INVEGA SUSTENNA SUSY 39mg/0.25ml	4	QL (1 syringe / 28 days)
INVEGA SUSTENNA SUSY 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml	5	QL (1 syringe / 28 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml	5	QL (1 syringe / 90 days)
<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	3	
<i>lurasidone hcl</i> TABS 20mg, 40mg, 60mg, 120mg	4	QL (30 tabs / 30 days)
<i>lurasidone hcl</i> TABS 80mg	4	QL (60 tabs / 30 days)
<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	4	
NUPLAZID CAPS 34mg	4	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10mg	4	QL (30 tabs / 30 days), NM, LA, PA
<i>olanzapine</i> SOLR 10mg	4	QL (3 vials / 1 day)
<i>olanzapine</i> TABS 2.5mg, 5mg, 10mg	2	QL (60 tabs / 30 days)
<i>olanzapine</i> TABS 7.5mg, 15mg, 20mg	2	QL (30 tabs / 30 days)
<i>olanzapine</i> TBDP 5mg, 15mg, 20mg	4	QL (30 tabs / 30 days)
<i>olanzapine</i> TBDP 10mg	4	QL (60 tabs / 30 days)
<i>paliperidone</i> TB24 1.5mg, 3mg, 9mg	4	QL (30 tabs / 30 days)
<i>paliperidone</i> TB24 6mg	4	QL (60 tabs / 30 days)
<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	3	
PERSERIS PRSY 90mg, 120mg	5	QL (1 syringe / 30 days)
<i>pimozide</i> TABS 1mg, 2mg	4	
<i>quetiapine fumarate</i> TABS 25mg	2	QL (180 tabs / 30 days)
<i>quetiapine fumarate</i> TABS 50mg, 100mg, 150mg, 200mg	2	QL (90 tabs / 30 days)
<i>quetiapine fumarate</i> TABS 300mg, 400mg	2	QL (60 tabs / 30 days)
<i>quetiapine fumarate</i> TB24 50mg, 300mg, 400mg	4	QL (60 tabs / 30 days), PA
<i>quetiapine fumarate</i> TB24 150mg, 200mg	4	QL (30 tabs / 30 days), PA
REXULTI TABS 3mg, 4mg	4	QL (30 tabs / 30 days)
REXULTI TABS .25mg, .5mg, 1mg, 2mg	4	QL (60 tabs / 30 days)
<i>risperidone</i> SOLN 1mg/ml	3	QL (240 mL / 30 days)
<i>risperidone</i> TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	2	
<i>risperidone</i> TBDP 1mg, 2mg, 3mg	4	QL (60 tabs / 30 days)
<i>risperidone</i> TBDP 4mg	4	QL (120 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, .5mg	4	QL (90 tabs / 30 days)
<i>risperidone microspheres</i> SRER 12.5mg, 25mg	4	QL (2 injections / 28 days)
<i>risperidone microspheres</i> SRER 37.5mg, 50mg	5	QL (2 injections / 28 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr	4	QL (30 patches / 30 days)
thioridazine hcl TABS 10mg, 25mg, 50mg, 100mg	3	
thiothixene CAPS 1mg, 2mg, 5mg, 10mg	4	
trifluoperazine hcl TABS 1mg, 2mg, 5mg, 10mg	3	
VERSACLOZ SUSP 50mg/ml	4	QL (600 mL / 30 days), PA
VRAYLAR CAPS 1.5mg	4	QL (60 caps / 30 days)
VRAYLAR CAPS 3mg, 4.5mg, 6mg	4	QL (30 caps / 30 days)
VRAYLAR CAP 1.5-3MG	4	QL (2 packs / year)
ziprasidone hcl CAPS 20mg, 40mg, 60mg, 80mg	4	QL (60 caps / 30 days)
ziprasidone mesylate SOLR 20mg	4	QL (6 injections / 3 days)
ZYPREXA RELPREVV SUSR 210mg, 300mg	5	QL (2 vials / 28 days), NM, PA
ZYPREXA RELPREVV SUSR 405mg	5	QL (1 vial / 28 days), NM, PA

ANTISEIZURE AGENTS

APTIOM TABS 200mg, 400mg	5	QL (30 tabs / 30 days)
APTIOM TABS 600mg, 800mg	5	QL (60 tabs / 30 days)
BRIVIACT SOLN 10mg/ml	5	QL (600 mL / 30 days), PA
BRIVIACT SOLN 50mg/5ml	4	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg	5	QL (60 tabs / 30 days), PA
carbamazepine CHEW 100mg; TABS 200mg	3	
carbamazepine CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TB12 100mg, 200mg, 400mg	4	
clobazam SUSP 2.5mg/ml	4	QL (480 mL / 30 days), PA
clobazam TABS 10mg, 20mg	4	QL (60 tabs / 30 days), PA
clonazepam TABS 2mg	2	QL (300 tabs / 30 days)
clonazepam TABS .5mg, 1mg	2	QL (90 tabs / 30 days)
clonazepam TBDP 2mg	3	QL (300 tabs / 30 days)
clonazepam TBDP .125mg, .25mg, .5mg, 1mg	3	QL (90 tabs / 30 days)
clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg	4	QL (180 tabs / 30 days), PA; PA if 65 years and older

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
DIACOMIT CAPS 250mg	5	QL (360 caps / 30 days), NM, LA, PA
DIACOMIT CAPS 500mg	5	QL (180 caps / 30 days), NM, LA, PA
DIACOMIT PACK 250mg	5	QL (360 packets / 30 days), NM, LA, PA
DIACOMIT PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
<i>diazepam</i> SOLN 5mg/5ml	3	QL (1200 mL / 30 days), PA; PA applies if 65 years and older after a 5 day supply in a calendar year
<i>diazepam</i> TABS 2mg, 5mg, 10mg	2	QL (120 tabs / 30 days), PA; PA applies if 65 years and older after a 5 day supply in a calendar year
<i>diazepam (anticonvulsant)</i> GEL 2.5mg, 10mg, 20mg	4	
<i>diazepam inj</i> SOLN 5mg/ml	4	
<i>diazepam intensol</i> CONC 5mg/ml	3	QL (240 mL / 30 days), PA; PA applies if 65 years and older after a 5 day supply in a calendar year
DILANTIN CAPS 30mg, 100mg	4	
DILANTIN INFATABS CHEW 50mg	4	
DILANTIN-125 SUSP 125mg/5ml	4	
<i>divalproex sodium</i> CSDR 125mg	4	
<i>divalproex sodium</i> TB24 250mg, 500mg	3	
<i>divalproex sodium</i> TBEC 125mg, 250mg, 500mg	2	
EPIDIOLEX SOLN 100mg/ml	5	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i> TABS 200mg	3	
EPRONTIA SOLN 25mg/ml	4	QL (480 mL / 30 days), PA
<i>ethosuximide</i> CAPS 250mg	4	
<i>ethosuximide</i> SOLN 250mg/5ml	3	
<i>felbamate</i> SUSP 600mg/5ml	5	
<i>felbamate</i> TABS 400mg, 600mg	4	
FINTEPLA SOLN 2.2mg/ml	5	QL (360 mL / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA SUSP .5mg/ml	5	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg	5	QL (30 tabs / 30 days), PA
<i>gabapentin</i> CAPS 100mg, 300mg, 400mg	1	GC, QL (180 caps / 30 days)
<i>gabapentin</i> SOLN 250mg/5ml, 300mg/6ml	3	QL (2160 mL / 30 days)
<i>gabapentin</i> TABS 600mg	3	QL (180 tabs / 30 days)
<i>gabapentin</i> TABS 800mg	3	QL (120 tabs / 30 days)
<i>lacosamide</i> SOLN 200mg/20ml	4	
<i>lacosamide</i> TABS 50mg	4	QL (120 tabs / 30 days)
<i>lacosamide</i> TABS 100mg, 150mg, 200mg	4	QL (60 tabs / 30 days)
<i>lacosamide oral</i> SOLN 10mg/ml	4	QL (1200 mL / 30 days)
<i>lamotrigine</i> CHEW 5mg, 25mg	3	
<i>lamotrigine</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
<i>lamotrigine</i> TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg; TBDP 25mg, 50mg, 100mg, 200mg	4	
<i>levetiracetam</i> SOLN 100mg/ml	3	
<i>levetiracetam</i> SOLN 500mg/5ml	4	
<i>levetiracetam</i> TABS 250mg, 500mg, 750mg, 1000mg; TB24 500mg, 750mg	2	
<i>levetiracetam in sodium chloride iv soln</i> 500 mg/100ml	4	
<i>levetiracetam in sodium chloride iv soln</i> 1000 mg/100ml	4	
<i>levetiracetam in sodium chloride iv soln</i> 1500 mg/100ml	4	
LIBERVANT FILM 5mg, 7.5mg, 10mg, 12.5mg, 15mg	4	
<i>methsuximide</i> CAPS 300mg	4	
NAYZILAM SOLN 5mg/0.1ml	4	
<i>oxcarbazepine</i> SUSP 300mg/5ml	4	
<i>oxcarbazepine</i> TABS 150mg, 300mg, 600mg	3	
<i>phenobarbital</i> ELIX 20mg/5ml	4	QL (1500 mL / 30 days), PA; PA if 70 years and older
<i>phenobarbital</i> TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	3	QL (120 tabs / 30 days), PA; PA if 70 years and older

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>phenobarbital sodium</i> SOLN 65mg/ml, 130mg/ml	4	PA; PA if 70 years and older
<i>phenytek</i> CAPS 200mg, 300mg	4	
<i>phenytoin</i> CHEW 50mg; SUSP 125mg/5ml	3	
<i>phenytoin sodium</i> SOLN 50mg/ml	3	
<i>phenytoin sodium extended</i> CAPS 100mg, 200mg, 300mg	2	
<i>pregabalin</i> CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days), PA
<i>pregabalin</i> CAPS 200mg	3	QL (90 caps / 30 days), PA
<i>pregabalin</i> CAPS 225mg, 300mg	3	QL (60 caps / 30 days), PA
<i>pregabalin</i> SOLN 20mg/ml	4	QL (900 mL / 30 days), PA
<i>primidone</i> TABS 50mg, 125mg, 250mg	2	
<i>roweepra</i> TABS 500mg	2	
<i>rufinamide</i> SUSP 40mg/ml	5	QL (2400 mL / 30 days), PA
<i>rufinamide</i> TABS 200mg	4	QL (480 tabs / 30 days), PA
<i>rufinamide</i> TABS 400mg	5	QL (240 tabs / 30 days), PA
SPRITAM TB3D 250mg	4	QL (360 tabs / 30 days)
SPRITAM TB3D 500mg	4	QL (180 tabs / 30 days)
SPRITAM TB3D 750mg	4	QL (120 tabs / 30 days)
SPRITAM TB3D 1000mg	4	QL (90 tabs / 30 days)
<i>subvenite</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
SYMPAZAN FILM 5mg, 10mg, 20mg	5	QL (60 films / 30 days), PA
<i>tiagabine hcl</i> TABS 2mg, 4mg, 12mg, 16mg	4	
<i>topiramate</i> CPSP 15mg, 25mg	3	
<i>topiramate</i> TABS 25mg, 50mg, 100mg, 200mg	2	
<i>valproate sodium</i> SOLN 100mg/ml	4	
<i>valproate sodium</i> SOLN 250mg/5ml	3	
<i>valproic acid</i> CAPS 250mg	3	
VALTOCO 5 MG DOSE LIQD 5mg/0.1ml	4	
VALTOCO 10 MG DOSE LIQD 10mg/0.1ml	4	
VALTOCO 15 MG DOSE LQPK 7.5mg/0.1ml	4	
VALTOCO 20 MG DOSE LQPK 10mg/0.1ml	4	
<i>vigabatrin</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>vigabatrin</i> TABS 500mg	5	QL (180 tabs / 30 days), NM, LA, PA
<i>vigadrone</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
<i>vigadrone</i> TABS 500mg	5	QL (180 tabs / 30 days), NM, LA, PA
VIGAFYDE SOLN 100mg/ml	5	QL (900 mL / 30 days), NM, LA, PA
<i>vigpoder</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
XCOPRI TABS 25mg, 50mg, 100mg	5	QL (30 tabs / 30 days)
XCOPRI TABS 150mg, 200mg	5	QL (60 tabs / 30 days)
XCOPRI PAK 12.5-25	4	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	5	QL (28 tabs / 28 days)
XCOPRI PAK 100-150	5	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (MAINTENANCE)	5	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (TITRATION)	5	QL (28 tabs / 28 days)
ZONISADE SUSP 100mg/5ml	5	QL (900 mL / 30 days), PA
<i>zonisamide</i> CAPS 25mg, 50mg, 100mg	2	
ZTALMY SUSP 50mg/ml	5	QL (1100 mL / 30 days), NM, LA, PA

ATTENTION DEFICIT HYPERACTIVITY DISORDER

<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	4	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	4	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	4	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	4	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	4	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	4	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine tab 5 mg</i>	3	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	3	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 10 mg</i>	3	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	3	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 15 mg</i>	3	QL (60 tabs / 30 days), PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>amphetamine-dextroamphetamine tab 20 mg</i>	3	QL (90 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 30 mg</i>	3	QL (60 tabs / 30 days), PA
<i>atomoxetine hcl CAPS 10mg, 18mg, 25mg</i>	4	QL (120 caps / 30 days)
<i>atomoxetine hcl CAPS 40mg</i>	4	QL (60 caps / 30 days)
<i>atomoxetine hcl CAPS 60mg, 80mg, 100mg</i>	4	QL (30 caps / 30 days)
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i>	3	QL (120 tabs / 30 days), PA
<i>dexmethylphenidate hcl TABS 10mg</i>	3	QL (60 tabs / 30 days), PA
<i>guanfacine hcl (adhd) TB24 1mg, 2mg, 4mg</i>	3	QL (30 tabs / 30 days), PA; PA if 70 years and older
<i>guanfacine hcl (adhd) TB24 3mg</i>	3	QL (60 tabs / 30 days), PA; PA if 70 years and older
<i>lisdexamfetamine dimesylate CAPS 10mg, 20mg, 30mg</i>	4	QL (60 caps / 30 days), PA
<i>lisdexamfetamine dimesylate CAPS 40mg, 50mg, 60mg, 70mg</i>	4	QL (30 caps / 30 days), PA
<i>lisdexamfetamine dimesylate CHEW 10mg, 20mg, 30mg</i>	4	QL (60 tabs / 30 days), PA
<i>lisdexamfetamine dimesylate CHEW 40mg, 50mg, 60mg</i>	4	QL (30 tabs / 30 days), PA
<i>methylphenidate hcl CHEW 2.5mg, 5mg, 10mg</i>	4	QL (180 tabs / 30 days), PA
<i>methylphenidate hcl SOLN 5mg/5ml</i>	4	QL (1800 mL / 30 days), PA
<i>methylphenidate hcl SOLN 10mg/5ml</i>	4	QL (900 mL / 30 days), PA
<i>methylphenidate hcl TABS 5mg, 10mg</i>	3	QL (180 tabs / 30 days), PA
<i>methylphenidate hcl TABS 20mg</i>	3	QL (90 tabs / 30 days), PA
<i>methylphenidate hcl TBCR 10mg, 20mg</i>	4	QL (90 tabs / 30 days), PA
VYVANSE CAPS 10mg, 20mg, 30mg	4	QL (60 caps / 30 days), PA
VYVANSE CAPS 40mg, 50mg, 60mg, 70mg	4	QL (30 caps / 30 days), PA
VYVANSE CHEW 10mg, 20mg, 30mg	4	QL (60 tabs / 30 days), PA
VYVANSE CHEW 40mg, 50mg, 60mg	4	QL (30 tabs / 30 days), PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

44

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
HYPNOTICS		
DAYVIGO TABS 5mg, 10mg	3	QL (30 tabs / 30 days)
doxepin hcl (sleep) TABS 3mg, 6mg	3	QL (30 tabs / 30 days)
tasimelteon CAPS 20mg	5	QL (30 caps / 30 days), NM, PA
temazepam CAPS 7.5mg, 30mg	4	QL (30 caps / 30 days), PA; PA if 65 years and older
temazepam CAPS 15mg	4	QL (60 caps / 30 days), PA; PA if 65 years and older
zolpidem tartrate TABS 5mg, 10mg	2	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
MIGRAINE		
AIMOVIG SOAJ 70mg/ml, 140mg/ml	3	QL (1 pen / 30 days), NM, PA
dihydroergotamine mesylate SOLN 1mg/ml	5	
dihydroergotamine mesylate SOLN 4mg/ml	5	QL (8 mL / 30 days), PA
ergotamine w/ caffeine tab 1-100 mg	3	QL (40 tabs / 28 days), PA
naratriptan hcl TABS 1mg, 2.5mg	3	QL (12 tabs / 30 days)
NURTEC TBDP 75mg	3	QL (16 tabs / 30 days), PA
QULIPTA TABS 10mg, 30mg, 60mg	3	QL (30 tabs / 30 days), PA
rizatriptan benzoate TABS 5mg, 10mg; TBDP 5mg, 10mg	3	QL (18 tabs / 30 days)
sumatriptan SOLN 5mg/act	4	QL (24 units / 30 days)
sumatriptan SOLN 20mg/act	4	QL (12 units / 30 days)
sumatriptan succinate SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml	4	QL (18 injections / 30 days)
sumatriptan succinate SOAJ 6mg/0.5ml; SOCT 6mg/0.5ml; SOLN 6mg/0.5ml	4	QL (12 injections / 30 days)
sumatriptan succinate TABS 25mg, 50mg, 100mg	2	QL (12 tabs / 30 days)
UBRELVY TABS 50mg, 100mg	3	QL (16 tabs / 30 days), PA
MISCELLANEOUS		
AUSTEDO TABS 6mg	5	QL (60 tabs / 30 days), NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO TABS 9mg, 12mg	5	QL (120 tabs / 30 days), NM, LA, PA
AUSTEDO XR TB24 6mg	5	QL (90 tabs / 30 days), NM, PA
AUSTEDO XR TB24 12mg	5	QL (120 tabs / 30 days), NM, PA
AUSTEDO XR TB24 18mg, 24mg	5	QL (60 tabs / 30 days), NM, PA
AUSTEDO XR TB24 30mg, 36mg, 42mg, 48mg	5	QL (30 tabs / 30 days), NM, PA
AUSTEDO XR TAB TITR KIT	5	QL (2 packs / year), NM, PA
<i>gabapentin (once-daily)</i> TABS 300mg	4	QL (180 tabs / 30 days), PA
<i>gabapentin (once-daily)</i> TABS 600mg	4	QL (90 tabs / 30 days), PA
GRALISE TABS 300mg	4	QL (180 tabs / 30 days), PA
GRALISE TABS 450mg, 600mg	4	QL (90 tabs / 30 days), PA
GRALISE TABS 750mg, 900mg	4	QL (60 tabs / 30 days), PA
<i>lithium</i> SOLN 8meq/5ml	4	
<i>lithium carbonate</i> CAPS 150mg, 300mg, 600mg	1	GC
<i>lithium carbonate</i> TABS 300mg; TBCR 300mg, 450mg	2	
NUEDEXTA CAP 20-10MG	4	QL (60 caps / 30 days), PA
<i>pyridostigmine bromide</i> TABS 60mg	3	
<i>riluzole</i> TABS 50mg	4	
SAVELLA TABS 12.5mg, 25mg, 50mg, 100mg	4	QL (60 tabs / 30 days), PA
SAVELLA MIS TITR PAK	4	QL (2 packs / year), PA
<i>tetrabenazine</i> TABS 12.5mg	5	QL (90 tabs / 30 days), NM, PA
<i>tetrabenazine</i> TABS 25mg	5	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BAFIERTAM CPDR 95mg	5	QL (120 caps / 30 days), NM, LA, PA
BETASERON KIT .3mg	5	QL (14 syringes / 28 days), NM, PA
<i>dalfampridine</i> TB12 10mg	3	QL (60 tabs / 30 days), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>fingolimod hcl</i> CAPS .5mg	5	QL (30 caps / 30 days), NM, PA
<i>glatiramer acetate</i> SOSY 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatiramer acetate</i> SOSY 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
<i>glatopa</i> SOSY 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatopa</i> SOSY 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
KESIMPTA SOAJ 20mg/0.4ml	5	QL (16 pens / year), NM, LA, PA

MUSCULOSKELETAL THERAPY AGENTS

<i>baclofen</i> TABS 5mg	3	QL (90 tabs / 30 days)
<i>baclofen</i> TABS 10mg, 20mg	3	
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	3	QL (90 tabs / 30 days), PA; PA applies if 70 years and older after a 30 day supply in a calendar year
<i>dantrolene sodium</i> CAPS 25mg, 50mg, 100mg	4	
<i>tizanidine hcl</i> TABS 2mg, 4mg	2	

NARCOLEPSY/CATAPLEXY

<i>armodafinil</i> TABS 50mg	4	QL (60 tabs / 30 days), PA
<i>armodafinil</i> TABS 150mg, 200mg, 250mg	4	QL (30 tabs / 30 days), PA
<i>modafinil</i> TABS 100mg	3	QL (30 tabs / 30 days), PA
<i>modafinil</i> TABS 200mg	3	QL (60 tabs / 30 days), PA
SODIUM OXYBATE SOLN 500mg/ml	5	QL (540 mL / 30 days), NM, LA, PA

PSYCHOTHERAPEUTIC-MISC

<i>acamprosate calcium</i> TBEC 333mg	4	
<i>buprenorphine hcl</i> SUBL 2mg, 8mg	3	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	4	QL (90 films / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	4	QL (60 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	2	QL (90 tabs / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	2	QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent) TB12 150mg</i>	2	QL (60 tabs / 30 days)
<i>disulfiram TABS 250mg, 500mg</i>	3	
<i>naloxone hcl LIQD 4mg/0.1ml</i>	3	
<i>naloxone hcl SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY .4mg/ml, 2mg/2ml</i>	2	
<i>naltrexone hcl TABS 50mg</i>	3	
<i>NICOTROL INHALER INHA 10mg</i>	4	
<i>NICOTROL NS SOLN 10mg/ml</i>	4	
<i>varenicline tartrate TABS .5mg, 1mg</i>	4	QL (56 tabs / 28 days), PA
<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	4	QL (2 packs / year), PA
<i>VIVITROL SUSR 380mg</i>	5	NM

ENDOCRINE AND METABOLIC

ANDROGENS

<i>depo-testosterone SOLN 100mg/ml, 200mg/ml</i>	3	PA
<i>methyltestosterone CAPS 10mg</i>	5	QL (600 caps / 30 days), PA
<i>testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm</i>	4	QL (300 gm / 30 days), PA
<i>testosterone GEL 1.62%</i>	4	QL (150 gm / 30 days), PA
<i>testosterone cypionate SOLN 100mg/ml, 200mg/ml</i>	3	PA
<i>testosterone enanthate SOLN 200mg/ml</i>	3	PA

ANTIDIABETICS

<i>acarbose TABS 25mg, 50mg, 100mg</i>	3	
<i>BYDUREON BCISE AUIJ 2mg/0.85ml</i>	3	QL (4 pens / 28 days), PA
<i>BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml</i>	4	QL (1 pen / 30 days), PA
<i>FARXIGA TABS 5mg, 10mg</i>	3	QL (30 tabs / 30 days)
<i>glimepiride TABS 1mg, 2mg</i>	1	GC, QL (90 tabs / 30 days)
<i>glimepiride TABS 4mg</i>	1	GC, QL (60 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>glipizide</i> TABS 5mg	1	GC, QL (240 tabs / 30 days)
<i>glipizide</i> TABS 10mg	1	GC, QL (120 tabs / 30 days)
<i>glipizide</i> TB24 2.5mg, 5mg	1	GC, QL (90 tabs / 30 days)
<i>glipizide</i> TB24 10mg	1	GC, QL (60 tabs / 30 days)
<i>glipizide xl</i> TB24 2.5mg, 5mg	1	GC, QL (90 tabs / 30 days)
<i>glipizide xl</i> TB24 10mg	1	GC, QL (60 tabs / 30 days)
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	GC, QL (120 tabs / 30 days)
GLYXAMBI TAB 10-5 MG	3	QL (30 tabs / 30 days)
GLYXAMBI TAB 25-5 MG	3	QL (30 tabs / 30 days)
JANUMET TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	QL (30 tabs / 30 days)
JANUVIA TABS 25mg, 50mg, 100mg	3	QL (30 tabs / 30 days)
JARDIANCE TABS 10mg, 25mg	3	QL (30 tabs / 30 days)
JENTADUETO TAB 2.5-500	3	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-850	3	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-1000	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000MG	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000MG	3	QL (30 tabs / 30 days)
<i>metformin hcl</i> TABS 500mg	1	GC, QL (150 tabs / 30 days)
<i>metformin hcl</i> TABS 850mg	1	GC, QL (90 tabs / 30 days)
<i>metformin hcl</i> TABS 1000mg	1	GC, QL (75 tabs / 30 days)
<i>metformin hcl</i> TB24 500mg	1	GC, QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl</i> TB24 750mg	1	GC, QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
MOUNJARO SOAJ 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml	3	QL (4 pens / 28 days), PA
<i>nateglinide</i> TABS 60mg, 120mg	1	GC, QL (90 tabs / 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOPN 2mg/1.5ml	3	QL (1 pen / 28 days), PA
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/3ml	3	QL (1 pen / 28 days), PA
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml	3	QL (1 pen / 28 days), PA
OZEMPIC (2MG/DOSE) SOPN 8mg/3ml	3	QL (1 pen / 28 days), PA
<i>pioglitazone hcl</i> TABS 15mg, 30mg, 45mg	1	GC, QL (30 tabs / 30 days)
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	1	GC, QL (90 tabs / 30 days)
<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	1	GC, QL (90 tabs / 30 days)
<i>repaglinide</i> TABS 2mg	1	GC, QL (240 tabs / 30 days)
<i>repaglinide</i> TABS .5mg, 1mg	1	GC, QL (120 tabs / 30 days)
RYBELSUS TABS 3mg, 7mg, 14mg	3	QL (30 tabs / 30 days), PA
SYNJARDY TAB 5-500MG	3	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000	3	QL (30 tabs / 30 days)
TRADJENTA TABS 5mg	3	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	3	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 10-5-1000MG	3	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 12.5-2.5- 1000MG	3	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000MG	3	QL (30 tabs / 30 days)
TRULICITY SOAJ .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml	3	QL (4 pens / 28 days), PA
XIGDUO XR TAB 2.5-1000	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000	3	QL (30 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
ANTIDIABETICS, INSULINS		
ADMELOG SOLN 100unit/ml	3	
ADMELOG SOLOSTAR SOPN 100unit/ml	3	
BASAGLAR KWIKPEN SOPN 100unit/ml	3	
BD ALCOHOL SWABS	3	
FIASP SOLN 100unit/ml	3	
FIASP FLEXTOUCH SOPN 100unit/ml	3	
FIASP PENFILL SOCT 100unit/ml	3	
FIASP PUMPCART SOCT 100unit/ml	3	B/D
GAUZE PADS 2" X 2"	3	
HUMULIN R U-500 (CONCENTRATE) SOLN 500unit/ml	5	B/D; VIAL
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	5	KWIKPEN
INSULIN PEN NEEDLES: BD/NOVO	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGES: BD	3	
LANTUS SOLN 100unit/ml	3	
LANTUS SOLOSTAR SOPN 100unit/ml	3	
NOVOLIN INJ 70/30	3	(brand RELION not covered)
NOVOLIN INJ 70/30 FP	3	(brand RELION not covered)
NOVOLIN N SUSP 100unit/ml	3	(brand RELION not covered)
NOVOLIN N FLEXPEN SUPN 100unit/ml	3	(brand RELION not covered)
NOVOLIN R SOLN 100unit/ml	3	(brand RELION not covered)
NOVOLIN R FLEXPEN SOPN 100unit/ml	3	(brand RELION not covered)
NOVOLOG SOLN 100unit/ml	3	(brand RELION not covered)
NOVOLOG FLEXPEN SOPN 100unit/ml	3	(brand RELION not covered)
NOVOLOG MIX INJ 70/30	3	(brand RELION not covered)
NOVOLOG MIX INJ FLEXPEN	3	(brand RELION not covered)
NOVOLOG PENFILL SOCT 100unit/ml	3	(brand RELION not covered)
OMNIPOD 5 DX KIT INT G7G6	4	QL (1 kit / year), PA
OMNIPOD 5 DX MIS POD G7G6	4	QL (15 pods / 30 days), PA
OMNIPOD 5 G7 KIT INTRO	4	QL (1 kit / year), PA

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD 5 G7 MIS PODS	4	QL (15 pods / 30 days), PA
OMNIPOD DASH KIT INTRO	4	QL (1 kit / year), PA
OMNIPOD DASH MIS PODS	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 10UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 15UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 20UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 25UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 30UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 35UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 40UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD MIS CLASSIC	4	QL (15 pods / 30 days), PA
SOLIQUA INJ 100/33	3	QL (5 pens / 25 days)
TOUJEO MAX SOLOSTAR SOPN 300unit/ml	3	
TOUJEO SOLOSTAR SOPN 300unit/ml	3	
TRESIBA SOLN 100unit/ml	3	
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	3	
V-GO 20 KIT	4	QL (30 devices / 30 days), PA
V-GO 30 KIT	4	QL (30 devices / 30 days), PA
V-GO 40 KIT	4	QL (30 devices / 30 days), PA
XULTOPHY INJ 100/3.6	3	QL (5 pens / 30 days)
CALCIUM REGULATORS		
<i>alendronate sodium</i> SOLN 70mg/75ml	4	
<i>alendronate sodium</i> TABS 10mg, 35mg, 70mg	1	GC
<i>calcitonin (salmon) spray</i> SOLN 200unit/act	3	B/D
FOSAMAX + D TAB 70-2800	4	
FOSAMAX + D TAB 70-5600	4	
<i>ibandronate sodium</i> SOLN 3mg/3ml	4	B/D, QL (1 injection / 90 days)
<i>ibandronate sodium</i> TABS 150mg	3	B/D

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	5	LA, PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	3	B/D
<i>pamidronate disodium</i> SOLN 30mg/10ml, 90mg/10ml	3	B/D
PROLIA SOSY 60mg/ml	4	QL (1 syringe / 180 days), NM
<i>risedronate sodium</i> TABS 5mg, 35mg, 150mg	3	
<i>risedronate sodium</i> TABS 30mg; TBEC 35mg	4	
TERIPARATIDE SOPN 620mcg/2.48ml	5	NM, PA
XGEVA SOLN 120mg/1.7ml	5	NM, PA
<i>zoledronic acid</i> CONC 4mg/5ml; SOLN 5mg/100ml	4	B/D, NM

CHELATING AGENTS

CHEMET CAPS 100mg	5	
<i>deferasirox</i> PACK 90mg, 180mg, 360mg; TABS 180mg, 360mg; TBSO 250mg, 500mg	5	NM, PA
<i>deferasirox</i> TABS 90mg	3	NM, PA
<i>deferasirox</i> TBSO 125mg	4	NM, PA
<i>kionex</i> SUSP 15gm/60ml	3	
LOKELMA PACK 5gm, 10gm	3	
<i>penicillamine</i> TABS 250mg	5	NM
<i>sodium polystyrene sulfonate powder</i>	3	
<i>sps</i> SUSP 15gm/60ml	3	
<i>trientine hcl</i> CAPS 250mg	5	NM, PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	3	

CONTRACEPTIVES

<i>afirmelle</i>	2	
<i>altavera</i>	3	
<i>alyacen 1/35</i>	3	
<i>alyacen 7/7/7</i>	3	
<i>apri</i>	2	
<i>aranelle</i>	3	
<i>aubra eq</i>	2	
<i>aurovela 1/20</i>	3	
<i>aurovela fe 1.5/30</i>	2	
<i>aurovela fe 1/20</i>	2	
<i>aviane</i>	2	
<i>ayuna</i>	3	
<i>azurette</i>	3	
<i>balziva</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>blisovi fe 1.5/30</i>	2	
<i>briellyn</i>	3	
<i>camila</i> TABS .35mg	2	
<i>chateal eq</i>	3	
<i>cryselle-28</i>	3	
<i>cyred eq</i>	2	
<i>dasetta 1/35</i>	3	
<i>dasetta 7/7/7</i>	3	
<i>deblitane</i> TABS .35mg	2	
DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml	4	
<i>desogest-eth estrad & eth estrad tab 0.15- 0.02/0.01 mg(21/5)</i>	3	
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	2	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	3	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	3	
<i>elinest</i>	3	
<i>eluryng</i>	4	
<i>emzahh</i> TABS .35mg	2	
<i>enilloring</i>	4	
<i>enpresse-28</i>	2	
<i>enskyce</i>	2	
<i>errin</i> TABS .35mg	2	
<i>estarylla</i>	2	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	2	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	3	
<i>etonogestrel-ethinyl estradiol va ring 0.12- 0.015 mg/24hr</i>	4	
<i>falmina</i>	2	
<i>hailey 1.5/30</i>	3	
<i>haloette</i>	4	
<i>heather</i> TABS .35mg	2	
<i>iclevia</i>	3	
<i>incassia</i> TABS .35mg	2	
<i>introvale</i>	3	
<i>isibloom</i>	2	
<i>jasmiel</i>	3	
<i>jolessa</i>	3	
<i>juleber</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>junel 1.5/30</i>	3	
<i>junel 1/20</i>	3	
<i>junel fe 1.5/30</i>	2	
<i>junel fe 1/20</i>	2	
<i>kariva</i>	3	
<i>kelnor 1/35</i>	2	
<i>kelnor 1/50</i>	3	
<i>kurvelo</i>	3	
<i>larin 1.5/30</i>	3	
<i>larin 1/20</i>	3	
<i>larin fe 1.5/30</i>	2	
<i>larin fe 1/20</i>	2	
<i>leena</i>	3	
<i>lessina</i>	2	
<i>levonest</i>	2	
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	3	
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	2	
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	3	
<i>levonorgestrel-eth estra tab 0.05- 30/0.075-40/0.125-30mg-mcg</i>	2	
<i>levora 0.15/30-28</i>	3	
<i>loestrin 1.5/30-21</i>	3	
<i>loestrin 1/20-21</i>	3	
<i>loestrin fe 1.5/30</i>	2	
<i>loestrin fe 1/20</i>	2	
<i>loryna</i>	3	
<i>low-ogestrel</i>	3	
<i>lutera</i>	2	
<i>lyleq TABS .35mg</i>	2	
<i>lyza TABS .35mg</i>	2	
<i>marlissa</i>	3	
<i>medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml</i>	3	
<i>microgestin 1.5/30</i>	3	
<i>microgestin 1/20</i>	3	
<i>microgestin fe 1.5/30</i>	2	
<i>microgestin fe 1/20</i>	2	
<i>mili</i>	2	
<i>mono-linyah</i>	2	
<i>necon 0.5/35-28</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>nikki</i>	3	
<i>nora-be</i> TABS .35mg	2	
<i>norelgestromin-ethinyl estradiol td ptwk</i> <i>150-35 mcg/24hr</i>	4	
<i>norethindrone (contraceptive)</i> TABS .35mg	2	
<i>norethindrone ac-ethinyl estrad-fe tab 1-</i> <i>20/1-30/1-35 mg-mcg</i>	3	
<i>norethindrone ace & ethinyl estradiol tab 1</i> <i>mg-20 mcg</i>	3	
<i>norethindrone ace & ethinyl estradiol tab</i> <i>1.5 mg-30 mcg</i>	3	
<i>norethindrone ace & ethinyl estradiol-fe</i> <i>tab 1 mg-20 mcg</i>	2	
<i>norgestimate & ethinyl estradiol tab 0.25</i> <i>mg-35 mcg</i>	2	
<i>norgestimate-eth estrad tab 0.18-</i> <i>25/0.215-25/0.25-25 mg-mcg</i>	3	
<i>norgestimate-eth estrad tab 0.18-</i> <i>35/0.215-35/0.25-35 mg-mcg</i>	3	
<i>norlyroc</i> TABS .35mg	2	
<i>nortrel 0.5/35 (28)</i>	3	
<i>nortrel 1/35 (21)</i>	3	
<i>nortrel 1/35 (28)</i>	3	
<i>nortrel 7/7/7</i>	3	
<i>nylia 1/35</i>	3	
<i>nylia 7/7/7</i>	3	
<i>nymyo</i>	2	
<i>ocella</i>	3	
<i>philiith</i>	3	
<i>pimtrea</i>	3	
<i>portia-28</i>	3	
<i>reclipsen</i>	2	
<i>setlakin</i>	3	
<i>sharobel</i> TABS .35mg	2	
<i>simliya</i>	3	
<i>sprintec 28</i>	2	
<i>sronyx</i>	2	
<i>syeda</i>	3	
<i>tarina fe 1/20 eq</i>	2	
<i>tilia fe</i>	3	
<i>tri-estarylla</i>	3	
<i>tri-legest fe</i>	3	
<i>tri-linyah</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>tri-lo-estarylla</i>	3	
<i>tri-lo-marzia</i>	3	
<i>tri-lo-mili</i>	3	
<i>tri-lo-sprintec</i>	3	
<i>tri-mili</i>	3	
<i>tri-nymyo</i>	3	
<i>tri-sprintec</i>	3	
<i>tri-vylibra</i>	3	
<i>tri-vylibra lo</i>	3	
<i>trivora-28</i>	2	
<i>turqoz</i>	3	
<i>velivet</i>	3	
<i>vestura</i>	3	
<i>vienva</i>	2	
<i>viorele</i>	3	
<i>vyfemla</i>	3	
<i>vylibra</i>	2	
<i>wera</i>	3	
<i>xulane</i>	4	
<i>zafemy</i>	4	
<i>zovia 1/35</i>	2	
<i>zumandimine</i>	3	

ENDOMETRIOSIS

<i>danazol</i> CAPS 50mg, 100mg, 200mg	4	
SYNAREL SOLN 2mg/ml	5	PA

ESTROGENS

<i>dotti</i> PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
<i>estradiol</i> PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	3	
<i>estradiol</i> TABS .5mg, 1mg, 2mg	2	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	3	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	3	
<i>estradiol vaginal</i> CREA .1mg/gm	3	
<i>estradiol vaginal</i> TABS 10mcg	4	
<i>estradiol valerate</i> OIL 10mg/ml, 20mg/ml, 40mg/ml	4	
<i>fyavolv tab 0.5mg-2.5mcg</i>	3	
<i>fyavolv tab 1mg-5mcg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>jinteli</i>	3	
<i>lyllana</i> PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
<i>mimvey</i>	3	
<i>norethindrone acetate-ethinyl estradiol tab</i> 0.5 mg-2.5 mcg	3	
<i>norethindrone acetate-ethinyl estradiol tab</i> 1 mg-5 mcg	3	
<i>yuvaferm</i> TABS 10mcg	4	

GLUCOCORTICOIDS

<i>dexamethasone</i> ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	3	B/D
DEXAMETHASONE INTENSOL CONC 1mg/ml	4	B/D
<i>dexamethasone sodium phosphate</i> SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml; SOSY 4mg/ml	3	
<i>fludrocortisone acetate</i> TABS .1mg	2	
<i>hydrocortisone</i> TABS 5mg, 10mg, 20mg	3	
<i>methylprednisolone</i> TABS 4mg, 8mg, 16mg, 32mg	3	B/D
<i>methylprednisolone</i> TBPK 4mg	2	
<i>methylprednisolone acetate</i> SUSP 40mg/ml, 80mg/ml	3	B/D
<i>methylprednisolone sod succ</i> SOLR 40mg, 125mg, 1000mg	3	B/D
<i>prednisolone</i> SOLN 15mg/5ml	2	B/D
<i>prednisolone sodium phosphate</i> SOLN 5mg/5ml, 25mg/5ml	4	B/D
<i>prednisolone sodium phosphate</i> SOLN 15mg/5ml	2	B/D
<i>prednisone</i> SOLN 5mg/5ml	4	B/D
<i>prednisone</i> TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	2	B/D
<i>prednisone</i> TBPK 5mg, 10mg	3	
PREDNISONE INTENSOL CONC 5mg/ml	4	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	4	

GLUCOSE ELEVATING AGENTS

<i>diazoxide</i> SUSP 50mg/ml	5	
GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	3	
GVOKE KIT SOLN 1mg/0.2ml	3	
GVOKE PFS SOSY 1mg/0.2ml	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	5	NM, LA, PA
<i>betaine powder for oral solution</i>	5	NM, LA
<i>cabergoline</i> TABS .5mg	3	
<i>carglumic acid</i> TBSO 200mg	5	NM, LA, PA
CERDELGA CAPS 84mg	5	NM, LA, PA
CEREZYME SOLR 400unit	5	NM, LA, PA
<i>cinacalcet hcl</i> TABS 30mg, 60mg	4	B/D, QL (60 tabs / 30 days), NM
<i>cinacalcet hcl</i> TABS 90mg	5	B/D, QL (120 tabs / 30 days), NM
CYSTAGON CAPS 50mg, 150mg	4	NM, LA, PA
<i>desmopressin acetate</i> SOLN 4mcg/ml	5	
<i>desmopressin acetate</i> TABS .1mg, .2mg	3	
<i>desmopressin acetate spray</i> SOLN .01%	4	
<i>desmopressin acetate spray refrigerated</i> SOLN .01%	4	
FABRAZYME SOLR 5mg, 35mg	5	NM, LA, PA
GENOTROPIN CART 5mg, 12mg	5	NM, PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NM, PA
INCRELEX SOLN 40mg/4ml	5	NM, LA, PA
<i>javygtor</i> PACK 100mg, 500mg; TABS 100mg	5	NM, LA, PA
KORLYM TABS 300mg	5	NM, LA, PA
<i>lanreotide acetate</i> SOLN 120mg/0.5ml	5	NM, PA
<i>levocarnitine (metabolic modifiers)</i> SOLN 1gm/10ml; TABS 330mg	4	B/D
LUMIZYME SOLR 50mg	5	NM, LA, PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	5	NM, PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	5	NM, PA
LUPRON DEPOT-PED (6-MONTH KIT 45mg	5	NM, PA
<i>mifepristone (hyperglycemia)</i> TABS 300mg	5	NM, PA
<i>miglustat</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA
NAGLAZYME SOLN 1mg/ml	5	NM, LA, PA
<i>nitisinone</i> CAPS 2mg, 5mg, 10mg, 20mg	5	NM, PA
<i>octreotide acetate</i> SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml; SOSY 50mcg/ml, 100mcg/ml	4	NM, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>octreotide acetate</i> SOLN 500mcg/ml, 1000mcg/ml; SOSY 500mcg/ml	5	NM, PA
<i>raloxifene hcl</i> TABS 60mg	3	
<i>sapropterin dihydrochloride</i> PACK 100mg, 500mg; TABS 100mg	5	NM, PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	5	NM, LA, PA
<i>sodium phenylbutyrate</i> POWD 3gm/tsp; TABS 500mg	5	NM, PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	5	NM, LA, PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	5	NM, LA, PA
<i>yargesa</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA

PHOSPHATE BINDER AGENTS

<i>calcium acetate (phosphate binder)</i> CAPS 667mg	3	QL (360 caps / 30 days)
<i>calcium acetate (phosphate binder)</i> TABS 667mg	3	QL (360 tabs / 30 days)
<i>lanthanum carbonate</i> CHEW 500mg, 1000mg	3	QL (90 tabs / 30 days)
<i>lanthanum carbonate</i> CHEW 750mg	3	QL (180 tabs / 30 days)
<i>sevelamer carbonate</i> PACK 2.4gm	4	QL (180 packets / 30 days)
<i>sevelamer carbonate</i> PACK .8gm	4	QL (540 packets / 30 days)
<i>sevelamer carbonate</i> TABS 800mg	4	QL (540 tabs / 30 days)
VELPHORO CHEW 500mg	5	QL (180 tabs / 30 days)

PROGESTINS

<i>medroxyprogesterone acetate</i> TABS 2.5mg, 5mg, 10mg	1	GC
<i>megestrol acetate</i> SUSP 40mg/ml	3	
<i>megestrol acetate (appetite)</i> SUSP 625mg/5ml	4	PA
<i>norethindrone acetate</i> TABS 5mg	3	
<i>progesterone</i> CAPS 100mg, 200mg	3	

THYROID AGENTS

<i>euthyrox</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	GC
<i>levo-t</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	GC

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>levothyroxine sodium</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	GC
<i>levoxyl</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	GC
<i>liothyronine sodium</i> TABS 5mcg, 25mcg, 50mcg	3	
<i>methimazole</i> TABS 5mg, 10mg	1	GC
<i>propylthiouracil</i> TABS 50mg	3	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	4	
<i>unithroid</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	GC

VITAMIN D ANALOGS

<i>calcitriol</i> CAPS .25mcg, .5mcg	2	B/D
<i>calcitriol (oral)</i> SOLN 1mcg/ml	4	B/D
<i>doxercalciferol</i> CAPS .5mcg, 1mcg, 2.5mcg	4	B/D
<i>paricalcitol</i> CAPS 1mcg, 2mcg, 4mcg	4	B/D
RAYALDEE CPR 30mcg	5	

GASTROINTESTINAL

ANTIEMETICS

<i>aprepitant</i> CAPS 40mg, 80mg, 125mg	4	B/D
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	4	B/D
<i>compro</i> SUPP 25mg	4	
<i>dronabinol</i> CAPS 2.5mg, 5mg, 10mg	4	B/D, QL (60 caps / 30 days)
<i>granisetron hcl</i> SOLN 1mg/ml, 4mg/4ml	4	
<i>granisetron hcl</i> TABS 1mg	4	B/D
<i>meclizine hcl</i> TABS 12.5mg, 25mg	2	
<i>metoclopramide hcl</i> SOLN 5mg/5ml, 5mg/ml	3	
<i>metoclopramide hcl</i> TABS 5mg, 10mg	1	GC
<i>ondansetron</i> TBDP 4mg, 8mg	3	B/D
<i>ondansetron hcl</i> SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	3	
<i>ondansetron hcl</i> SOLN 4mg/5ml	4	B/D
<i>ondansetron hcl</i> TABS 4mg, 8mg	3	B/D

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>prochlorperazine</i> SUPP 25mg	4	
<i>prochlorperazine edisylate</i> SOLN 10mg/2ml	4	
<i>prochlorperazine maleate</i> TABS 5mg, 10mg	2	
<i>promethazine hcl</i> SOLN 6.25mg/5ml, 25mg/ml, 50mg/ml; TABS 12.5mg, 25mg, 50mg	3	PA; PA if 70 years and older
<i>scopolamine</i> PT72 1mg/3days	4	QL (10 patches / 30 days), PA; PA if 70 years and older

ANTISPASMODICS

<i>dicyclomine hcl</i> CAPS 10mg; TABS 20mg	2	
<i>dicyclomine hcl</i> SOLN 10mg/5ml	4	
<i>glycopyrrolate</i> TABS 1mg	3	QL (90 tabs / 30 days)
<i>glycopyrrolate</i> TABS 2mg	3	QL (120 tabs / 30 days)

H2-RECEPTOR ANTAGONISTS

<i>famotidine</i> SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	3	
<i>famotidine</i> SUSR 40mg/5ml	4	QL (300 mL / 30 days)
<i>famotidine</i> TABS 20mg	1	GC, QL (120 tabs / 30 days)
<i>famotidine</i> TABS 40mg	1	GC, QL (60 tabs / 30 days)
<i>famotidine in nacl 0.9% iv soln</i> 20 mg/50ml	3	
<i>nizatidine</i> CAPS 150mg, 300mg	4	

INFLAMMATORY BOWEL DISEASE

<i>balsalazide disodium</i> CAPS 750mg	3	
<i>budesonide</i> CPEP 3mg	4	QL (90 caps / 30 days), PA
<i>budesonide</i> TB24 9mg	5	QL (30 tabs / 30 days), PA
<i>hydrocortisone (intrarectal)</i> ENEM 100mg/60ml	4	
<i>mesalamine</i> CP24 .375gm	4	QL (120 caps / 30 days)
<i>mesalamine</i> CPDR 400mg	4	QL (180 caps / 30 days)
<i>mesalamine</i> ENEM 4gm; SUPP 1000mg	4	
<i>mesalamine</i> TBEC 1.2gm	4	QL (120 tabs / 30 days)
<i>mesalamine w/ cleanser</i> KIT 4gm	4	
<i>sulfasalazine</i> TABS 500mg	2	
<i>sulfasalazine</i> TBEC 500mg	3	

LAXATIVES

<i>constulose</i> SOLN 10gm/15ml	2	
----------------------------------	---	--

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>enulose</i> SOLN 10gm/15ml	2	
<i>gavilyte-c</i>	2	
<i>gavilyte-g</i>	2	
<i>gavilyte-n/ flavor pack</i>	2	
<i>generlac</i> SOLN 10gm/15ml	2	
<i>lactulose</i> SOLN 10gm/15ml	2	
<i>lactulose (encephalopathy)</i> SOLN 10gm/15ml	2	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	2	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	2	
PLENVU SOL	4	
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	3	

MISCELLANEOUS

<i>alose tron hcl</i> TABS .5mg, 1mg	5	QL (60 tabs / 30 days), PA
<i>cromolyn sodium (mastocytosis)</i> CONC 100mg/5ml	4	
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	4	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	3	
GATTEX KIT 5mg	5	NM, LA, PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	4	QL (30 caps / 30 days)
<i>loperamide hcl</i> CAPS 2mg	3	
<i>misoprostol</i> TABS 100mcg, 200mcg	3	
MOVANTIK TABS 12.5mg, 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	5	QL (28 syringes / 28 days), PA
<i>sucral fate</i> TABS 1gm	2	
<i>ursodiol</i> CAPS 300mg	3	
<i>ursodiol</i> TABS 250mg, 500mg	4	
XERMELO TABS 250mg	5	QL (84 tabs / 28 days), NM, LA, PA
XIFAXAN TABS 550mg	5	PA

PANCREATIC ENZYMES

CREON CAP 3000UNIT	3	
CREON CAP 6000UNIT	3	
CREON CAP 12000UNT	3	
CREON CAP 24000UNT	3	
CREON CAP 36000UNT	3	
ZENPEP CAP 3000UNIT	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
ZENPEP CAP 5000UNIT	4	
ZENPEP CAP 10000UNT	4	
ZENPEP CAP 15000UNT	4	
ZENPEP CAP 20000UNT	4	
ZENPEP CAP 25000UNT	4	
ZENPEP CAP 40000UNT	4	
ZENPEP CAP 60000UNT	4	

PROTON PUMP INHIBITORS

<i>esomeprazole magnesium</i> CPDR 20mg, 40mg	4	QL (30 caps / 30 days)
<i>lansoprazole</i> CPDR 15mg, 30mg	3	QL (60 caps / 30 days)
<i>lansoprazole</i> TBDD 15mg, 30mg	4	QL (60 tabs / 30 days)
<i>omeprazole</i> CPDR 10mg, 20mg, 40mg	1	GC
<i>pantoprazole sodium</i> SOLR 40mg	4	
<i>pantoprazole sodium</i> TBEC 20mg, 40mg	1	GC
<i>rabeprazole sodium</i> TBEC 20mg	3	QL (30 tabs / 30 days)

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

<i>alfuzosin hcl</i> TB24 10mg	2	QL (30 tabs / 30 days)
<i>dutasteride</i> CAPS .5mg	3	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl cap</i> 0.5-0.4 mg	4	QL (30 caps / 30 days)
<i>finasteride</i> TABS 5mg	1	GC, QL (30 tabs / 30 days)
<i>silodosin</i> CAPS 4mg, 8mg	3	QL (30 caps / 30 days)
<i>tamsulosin hcl</i> CAPS .4mg	1	GC, QL (60 caps / 30 days)

MISCELLANEOUS

<i>acetic acid</i> SOLN .25%	2	
<i>bethanechol chloride</i> TABS 5mg, 10mg, 25mg, 50mg	3	
<i>potassium citrate (alkalinizer)</i> TBCR 15meq, 540mg, 1080mg	4	

URINARY ANTISPASMODICS

<i>darifenacin hydrobromide</i> TB24 7.5mg, 15mg	4	QL (30 tabs / 30 days)
<i>fesoterodine fumarate</i> TB24 4mg, 8mg	4	QL (30 tabs / 30 days)
GEMTESA TABS 75mg	4	QL (30 tabs / 30 days)
MYRBETRIQ SRER 8mg/ml	4	QL (300 mL / 28 days)
MYRBETRIQ TB24 25mg, 50mg	4	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> SOLN 5mg/5ml	3	QL (600 mL / 30 days)
<i>oxybutynin chloride</i> TABS 5mg	2	QL (120 tabs / 30 days)
<i>oxybutynin chloride</i> TB24 5mg	3	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> TB24 10mg, 15mg	3	QL (60 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>solifenacin succinate</i> TABS 5mg, 10mg	4	QL (30 tabs / 30 days)
<i>tolterodine tartrate</i> CP24 2mg, 4mg	4	QL (30 caps / 30 days)
<i>tolterodine tartrate</i> TABS 1mg, 2mg	4	QL (60 tabs / 30 days)
<i>tropium chloride</i> CP24 60mg	4	QL (30 caps / 30 days)
<i>tropium chloride</i> TABS 20mg	3	QL (60 tabs / 30 days)

VAGINAL ANTI-INFECTIVES

<i>clindamycin phosphate vaginal</i> CREA 2%	3	
<i>metronidazole vaginal</i> GEL .75%	3	
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	3	

HEMATOLOGIC

ANTICOAGULANTS

<i>dabigatran etexilate mesylate</i> CAPS 75mg, 150mg	4	QL (60 caps / 30 days)
<i>dabigatran etexilate mesylate</i> CAPS 110mg	4	QL (120 caps / 30 days)
ELIQUIS TABS 2.5mg	3	QL (60 tabs / 30 days)
ELIQUIS TABS 5mg	3	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK TBPK 5mg	3	QL (74 tabs / 30 days)
<i>enoxaparin sodium</i> SOLN 300mg/3ml; SOSY 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	4	
<i>fondaparinux sodium</i> SOLN 2.5mg/0.5ml	4	
<i>fondaparinux sodium</i> SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	
HEP SOD/D5W INJ 20000UNT	4	
HEP SOD/D5W INJ 25000UNT	4	
HEP SOD/NAACL INJ 12500UNT	3	
HEP SOD/NAACL INJ 25000UNT	3	
<i>heparin sodium (porcine)</i> SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	3	B/D
HEPARIN/NAACL INJ 25000UNT	3	
<i>jantoven</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
PRADAXA CAPS 110mg	4	QL (120 caps / 30 days)
<i>warfarin sodium</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
XARELTO SUSR 1mg/ml	3	QL (620 mL / 30 days)
XARELTO TABS 2.5mg	3	QL (60 tabs / 30 days)
XARELTO TABS 10mg, 15mg, 20mg	3	QL (30 tabs / 30 days)
XARELTO STAR TAB 15/20MG	3	QL (51 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	NM, PA
PROCRIT SOLN 20000unit/ml, 40000unit/ml	5	NM, PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	5	NM, PA
ZIEXTENZO SOSY 6mg/0.6ml	5	QL (2 syringes / 28 days), NM, PA
MISCELLANEOUS		
ALVAIZ TABS 9mg, 54mg	5	QL (60 tabs / 30 days), NM, LA, PA
ALVAIZ TABS 18mg, 36mg	5	QL (90 tabs / 30 days), NM, LA, PA
<i>anagrelide hcl</i> CAPS .5mg, 1mg	4	
BERINERT KIT 500unit	5	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i> TABS 50mg, 100mg	2	
DOPTELET TABS 20mg	5	NM, LA, PA
DROXIA CAPS 200mg, 300mg, 400mg	3	
ENDARI PACK 5gm	5	NM, LA, PA
HAEGARDA SOLR 2000unit	5	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA SOLR 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
<i>icatibant acetate</i> SOSY 30mg/3ml	5	QL (9 syringes / 30 days), NM, PA
<i>l-glutamine (sickle cell)</i> PACK 5gm	5	NM, PA
<i>pentoxifylline</i> TBCR 400mg	2	
PROMACTA PACK 12.5mg	5	QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	5	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	5	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>sajazir</i> SOSY 30mg/3ml	5	QL (9 syringes / 30 days), NM, LA, PA
<i>tranexamic acid</i> SOLN 1000mg/10ml	4	
<i>tranexamic acid</i> TABS 650mg	3	
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	4	
BRILINTA TABS 60mg, 90mg	3	

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>clopidogrel bisulfate</i> TABS 75mg	1	GC
<i>dipyridamole</i> TABS 25mg, 50mg, 75mg	3	PA; PA if 70 years and older
<i>prasugrel hcl</i> TABS 5mg, 10mg	3	

IMMUNOLOGIC AGENTS

AUTOIMMUNE AGENTS

ADALIMUMAB-AACF (2 PEN) AJKT 40mg/0.8ml	5	QL (56 pens / 365 days), NM, PA
ADALIMUMAB-AACF (2 SYRING PSKT 40mg/0.8ml	5	QL (56 syringes / 365 days), NM, PA
DUPIXENT SOAJ 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	5	NM, PA
ENBREL SOLN 25mg/0.5ml	5	QL (16 vials / 28 days), NM, PA
ENBREL SOSY 25mg/0.5ml	5	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	5	QL (8 syringes / 28 days), NM, PA
ENBREL MINI SOCT 50mg/ml	5	QL (8 cartridges / 28 days), NM, PA
ENBREL SURECLICK SOAJ 50mg/ml	5	QL (8 pens / 28 days), NM, PA
HUMIRA PSKT 10mg/0.1ml	5	QL (2 syringes / 28 days), NM, PA
HUMIRA PSKT 20mg/0.2ml	5	QL (4 syringes / 28 days), NM, PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml	5	QL (6 syringes / 28 days), NM, PA
HUMIRA PEN AJKT 40mg/0.4ml, 40mg/0.8ml	5	QL (6 pens / 28 days), NM, PA
HUMIRA PEN AJKT 80mg/0.8ml	5	QL (4 pens / 28 days), NM, PA
HUMIRA PEN KIT PS/UV	5	QL (3 pens / 28 days), NM, PA
HUMIRA PEN-CD/UC/HS START AJKT 80mg/0.8ml	5	QL (3 pens / 28 days), NM, PA
HUMIRA PEN-PEDIATRIC UC S AJKT 80mg/0.8ml	5	QL (4 pens / 28 days), NM, PA
IDACIO (2 PEN) AJKT 40mg/0.8ml	5	QL (56 pens / 365 days), NM, PA
IDACIO (2 SYRINGE) PSKT 40mg/0.8ml	5	QL (56 syringes / 365 days), NM, PA
IDACIO CROHN INJ DISEASE AJKT 40mg/0.8ml	5	QL (2 packs / year), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
IDACIO PLAQU INJ PSORIASIS AJKT 40mg/0.8ml	5	QL (2 packs / year), NM, PA
INFLIXIMAB SOLR 100mg	5	NM, LA, PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml	5	QL (2 pens / 28 days), NM, PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml	5	QL (2 syringes / 28 days), NM, PA
OTEZLA TABS 20mg, 30mg	5	QL (60 tabs / 30 days), NM, PA
OTEZLA TAB 10/20	5	QL (110 tabs / year), NM, PA
OTEZLA TAB 10/20/30	5	QL (110 tabs / year), NM, PA
REMICADE SOLR 100mg	5	NM, LA, PA
RENFLIXIS SOLR 100mg	5	NM, LA, PA
RINVOQ TB24 15mg, 30mg	5	QL (30 tabs / 30 days), NM, PA
RINVOQ TB24 45mg	5	QL (168 tabs / year), NM, PA
RINVOQ LQ SOLN 1mg/ml	5	QL (360 mL / 30 days), NM, PA
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml	5	QL (1 cartridge / 56 days), NM, PA
SKYRIZI SOLN 600mg/10ml	5	QL (12 vials / 365 days), NM, PA
SKYRIZI SOSY 150mg/ml	5	QL (6 syringes / 365 days), NM, PA
SKYRIZI PEN SOAJ 150mg/ml	5	QL (6 pens / 365 days), NM, PA
STELARA SOLN 45mg/0.5ml	5	QL (1 vial / 28 days), NM, LA, PA
STELARA SOLN 130mg/26ml	5	NM, LA, PA
STELARA SOSY 45mg/0.5ml, 90mg/ml	5	QL (1 syringe / 28 days), NM, PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml	5	QL (3 syringes / 28 days), NM, LA, PA
TALTZ SOSY 20mg/0.25ml, 40mg/0.5ml	5	QL (1 syringe / 28 days), NM, LA, PA
TREMFYA SOAJ 100mg/ml	5	QL (1 pen / 28 days), NM, PA
TREMFYA SOSY 100mg/ml	5	QL (1 syringe / 28 days), NM, PA
XELJANZ SOLN 1mg/ml	5	QL (480 mL / 24 days), NM, PA
XELJANZ TABS 5mg, 10mg	5	QL (60 tabs / 30 days), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
XELJANZ XR TB24 11mg, 22mg	5	QL (30 tabs / 30 days), NM, PA
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
<i>hydroxychloroquine sulfate</i> TABS 200mg	2	
JYLAMVO SOLN 2mg/ml	4	B/D
<i>leflunomide</i> TABS 10mg, 20mg	3	QL (30 tabs / 30 days)
<i>methotrexate sodium</i> TABS 2.5mg	2	
TREXALL TABS 5mg, 7.5mg, 10mg, 15mg	4	B/D
XATMEP SOLN 2.5mg/ml	4	B/D
IMMUNOGLOBULINS		
ALYGLO SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml	5	PA
BIVIGAM SOLN 5gm/50ml, 10%	5	NM, LA, PA
FLEBOGAMMA DIF SOLN 5gm/100ml, 10gm/200ml, 20gm/400ml	5	NM, PA
GAMASTAN INJ	4	B/D, NM, LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NM, PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	5	NM, PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	5	NM, PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	NM, LA, PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NM, PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 30gm/300ml	5	NM, PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NM, PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 100mcg/0.5ml	5	NM, LA, PA
ARCALYST SOLR 220mg	5	NM, LA, PA
IMMUNOSUPPRESSANTS		
ASTAGRAF XL CP24 5mg	5	B/D
ASTAGRAF XL CP24 .5mg, 1mg	4	B/D

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>azathioprine</i> TABS 50mg	2	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	5	QL (8 syringes / 28 days), NM, LA, PA
BENLYSTA SOLR 120mg, 400mg	5	NM, LA, PA
<i>cyclosporine</i> CAPS 25mg, 100mg	4	B/D
<i>cyclosporine modified (for microemulsion)</i> CAPS 25mg, 50mg, 100mg; SOLN 100mg/ml	4	B/D
<i>everolimus (immunosuppressant)</i> TABS .25mg, .5mg, .75mg, 1mg	5	B/D
<i>gengraf</i> CAPS 25mg, 100mg; SOLN 100mg/ml	4	B/D
<i>mycophenolate mofetil</i> CAPS 250mg; TABS 500mg	3	B/D
<i>mycophenolate mofetil</i> SUSR 200mg/ml	5	B/D
<i>mycophenolate sodium</i> TBEC 180mg, 360mg	4	B/D
NULOJIX SOLR 250mg	5	B/D
PROGRAF PACK .2mg, 1mg	4	B/D
REZUROCK TABS 200mg	5	NM, LA, PA
SANDIMMUNE SOLN 100mg/ml	4	B/D
<i>sirolimus</i> SOLN 1mg/ml	5	B/D
<i>sirolimus</i> TABS .5mg, 1mg, 2mg	4	B/D
<i>tacrolimus</i> CAPS .5mg, 1mg, 5mg	4	B/D

VACCINES

ABRYSVO SOLR 120mcg/0.5ml	1	GC
ACTHIB INJ	1	GC
ADACEL INJ	1	GC
AREXVY SUSR 120mcg/0.5ml	1	GC
BCG VACCINE SOLR 50mg	1	GC
BEXSERO INJ	1	GC
BOOSTRIX INJ	1	GC
DAPTACEL INJ	1	GC
DENGVAXIA SUS	1	GC
DIP/TET PED INJ 25-5LFU	1	GC, B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	1	GC, B/D
GARDASIL 9 INJ	1	GC
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	1	GC
HEPLISAV-B SOSY 20mcg/0.5ml	1	GC, B/D
HIBERIX SOLR 10mcg	1	GC
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	1	GC, B/D
INFANRIX INJ	1	GC

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
IPOL INJ INACTIVE	1	GC
IXCHIQ INJ	1	GC
IXIARO INJ	1	GC
JYNNEOS SUSP .5ml	1	GC, B/D
KINRIX INJ	1	GC
M-M-R II INJ	1	GC
MENACTRA INJ	1	GC
MENQUADFI INJ	1	GC
MENVEO INJ	1	GC
MENVEO SOL	1	GC
MRESVIA SUSY 50mcg/0.5ml	1	GC
PEDIARIX INJ 0.5ML	1	GC
PEDVAX HIB SUSP 7.5mcg/0.5ml	1	GC
PENBRAYA INJ	1	GC
PENTACEL INJ	1	GC
PREHEVBRIO SUSP 10mcg/ml	1	GC, B/D
PRIORIX INJ	1	GC
PROQUAD INJ	1	GC
QUADRACEL INJ	1	GC
QUADRACEL INJ 0.5ML	1	GC
RABAVERT INJ	1	GC, B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml; SUSY 5mcg/0.5ml, 10mcg/ml	1	GC, B/D
ROTARIX SUS	1	GC
ROTATEQ SOL	1	GC
SHINGRIX SUSR 50mcg/0.5ml	1	GC, QL (2 vials per lifetime)
TDVAX INJ 2-2 LF	1	GC, B/D
TENIVAC INJ 5-2LF	1	GC, B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	1	GC
TRUMENBA INJ	1	GC
TWINRIX INJ	1	GC
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	1	GC
VAQTA SUSP 25unit/0.5ml, 50unit/ml	1	GC
VARIVAX SUSR 1350pfu/0.5ml	1	GC
VAXCHORA SUS	1	GC
YF-VAX INJ	1	GC

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES/MINERALS, INJECTABLE

D2.5W/NACL INJ 0.45%	4
D5W/LYTES INJ #48	4

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
D10W/NACL INJ 0.2%	3	
<i>dextrose 2.5% w/ sodium chloride 0.45%</i>	3	
<i>dextrose 5% in lactated ringers</i>	3	
<i>dextrose 5% w/ sodium chloride 0.2%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.3%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.9%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.45%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.225%</i>	3	
<i>dextrose 10% w/ sodium chloride 0.45%</i>	3	
ISOLYTE-P INJ /D5W	4	
ISOLYTE-S INJ	4	
ISOLYTE-S INJ PH 7.4	4	
<i>kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	3	
<i>kcl 20 meq/l (0.149%) in nacl 0.45% inj</i>	3	
<i>kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj</i>	3	
<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.9% inj</i>	3	
<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj</i>	3	
<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj</i>	3	
KCL/D5W/NACL INJ 0.3/0.9%	4	
<i>lactated ringer's solution</i>	3	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
<i>magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%</i>	3	
<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>	3	
MG SO4/D5W INJ 10MG/ML	3	
<i>multiple electrolytes ph 5.5</i>	4	
<i>multiple electrolytes ph 7.4</i>	4	
PLASMA-LYTE INJ -148	4	
PLASMA-LYTE INJ -A	4	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
POT CHL 20MEQ/L IN NAACL 0.9% INJ	4	
POT CHL 20MEQ/L IN NAACL 0.45% INJ	4	
POT CHL 40MEQ/L IN NAACL 0.9% INJ	4	
<i>potassium chloride</i> SOLN 2meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 20meq/50ml, 40meq/100ml	3	
POTASSIUM CHLORIDE SOLN 10meq/50ml	4	
<i>potassium chloride 20 meq/l (0.15%) in dextrose 5% inj</i>	3	
<i>sodium chloride</i> SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	3	
TPN ELECTROL INJ	4	B/D

ELECTROLYTES/MINERALS/VITAMINS, ORAL

<i>klor-con</i> PACK 20meq	4	
<i>klor-con 8</i> TBCR 8meq	1	GC
<i>klor-con 10</i> TBCR 10meq	1	GC
<i>klor-con m10</i> TBCR 10meq	1	GC
<i>klor-con m15</i> TBCR 15meq	1	GC
<i>klor-con m20</i> TBCR 20meq	1	GC
M-NATAL PLUS TAB	3	
<i>potassium chloride</i> CPCR 8meq, 10meq	3	
<i>potassium chloride</i> PACK 20meq; SOLN 10%, 20%	4	
<i>potassium chloride</i> TBCR 8meq, 10meq, 20meq	1	GC
<i>potassium chloride microencapsulated crystals er</i> TBCR 10meq, 15meq, 20meq	1	GC
PRENATAL TAB 27-1MG	3	
PRENATAL TAB PLUS	3	
<i>sodium fluoride</i> chew; tab; 1.1 (0.5 f) mg/ml soln	2	

IV NUTRITION

CLINIMIX INJ 4.25/D5W	4	B/D
CLINIMIX INJ 4.25/D10	4	B/D
CLINIMIX INJ 5%/D15W	4	B/D
CLINIMIX INJ 5%/D20W	4	B/D
CLINIMIX INJ 6/5	4	B/D
CLINIMIX INJ 8/10	4	B/D
CLINIMIX INJ 8/14	4	B/D
<i>clinisol sf 15%</i>	4	B/D
CLINOLIPID EMU 20%	4	B/D
<i>dextrose</i> SOLN 5%, 10%	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>dextrose</i> SOLN 50%, 70%	3	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	4	B/D
NUTRILIPID EMUL 20gm/100ml	4	B/D
<i>plenamine</i>	4	B/D
PREMASOL SOL 10%	5	B/D
PROSOL INJ 20%	4	B/D
TRAVASOL INJ 10%	4	B/D
TROPHAMINE INJ 10%	4	B/D

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	3	
<i>neo-polycin hc ophth oint 1%</i>	3	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	2	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	2	
<i>neomycin-polymyxin-hc ophth susp</i>	4	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	2	
TOBRADEX OIN 0.3-0.1%	3	
TOBRADEX ST SUS 0.3-0.05	3	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	4	
ZYLET SUS 0.5-0.3%	3	

ANTI-INFECTIVES

<i>bacitracin (ophthalmic) OINT 500unit/gm</i>	3	
<i>bacitracin-polymyxin b ophth oint</i>	2	
BESIVANCE SUSP .6%	3	
CILOXAN OINT .3%	3	
<i>ciprofloxacin hcl (ophth) SOLN .3%</i>	2	
<i>erythromycin (ophth) OINT 5mg/gm</i>	2	
<i>gatifloxacin (ophth) SOLN .5%</i>	3	
<i>gentamicin sulfate (ophth) SOLN .3%</i>	2	
<i>moxifloxacin hcl (ophth) SOLN .5%</i>	3	
NATACYN SUSP 5%	4	
<i>neo-polycin 5(3.5)mg-400unt-10000unt op oin</i>	3	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	3	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	3	
<i>ofloxacin (ophth) SOLN .3%</i>	2	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>polycin ophth oint</i>	2	
<i>polymyxin b-trimethoprim ophth soln</i> 10000 unit/ml-0.1%	1	GC
<i>sulfacetamide sodium (ophth)</i> OINT 10%; SOLN 10%	3	
<i>tobramycin (ophth)</i> SOLN .3%	1	GC
<i>trifluridine</i> SOLN 1%	4	
XDEMVI SOLN .25%	5	NM, LA, PA
ZIRGAN GEL .15%	4	

ANTI-INFLAMMATORIES

ALREX SUSP .2%	3	
<i>bromfenac sodium (ophth)</i> SOLN .07%	3	
<i>bromfenac sodium (ophth)</i> SOLN .075%, .09%	4	
BROMSITE SOLN .075%	4	
<i>dexamethasone sodium phosphate (ophth)</i> SOLN .1%	3	
<i>diclofenac sodium (ophth)</i> SOLN .1%	2	
<i>difluprednate</i> EMUL .05%	4	
EYSUVIS SUSP .25%	4	
FLAREX SUSP .1%	4	
<i>fluorometholone (ophth)</i> SUSP .1%	3	
<i>flurbiprofen sodium</i> SOLN .03%	3	
<i>ketorolac tromethamine (ophth)</i> SOLN .4%	3	
<i>ketorolac tromethamine (ophth)</i> SOLN .5%	2	
LOTEMAX OINT .5%	3	
<i>loteprednol etabonate</i> SUSP .2%	3	
<i>prednisolone acetate (ophth)</i> SUSP 1%	3	
PREDNISOLONE SODIUM PHOSP SOLN 1%	3	
PROLENSA SOLN .07%	3	

ANTIALLERGICS

<i>azelastine hcl (ophth)</i> SOLN .05%	3	
<i>cromolyn sodium (ophth)</i> SOLN 4%	2	
ZERVIAE SOLN .24%	4	

ANTIGLAUCOMA

<i>betaxolol hcl (ophth)</i> SOLN .5%	3	
BETOPTIC-S SUSP .25%	4	
<i>brimonidine tartrate</i> SOLN .2%	1	GC
<i>brimonidine tartrate</i> SOLN .15%	4	
<i>brinzolamide</i> SUSP 1%	4	
<i>carteolol hcl (ophth)</i> SOLN 1%	2	
COMBIGAN SOL 0.2/0.5%	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>dorzolamide hcl</i> SOLN 2%	2	
<i>dorzolamide hcl-timolol maleate ophth soln</i> 2-0.5%	2	
<i>latanoprost</i> SOLN .005%	1	GC
<i>levobunolol hcl</i> SOLN .5%	2	
LUMIGAN SOLN .01%	3	
<i>pilocarpine hcl</i> SOLN 1%, 2%, 4%	3	
RHOPRESSA SOLN .02%	4	
ROCKLATAN DRO	4	
SIMBRINZA SUS 1-0.2%	4	
<i>timolol maleate (ophth)</i> SOLG .25%, .5%	4	
<i>timolol maleate (ophth)</i> SOLN .25%, .5%	1	GC
<i>travoprost</i> SOLN .004%	4	
VYZULTA SOLN .024%	4	

MISCELLANEOUS

ATROPINE SULFATE SOLN 1%	3	
<i>atropine sulfate (ophthalmic)</i> SOLN 1%	3	
CYSTADROPS SOLN .37%	5	NM, LA, PA
CYSTARAN SOLN .44%	5	NM, LA, PA
MIEBO SOLN 1.338gm/ml	3	
<i>proparacaine hcl</i> SOLN .5%	3	
RESTASIS EMUL .05%	3	
RESTASIS MULTIDOSE EMUL .05%	3	
TYRVAYA SOLN .03mg/act	4	
XIIDRA SOLN 5%	3	

OTIC

OTIC AGENTS

<i>acetic acid (otic)</i> SOLN 2%	3	
CIPRO HC SUS OTIC	4	
<i>ciprofloxacin-dexamethasone otic susp</i> 0.3-0.1%	4	
<i>flac</i> OIL .01%	3	
<i>fluocinolone acetonide (otic)</i> OIL .01%	3	
<i>neomycin-polymyxin-hc otic soln</i> 1%	3	
<i>neomycin-polymyxin-hc otic susp</i> 3.5 mg/ml-10000 unit/ml-1%	3	
<i>ofloxacin (otic)</i> SOLN .3%	4	

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

ANORO ELLIPT AER 62.5-25	3	QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	3	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE	3	QL (1 inhaler / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	3	QL (4 inhalers / 28 days)
COMBIVENT AER 20-100	4	QL (2 inhalers / 30 days)
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	3	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG	3	QL (60 blisters / 30 days)
TRELEGY AER ELLIPTA 200-62.5-25 MCG	3	QL (60 blisters / 30 days)

ANTICHOLINERGICS

ATROVENT HFA AERS 17mcg/act	4	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA AEPB 62.5mcg/inh	3	QL (30 blisters / 30 days)
<i>ipratropium bromide SOLN .02%</i>	2	B/D
<i>ipratropium bromide (nasal) SOLN .03%, .06%</i>	3	

ANTI HISTAMINES

<i>azelastine hcl SOLN .1%</i>	3	
<i>cetirizine hcl SOLN 5mg/5ml</i>	2	QL (300 mL / 30 days)
<i>cyproheptadine hcl SYRP 2mg/5ml; TABS 4mg</i>	3	PA; PA if 70 years and older
<i>desloratadine TABS 5mg</i>	3	QL (30 tabs / 30 days)
<i>diphenhydramine hcl SOLN 50mg/ml</i>	3	
<i>hydroxyzine hcl SOLN 25mg/ml, 50mg/ml</i>	4	PA; PA if 70 years and older
<i>hydroxyzine hcl SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg</i>	3	PA; PA if 70 years and older
<i>hydroxyzine pamoate CAPS 25mg, 50mg</i>	3	PA; PA if 70 years and older
<i>levocetirizine dihydrochloride SOLN 2.5mg/5ml</i>	4	QL (300 mL / 30 days)
<i>levocetirizine dihydrochloride TABS 5mg</i>	3	QL (30 tabs / 30 days)
<i>olopatadine hcl (nasal) SOLN .6%</i>	4	

BETA AGONISTS

<i>albuterol sulfate AERS 108mcg/act</i>	2	QL (2 inhalers / 30 days); (generic of Proair HFA)
<i>albuterol sulfate AERS 108mcg/act</i>	2	QL (2 inhalers / 30 days); (generic of Proventil HFA)
<i>albuterol sulfate AERS 108mcg/act</i>	2	QL (2 inhalers / 30 days); (generic of Ventolin HFA)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>albuterol sulfate</i> NEBU .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	3	B/D
<i>albuterol sulfate</i> NEBU .083%	2	B/D
<i>albuterol sulfate</i> SYRP 2mg/5ml	3	
<i>albuterol sulfate</i> TABS 2mg, 4mg	4	
<i>arformoterol tartrate</i> NEBU 15mcg/2ml	4	B/D
<i>formoterol fumarate</i> NEBU 20mcg/2ml	4	B/D
<i>levalbuterol hcl</i> NEBU .31mg/3ml, .63mg/3ml, 1.25mg/0.5ml, 1.25mg/3ml	4	B/D
<i>levalbuterol tartrate</i> AERO 45mcg/act	3	QL (2 inhalers / 30 days)
SEREVENT DISKUS AEPB 50mcg/dose	3	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS 2.5mg, 5mg	4	
VENTOLIN HFA AERS 108mcg/act	3	QL (2 inhalers / 30 days)
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act	3	QL (6 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> CHEW 4mg, 5mg	2	
<i>montelukast sodium</i> PACK 4mg	4	
<i>montelukast sodium</i> TABS 10mg	1	GC
<i>zafirlukast</i> TABS 10mg, 20mg	3	
MISCELLANEOUS		
<i>acetylcysteine</i> SOLN 10%, 20%	4	B/D
ARALAST NP SOLR 500mg, 1000mg	5	NM, LA, PA
BRONCHITOL CAPS 40mg	5	QL (560 caps / 28 days), NM, LA, PA
<i>cromolyn sodium</i> NEBU 20mg/2ml	3	B/D
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.3ml, .3mg/0.3ml	3	(generic of EpiPen)
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.15ml, .3mg/0.3ml	3	(generic of Adrenaclick)
FASENRA SOSY 10mg/0.5ml, 30mg/ml	5	NM, LA, PA
FASENRA PEN SOAJ 30mg/ml	5	NM, LA, PA
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg	5	QL (56 packs / 28 days), NM, LA, PA
KALYDECO TABS 150mg	5	QL (60 tabs / 30 days), NM, LA, PA
OFEV CAPS 100mg, 150mg	5	QL (60 caps / 30 days), NM, LA, PA
ORKAMBI GRA 75-94MG	5	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 100-125	5	QL (56 packs / 28 days), NM, LA, PA

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

78

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
ORKAMBI GRA 150-188	5	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI TAB 100-125	5	QL (112 tabs / 28 days), NM, LA, PA
ORKAMBI TAB 200-125	5	QL (112 tabs / 28 days), NM, LA, PA
<i>pirfenidone</i> CAPS 267mg	5	QL (270 caps / 30 days), NM, PA
<i>pirfenidone</i> TABS 267mg	5	QL (270 tabs / 30 days), NM, PA
<i>pirfenidone</i> TABS 534mg, 801mg	5	QL (90 tabs / 30 days), NM, PA
PROLASTIN-C SOLN 1000mg/20ml	5	NM, LA, PA
PULMOZYME SOLN 2.5mg/2.5ml	5	NM, PA
<i>roflumilast</i> TABS 250mcg	3	QL (56 tabs / year)
<i>roflumilast</i> TABS 500mcg	3	QL (30 tabs / 30 days)
SYMDEKO TAB 50-75MG	5	QL (56 tabs / 28 days), NM, LA, PA
SYMDEKO TAB 100-150	5	QL (56 tabs / 28 days), NM, LA, PA
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	4	
<i>theophylline</i> ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 100mg, 200mg, 300mg, 450mg	4	
<i>theophylline</i> TB24 400mg, 600mg	3	
TRIKAFTA PAK 59.5MG	5	QL (56 packs / 28 days), NM, LA, PA
TRIKAFTA PAK 75MG	5	QL (56 packs / 28 days), NM, LA, PA
TRIKAFTA TAB 50-25-37.5MG & 75MG	5	QL (84 tabs / 28 days), NM, LA, PA
TRIKAFTA TAB 100-50-75MG & 150MG	5	QL (84 tabs / 28 days), NM, LA, PA
XOLAIR SOAJ 75mg/0.5ml, 150mg/ml, 300mg/2ml; SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml, 300mg/2ml	5	NM, LA, PA
ZEMAIRA SOLR 1000mg, 4000mg, 5000mg	5	NM, LA, PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i> SOLN .025%	3	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i> SUSP 50mcg/act	2	QL (1 bottle / 30 days)
<i>mometasone furoate (nasal)</i> SUSP 50mcg/act	4	QL (2 inhalers / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
OMNARIS SUSP 50mcg/act	4	QL (1 inhaler / 30 days)
XHANCE EXHU 93mcg/act	4	QL (32 mL / 30 days), PA

STEROID INHALANTS

ALVESCO AERS 80mcg/act	4	QL (3 inhalers / 30 days)
ALVESCO AERS 160mcg/act	4	QL (2 inhalers / 30 days)
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	3	QL (30 inhalations / 30 days)
<i>budesonide (inhalation)</i> SUSP .25mg/2ml, .5mg/2ml	4	B/D

STEROID/BETA-AGONIST COMBINATIONS

ADVAIR HFA AER 45/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	3	QL (1 inhaler / 30 days)
AIRSUPRA AER 90-80MCG	3	QL (3 inhalers / 30 days)
BREO ELLIPTA INH 50-25MCG	3	QL (60 blisters / 30 days)
BREO ELLIPTA INH 100-25	3	QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	3	QL (60 blisters / 30 days)
DULERA AER 50-5MCG	4	QL (3 inhalers / 30 days)
DULERA AER 100-5MCG	4	QL (3 inhalers / 30 days)
DULERA AER 200-5MCG	4	QL (3 inhalers / 30 days)
<i>fluticasone-salmeterol aer powder ba 100-50 mcg/act</i>	3	QL (60 inhalations / 30 days); (generic PRASCO not covered)
<i>fluticasone-salmeterol aer powder ba 250-50 mcg/act</i>	3	QL (60 inhalations / 30 days); (generic PRASCO not covered)
<i>fluticasone-salmeterol aer powder ba 500-50 mcg/act</i>	3	QL (60 inhalations / 30 days); (generic PRASCO not covered)
<i>wixela inhub</i>	3	QL (60 inhalations / 30 days)

Sexual Dysfunction Agents

Sexual Dysfunction Agents

<i>sildenafil citrate</i> TABS 25mg, 50mg, 100mg	2	ED, QL (4 tabs / 30 days); Males Only
--	---	---------------------------------------

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>tadalafil</i> TABS 2.5mg	2	ED, QL (30 tabs / 30 days); Males Only
<i>tadalafil</i> TABS 5mg, 10mg, 20mg	2	ED, QL (4 tabs / 30 days); Males Only
<i>vardenafil hcl</i> TABS 2.5mg, 5mg, 10mg, 20mg; TBP 10mg	2	ED, QL (4 tabs / 30 days); Males Only

TOPICAL

DERMATOLOGY, ACNE

<i>acutane</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>amneesteem</i> CAPS 10mg, 20mg, 40mg	4	PA
<i>benzoyl peroxide-erythromycin gel</i> 5-3%	4	QL (46.6 gm / 30 days)
<i>claravis</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>clindamycin phosphate (topical)</i> GEL 1%	3	QL (75 gm / 30 days)
<i>clindamycin phosphate (topical)</i> LOTN 1%; SOLN 1%	3	QL (60 mL / 30 days)
<i>ery</i> PADS 2%	3	QL (60 pledgets / 30 days)
<i>erythromycin (acne aid)</i> GEL 2%	3	QL (60 gm / 30 days)
<i>erythromycin (acne aid)</i> SOLN 2%	3	QL (60 mL / 30 days)
<i>isotretinoin</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>sulfacetamide sodium (acne)</i> LOTN 10%	4	QL (118 mL / 30 days)
<i>tretinoin</i> CREA .025%, .05%, .1%; GEL .01%, .025%	4	QL (45 gm / 30 days), PA
<i>zenatane</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA

DERMATOLOGY, ANTIBIOTICS

<i>gentamicin sulfate (topical)</i> CREA .1%; OINT .1%	3	QL (30 gm / 30 days)
<i>mupirocin</i> OINT 2%	2	QL (220 gm / 30 days)
<i>silver sulfadiazine</i> CREA 1%	2	
<i>ssd</i> CREA 1%	2	
SULFAMYLON CREA 85mg/gm	4	QL (453.6 gm / 30 days)

DERMATOLOGY, ANTIFUNGALS

<i>ciclopirox olamine</i> CREA .77%	3	QL (90 gm / 30 days)
<i>ciclopirox olamine</i> SUSP .77%	3	QL (60 mL / 30 days)
<i>clotrimazole (topical)</i> CREA 1%	2	QL (45 gm / 30 days)
<i>clotrimazole (topical)</i> SOLN 1%	3	QL (60 mL / 30 days)
<i>clotrimazole w/ betamethasone cream</i> 1-0.05%	3	QL (45 gm / 30 days)
<i>ketconazole (topical)</i> CREA 2%	3	QL (60 gm / 30 days)
<i>klayesta</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
<i>nyamyc</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
<i>nystatin (topical)</i> CREA 100000unit/gm; OINT 100000unit/gm	2	QL (30 gm / 30 days)

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>nystatin (topical)</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
<i>nystop</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin</i> CAPS 10mg, 17.5mg, 25mg	4	PA
<i>calcipotriene</i> CREA .005%; OINT .005%	4	QL (120 gm / 30 days), PA
<i>calcipotriene</i> SOLN .005%	4	QL (120 mL / 30 days), PA
<i>calcitrene</i> OINT .005%	4	QL (120 gm / 30 days), PA
<i>tazarotene</i> CREA .1%	3	QL (60 gm / 30 days), PA
TAZORAC CREA .05%	4	QL (60 gm / 30 days), PA
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketconazole (topical)</i> SHAM 2%	2	QL (120 mL / 30 days)
<i>selenium sulfide</i> LOTN 2.5%	2	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort</i> CREA 1%	1	GC
<i>ala-cort</i> CREA 2.5%	2	
<i>alclometasone dipropionate</i> CREA .05%; OINT .05%	3	QL (60 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> CREA .05%	3	QL (120 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> LOTN .05%	3	QL (120 mL / 30 days)
<i>betamethasone dipropionate (topical)</i> OINT .05%	4	QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> CREA .05%	2	QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> GEL .05%; OINT .05%	4	QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> LOTN .05%	4	QL (120 mL / 30 days)
<i>betamethasone valerate</i> CREA .1%; OINT .1%	3	QL (120 gm / 30 days)
<i>betamethasone valerate</i> LOTN .1%	3	QL (120 mL / 30 days)
<i>clobetasol propionate</i> CREA .05%; GEL .05%; OINT .05%	4	QL (60 gm / 30 days)
<i>clobetasol propionate</i> SOLN .05%	4	QL (50 mL / 30 days)
<i>clobetasol propionate e</i> CREA .05%	4	QL (60 gm / 30 days)
ENSTILAR AER	4	QL (120 gm / 30 days), PA
<i>fluocinolone acetonide</i> CREA .01%	4	QL (60 gm / 30 days)
<i>fluocinolone acetonide</i> CREA .025%	4	QL (120 gm / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.

82

B/D - Covered under Medicare B or D **LA** - Limited Access

ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>fluocinolone acetonide</i> OIL .01%	3	QL (118.28 mL / 30 days)
<i>fluocinolone acetonide</i> OINT .025%	3	QL (120 gm / 30 days)
<i>fluocinolone acetonide</i> SOLN .01%	4	QL (90 mL / 30 days)
<i>fluocinonide</i> CREA .05%	3	QL (120 gm / 30 days)
<i>fluocinonide</i> GEL .05%; OINT .05%	4	QL (60 gm / 30 days)
<i>fluocinonide</i> SOLN .05%	3	QL (60 mL / 30 days)
<i>fluocinonide emulsified base</i> CREA .05%	3	QL (120 gm / 30 days)
<i>fluticasone propionate</i> CREA .05%; OINT .005%	3	
<i>halobetasol propionate</i> CREA .05%; OINT .05%	4	QL (50 gm / 30 days)
<i>hydrocortisone (topical)</i> CREA 1%	1	GC
<i>hydrocortisone (topical)</i> CREA 2.5%; LOTN 2.5%; OINT 2.5%	2	
<i>mometasone furoate</i> CREA .1%; OINT .1%; SOLN .1%	3	
<i>triamcinolone acetonide (topical)</i> CREA .025%, .1%, .5%	2	QL (454 gm / 30 days)
<i>triamcinolone acetonide (topical)</i> LOTN .025%, .1%	3	
<i>triamcinolone acetonide (topical)</i> OINT .025%, .1%, .5%	2	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo</i> PRSY 2%	4	QL (60 mL / 30 days), PA
<i>lidocaine</i> OINT 5%	4	QL (50 gm / 30 days), PA
<i>lidocaine</i> PTCH 5%	4	QL (3 patches / 1 day), PA
<i>lidocaine hcl</i> SOLN 4%	3	QL (50 mL / 30 days), PA
<i>lidocaine-prilocaine cream</i> 2.5-2.5%	3	B/D, QL (30 gm / 30 days)
<i>lidocan</i> PTCH 5%	4	QL (3 patches / 1 day), PA
<i>tridacaine ii</i> PTCH 5%	4	QL (3 patches / 1 day), PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>azelaic acid</i> GEL 15%	4	QL (50 gm / 30 days)
<i>bexarotene (topical)</i> GEL 1%	5	QL (60 gm / 30 days), NM, PA
<i>diclofenac sodium (topical)</i> GEL 1%	3	QL (1000 gm / 30 days)
<i>diclofenac sodium (topical)</i> SOLN 1.5%	3	QL (300 mL / 28 days)
FINACEA FOAM 15%	4	QL (50 gm / 30 days)

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

83

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>fluorouracil (topical)</i> CREA 5%	4	QL (40 gm / 30 days)
<i>fluorouracil (topical)</i> SOLN 2%, 5%	3	QL (10 mL / 30 days)
<i>hydrocortisone (rectal)</i> CREA 1%, 2.5%	3	
<i>imiquimod</i> CREA 5%	3	QL (24 packets / 30 days)
<i>lactic acid (ammonium lactate)</i> CREA 12%	2	
<i>lactic acid (ammonium lactate)</i> LOTN 12%	3	
<i>metronidazole (topical)</i> CREA .75%	4	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> GEL .75%	3	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> LOTN .75%	4	QL (59 mL / 30 days)
<i>nitroglycerin (intra-anal)</i> OINT .4%	4	QL (30 gm / 30 days)
NORITATE CREA 1%	5	QL (60 gm / 30 days)
PANRETIN GEL .1%	5	QL (60 gm / 30 days), PA
<i>podofilox</i> SOLN .5%	3	QL (7 mL / 28 days)
<i>procto-med hc</i> CREA 2.5%	3	
<i>proctocort</i> CREA 1%	3	
<i>proctosol hc</i> CREA 2.5%	3	
<i>proctozone-hc</i> CREA 2.5%	3	
RECTIV OINT .4%	4	QL (30 gm / 30 days)
<i>tacrolimus (topical)</i> OINT .03%, .1%	4	QL (100 gm / 30 days)
VALCHLOR GEL .016%	5	QL (60 gm / 30 days), NM, LA, PA
ZYCLARA PUMP CREA 2.5%	5	QL (7.5 gm / 28 days)
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i> LOTN .5%	4	QL (59 mL / 30 days)
<i>permethrin</i> CREA 5%	3	QL (60 gm / 30 days)
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01%	5	QL (30 gm / 30 days), PA
SANTYL OINT 250unit/gm	4	QL (180 gm / 30 days)
<i>sodium chloride (gu irrigant)</i> SOLN .9%	3	
<i>water for irrigation, sterile irrigation soln</i>	2	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl</i> CAPS 30mg	4	
<i>chlorhexidine gluconate (mouth-throat)</i> SOLN .12%	1	GC
<i>clotrimazole</i> TROC 10mg	3	QL (150 lozenges / 30 days)
<i>kourzeq</i> PSTE .1%	3	
<i>lidocaine hcl (mouth-throat)</i> SOLN 2%	2	
<i>nystatin (mouth-throat)</i> SUSP 100000unit/ml	2	
<i>periogard</i> SOLN .12%	1	GC

PA - Prior Authorization QL - Quantity Limits NM - Not available at mail-order.

B/D - Covered under Medicare B or D LA - Limited Access

ED - Supplemental Drug Coverage GC - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Drug Name	Drug Tier	Requirements/Limits
<i>pilocarpine hcl (oral)</i> TABS 5mg, 7.5mg	3	
<i>triamcinolone acetonide (mouth)</i> PSTE .1%	3	

PA - Prior Authorization **QL** - Quantity Limits **NM** - Not available at mail-order.
B/D - Covered under Medicare B or D **LA** - Limited Access
ED - Supplemental Drug Coverage **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage .

Index

A	
<i>abacavir sulfate</i>	6
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	7
ABELCET.....	5
ABILIFY MAINTENA.....	36, 37
<i>abiraterone acetate</i>	14
ABRYSVO.....	70
<i>acamprosate calcium</i>	47
<i>acarbose</i>	48
<i>accutane</i>	81
<i>acebutolol hcl</i>	29
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	2
<i>acetaminophen w/ codeine tab 300-15 mg</i>	2
<i>acetaminophen w/ codeine tab 300-30 mg</i>	2
<i>acetaminophen w/ codeine tab 300-60 mg</i>	2
<i>acetazolamide</i>	31
<i>acetic acid</i>	64
<i>acetic acid (otic)</i>	76
<i>acetylcysteine</i>	78
<i>acitretin</i>	82
ACTHIB INJ.....	70
ACTIMMUNE.....	69
<i>acyclovir</i>	8
<i>acyclovir sodium</i>	8
ADACEL INJ.....	70
ADALIMUMAB-AACF (2 PEN).....	67
ADALIMUMAB-AACF (2 SYRING).....	67
<i>adefovir dipivoxil</i>	8
ADEMPAS.....	33
ADMELOG.....	51
ADMELOG SOLOSTAR.....	51
ADVAIR HFA AER 115/21.....	80
ADVAIR HFA AER 230/21.....	80
ADVAIR HFA AER 45/21.....	80
<i>afirmelle</i>	53
AIMOVIG.....	45
AIRSUPRA AER 90-80MCG.....	80
AKEEGA TAB 100/500.....	14
AKEEGA TAB 50/500MG.....	14
<i>ala-cort</i>	82
<i>albendazole</i>	3
<i>albuterol sulfate</i>	77, 78
<i>alclometasone dipropionate</i>	82
ALDURAZYME.....	59
ALECENSA.....	16
<i>alendronate sodium</i>	52
<i>alfuzosin hcl</i>	64
<i>aliskiren fumarate</i>	31
<i>allopurinol</i>	1
<i>alosetron hcl</i>	63
<i>alprazolam</i>	33
ALREX.....	75
<i>altavera</i>	53
ALTOPREV.....	28
ALUNBRIG.....	16
ALUNBRIG PAK.....	16
ALVAIZ.....	66
ALVESCO.....	80
<i>alyacen 1/35</i>	53
<i>alyacen 7/7/7</i>	53
ALYGLO.....	69
<i>amantadine hcl</i>	35
<i>ambrisentan</i>	33
<i>amikacin sulfate</i>	3
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	31
<i>amiloride hcl</i>	31
<i>amiodarone hcl</i>	27
<i>amitriptyline hcl</i>	34
<i>amlodipine besylate</i>	30
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	32
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	32
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	32
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	32
<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	31
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	31
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	31
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	31

<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	31	<i>amoxicillin & k clavulanate tab 250-125 mg</i>	11
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	32	<i>amoxicillin & k clavulanate tab 500-125 mg</i>	11
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	32	<i>amoxicillin & k clavulanate tab 875-125 mg</i>	11
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	24	<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	11
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	24	<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	43
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	23	<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	43
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	23	<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	43
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	23	<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	43
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	24	<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	43
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	25	<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	43
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	25	<i>amphetamine-dextroamphetamine tab 10 mg</i>	43
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	25	<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	43
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	25	<i>amphetamine-dextroamphetamine tab 15 mg</i>	43
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	25	<i>amphetamine-dextroamphetamine tab 20 mg</i>	44
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	25	<i>amphetamine-dextroamphetamine tab 30 mg</i>	44
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	25	<i>amphetamine-dextroamphetamine tab 5 mg</i>	43
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	25	<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	43
<i>amnestem</i>	81	<i>amphotericin b</i>	5
<i>amoxapine</i>	34	<i>amphotericin b liposome</i>	5
<i>amoxicillin</i>	11	<i>ampicillin</i>	11
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	11	<i>ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm</i>	11
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	11	<i>ampicillin & sulbactam sodium for inj 3 (2-1) gm</i>	11
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	11	<i>ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm</i>	11
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	11	<i>ampicillin & sulbactam sodium for iv soln 15 (10-5) gm</i>	11
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	11	<i>ampicillin & sulbactam sodium for iv soln 3 (2-1) gm</i>	11

<i>ampicillin sodium</i>	11	AUSTEDO XR TAB TITR KIT	46
<i>anagrelide hcl</i>	66	AUVELITY TAB 45-105MG.....	34
<i>anastrozole</i>	14	<i>aviane</i>	53
ANORO ELLIPT AER 62.5-25	76	<i>ayuna</i>	53
<i>aprepitant</i>	61	AYVAKIT	16
<i>aprepitant capsule therapy pack 80 &</i> <i>125 mg</i>	61	<i>azacitidine</i>	13
<i>apri</i>	53	<i>azathioprine</i>	70
APTIOM.....	39	<i>azelaic acid</i>	83
APTIVUS	6	<i>azelastine hcl</i>	77
ARALAST NP	78	<i>azelastine hcl (ophth)</i>	75
<i>aranelle</i>	53	<i>azithromycin</i>	10
ARCALYST	69	<i>aztreonam</i>	3
AREXVY.....	70	<i>azurette</i>	53
<i>arformoterol tartrate</i>	78	B	
<i>aripiprazole</i>	37	<i>bacitracin (ophthalmic)</i>	74
ARISTADA	37	<i>bacitracin-polymyxin b ophth oint</i>	74
ARISTADA INITIO.....	37	<i>bacitracin-polymyxin-neomycin-hc</i> <i>ophth oint 1%</i>	74
<i>armodafinil</i>	47	<i>baclofen</i>	47
ARNUITY ELLIPTA.....	80	BAFIERTAM	46
<i>asenapine maleate</i>	37	<i>balsalazide disodium</i>	62
<i>aspirin-dipyridamole cap er 12hr 25-</i> <i>200 mg</i>	66	BALVERSA.....	16
ASTAGRAF XL	69	<i>balziva</i>	53
<i>atazanavir sulfate</i>	6	BARACLUDE	8
<i>atenolol</i>	29	BASAGLAR KWIKPEN	51
<i>atenolol & chlorthalidone tab 100-25</i> <i>mg</i>	29	BCG VACCINE.....	70
<i>atenolol & chlorthalidone tab 50-25 mg</i>	29	BD ALCOHOL SWABS.....	51
<i>atomoxetine hcl</i>	44	<i>benazepril & hydrochlorothiazide tab</i> <i>10-12.5 mg</i>	24
<i>atorvastatin calcium</i>	28	<i>benazepril & hydrochlorothiazide tab</i> <i>20-12.5 mg</i>	24
<i>atovaquone</i>	3	<i>benazepril & hydrochlorothiazide tab</i> <i>20-25 mg</i>	24
<i>atovaquone-proguanil hcl tab 250-100</i> <i>mg</i>	6	<i>benazepril & hydrochlorothiazide tab 5-</i> <i>6.25mg</i>	24
<i>atovaquone-proguanil hcl tab 62.5-25</i> <i>mg</i>	6	<i>benazepril hcl</i>	24
ATROPINE SULFATE.....	76	BENDAMUSTINE HYDROCHLORID.....	12
<i>atropine sulfate (ophthalmic)</i>	76	BENDEKA	12
ATROVENT HFA	77	BENLYSTA	70
<i>aubra eq</i>	53	<i>benzoyl peroxide-erythromycin gel 5-</i> <i>3%</i>	81
AUGTYRO	16	<i>benztropine mesylate</i>	35
<i>aurovela 1/20</i>	53	BERINERT	66
<i>aurovela fe 1.5/30</i>	53	BESIVANCE	74
<i>aurovela fe 1/20</i>	53	BESREMI.....	15
AUSTEDO	45, 46	<i>betaine powder for oral solution</i>	59
AUSTEDO XR	46		

<i>betamethasone dipropionate (topical)</i>	BRUKINSA.....	16
.....	<i>budesonide</i>	62
<i>betamethasone dipropionate</i>	<i>budesonide (inhalation)</i>	80
<i>augmented</i>	<i>bumetanide</i>	31
.....	<i>buprenorphine hcl</i>	47
<i>betamethasone valerate</i>	<i>buprenorphine hcl-naloxone hcl sl film</i>	
BETASERON.....	12-3 mg (base equiv)	48
<i>betaxolol hcl (ophth)</i>	<i>buprenorphine hcl-naloxone hcl sl film</i>	
<i>bethanechol chloride</i>	2-0.5 mg (base equiv)	47
BETOPTIC-S	<i>buprenorphine hcl-naloxone hcl sl film</i>	
BEVESPI AER 9-4.8MCG	4-1 mg (base equiv)	47
<i>bexarotene</i>	<i>buprenorphine hcl-naloxone hcl sl film</i>	
<i>bexarotene (topical)</i>	8-2 mg (base equiv)	47
BEXSERO INJ.....	<i>buprenorphine hcl-naloxone hcl sl tab</i>	
<i>bicalutamide</i>	2-0.5 mg (base equiv)	48
BICILLIN L-A	<i>buprenorphine hcl-naloxone hcl sl tab</i>	
BIKTARVY TAB 30-120-15 MG.....	8-2 mg (base equiv)	48
BIKTARVY TAB 50-200-25 MG.....	<i>bupropion hcl</i>	34
<i>bisoprolol & hydrochlorothiazide tab</i>	<i>bupropion hcl (smoking deterrent)</i> ...	48
10-6.25 mg	<i>bupirone hcl</i>	33
.....	<i>butorphanol tartrate</i>	2
<i>bisoprolol & hydrochlorothiazide tab</i>	BYDUREON BCISE	48
2.5-6.25 mg	BYETTA.....	48
.....	C	
<i>bisoprolol & hydrochlorothiazide tab 5-</i>	<i>cabergoline</i>	59
6.25 mg	CABOMETYX	16
.....	<i>calcipotriene</i>	82
<i>bisoprolol fumarate</i>	<i>calcitonin (salmon) spray</i>	52
.....	<i>calcitrene</i>	82
BIVIGAM	<i>calcitriol</i>	61
<i>blisovi fe 1.5/30</i>	<i>calcitriol (oral)</i>	61
.....	<i>calcium acetate (phosphate binder)</i> ..	60
BOOSTRIX INJ	CALQUENCE	17
<i>bortezomib</i>	<i>camila</i>	54
BORTEZOMIB.....	<i>candesartan cilexetil</i>	27
<i>bosentan</i>	<i>candesartan cilexetil-</i>	
BOSULIF	<i>hydrochlorothiazide tab 16-12.5 mg</i>	
BRAFTOVI .....	.....	25
BREO ELLIPTA INH 100-25	<i>candesartan cilexetil-</i>	
BREO ELLIPTA INH 200-25	<i>hydrochlorothiazide tab 32-12.5 mg</i>	
BREO ELLIPTA INH 50-25MCG.....	.....	25
BREZTRI AERO AER SPHERE	<i>candesartan cilexetil-</i>	
BREZTRI AERO AER SPHERE	<i>hydrochlorothiazide tab 32-25 mg</i> .	25
(INSTITUTIONAL PACK).....	CAPLYTA	37
.....	CAPRELSA	17
<i>briellyn</i>	<i>captopril</i>	24
.....		
BRILINTA		
<i>brimonidine tartrate</i>		
.....		
<i>brinzolamide</i>		
.....		
BRIVIACT		
<i>bromfenac sodium (ophth)</i>		
.....		
<i>bromocriptine mesylate</i>		
.....		
BROMSITE.....		
.....		
BRONCHITOL.....		

<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	24	<i>cefazolin sodium</i>	9
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	24	CEFAZOLIN SOLN 2GM/100ML-4%	9
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	24	<i>cefdinir</i>	9
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	24	<i>cefepime hcl</i>	9
<i>carb/levo orally disintegrating tab 10-100mg</i>	35	<i>cefixime</i>	10
<i>carb/levo orally disintegrating tab 25-100mg</i>	36	<i>cefoxitin sodium</i>	10
<i>carb/levo orally disintegrating tab 25-250mg</i>	36	<i>cefpodoxime proxetil</i>	10
<i>carbamazepine</i>	39	<i>cefprozil</i>	10
<i>carbidopa</i>	36	<i>ceftazidime</i>	10
<i>carbidopa & levodopa tab 10-100 mg</i> 36		<i>ceftriaxone sodium</i>	10
<i>carbidopa & levodopa tab 25-100 mg</i> 36		<i>cefuroxime axetil</i>	10
<i>carbidopa & levodopa tab 25-250 mg</i> 36		<i>cefuroxime sodium</i>	10
<i>carbidopa & levodopa tab er 25-100 mg</i>	36	<i>celecoxib</i>	1
<i>carbidopa & levodopa tab er 50-200 mg</i>	36	<i>cephalexin</i>	10
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	36	CERDELGA	59
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	36	CEREZYME	59
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	36	<i>cetirizine hcl</i>	77
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	36	<i>cevimeline hcl</i>	84
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	36	<i>chateal eq</i>	54
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	36	CHEMET	53
<i>carboplatin</i>	12	<i>chlorhexidine gluconate (mouth-throat)</i>	84
<i>carglumic acid</i>	59	<i>chloroquine phosphate</i>	6
<i>carteolol hcl (ophth)</i>	75	<i>chlorpromazine hcl</i>	37
<i>cartia xt</i>	30	<i>chlorthalidone</i>	31
<i>carvedilol</i>	29	<i>cholestyramine</i>	28
<i>caspofungin acetate</i>	5	<i>cholestyramine light</i>	28
CAYSTON	3	<i>choline fenofibrate</i>	28
<i>cefaclor</i>	9	<i>ciclopirox olamine</i>	81
CEFACLOR ER	9	<i>cilostazol</i>	66
<i>cefadroxil</i>	9	CILOXAN	74
CEFAZOLIN.....	9	CIMDUO TAB 300-300	7
CEFAZOLIN INJ 1GM/50ML	9	<i>cinacalcet hcl</i>	59
		CIPRO.....	10
		CIPRO HC SUS OTIC.....	76
		<i>ciprofloxacin 200 mg/100ml in d5w</i> ..	10
		<i>ciprofloxacin 400 mg/200ml in d5w</i> ..	10
		<i>ciprofloxacin hcl</i>	10
		<i>ciprofloxacin hcl (ophth)</i>	74
		<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	76
		<i>cisplatin</i>	12
		<i>citalopram hydrobromide</i>	34
		<i>claravis</i>	81
		<i>clarithromycin</i>	10
		<i>clindamycin hcl</i>	3
		<i>clindamycin palmitate hydrochloride</i> ..	3

<i>clindamycin phosphate</i>	3	COMPLERA TAB.....	7
<i>clindamycin phosphate (topical)</i>	81	<i>compro</i>	61
<i>clindamycin phosphate in d5w iv soln</i> <i>300 mg/50ml</i>	3	<i>constulose</i>	62
<i>clindamycin phosphate in d5w iv soln</i> <i>600 mg/50ml</i>	3	COPIKTRA	17
<i>clindamycin phosphate in d5w iv soln</i> <i>900 mg/50ml</i>	4	CORLANOR.....	32
<i>clindamycin phosphate vaginal</i>	65	COTELLIC.....	17
CLINDMYC/NAC INJ 300/50ML	4	CREON CAP 12000UNT.....	63
CLINDMYC/NAC INJ 600/50ML	4	CREON CAP 24000UNT.....	63
CLINDMYC/NAC INJ 900/50ML	4	CREON CAP 3000UNIT	63
CLINIMIX INJ 4.25/D10.....	73	CREON CAP 36000UNT.....	63
CLINIMIX INJ 4.25/D5W.....	73	CREON CAP 6000UNIT	63
CLINIMIX INJ 5%/D15W	73	<i>cromolyn sodium</i>	78
CLINIMIX INJ 5%/D20W	73	<i>cromolyn sodium (mastocytosis)</i>	63
CLINIMIX INJ 6/5	73	<i>cromolyn sodium (ophth)</i>	75
CLINIMIX INJ 8/10	73	<i>cryselle-28</i>	54
CLINIMIX INJ 8/14	73	<i>cyclobenzaprine hcl</i>	47
<i>clinisol sf 15%</i>	73	<i>cyclophosphamide</i>	12, 13
CLINOLIPID EMU 20%	73	CYCLOPHOSPHAMIDE	13
<i>clobazam</i>	39	CYCLOPHOSPHAMIDE MONOHYDR....	13
<i>clobetasol propionate</i>	82	<i>cycloserine</i>	8
<i>clobetasol propionate e</i>	82	<i>cyclosporine</i>	70
<i>clomipramine hcl</i>	34	<i>cyclosporine modified (for</i> <i>microemulsion)</i>	70
<i>clonazepam</i>	39	<i>cyproheptadine hcl</i>	77
<i>clonidine</i>	32	<i>cyred eq</i>	54
<i>clonidine hcl</i>	32	CYSTADROPS.....	76
<i>clopidogrel bisulfate</i>	67	CYSTAGON	59
<i>clorazepate dipotassium</i>	39	CYSTARAN	76
<i>clotrimazole</i>	84	<i>cytarabine</i>	13
<i>clotrimazole (topical)</i>	81	D	
<i>clotrimazole w/ betamethasone cream</i> <i>1-0.05%</i>	81	D10W/NACL INJ 0.2%	72
<i>clozapine</i>	37	D2.5W/NACL INJ 0.45%.....	71
COARTEM TAB 20-120MG.....	6	D5W/LYTES INJ #48.....	71
<i>colchicine</i>	1	<i>dabigatran etexilate mesylate</i>	65
<i>colchicine w/ probenecid tab 0.5-500</i> <i>mg</i>	1	<i>dalfampridine</i>	46
<i>colesevelam hcl</i>	28	<i>danazol</i>	57
<i>colestipol hcl</i>	28	<i>dantrolene sodium</i>	47
<i>colistimethate sodium</i>	4	<i>dapsone</i>	4
COMBIGAN SOL 0.2/0.5%	75	DAPTACEL INJ	70
COMBIVENT AER 20-100	77	<i>daptomycin</i>	4
COMETRIQ (60MG DOSE).....	17	DAPTOMYCIN.....	4
COMETRIQ KIT 100MG.....	17	<i>darifenacin hydrobromide</i>	64
COMETRIQ KIT 140MG.....	17	<i>darunavir</i>	6
		<i>dasatinib</i>	17
		<i>dasetta 1/35</i>	54
		<i>dasetta 7/7/7</i>	54
		DAURISMO	17

DAYVIGO	45	<i>diazoxide</i>	58
<i>deblitane</i>	54	<i>diclofenac potassium</i>	1
<i>deferasirox</i>	53	<i>diclofenac sodium</i>	1
DELSTRIGO TAB.....	7	<i>diclofenac sodium (ophth)</i>	75
DENGVAXIA SUS.....	70	<i>diclofenac sodium (topical)</i>	83
DEPO-SUBQ PROVERA 104	54	<i>diclofenac w/ misoprostol tab delayed</i>	
<i>depo-testosterone</i>	48	<i>release 50-0.2 mg</i>	1
DESCOVY TAB 120-15MG	7	<i>diclofenac w/ misoprostol tab delayed</i>	
DESCOVY TAB 200/25MG	7	<i>release 75-0.2 mg</i>	1
<i>desipramine hcl</i>	34	<i>dicloxacillin sodium</i>	11
<i>desloratadine</i>	77	<i>dicyclomine hcl</i>	62
<i>desmopressin acetate</i>	59	DIFICID	10
<i>desmopressin acetate spray</i>	59	<i>diflunisal</i>	1
<i>desmopressin acetate spray</i>		<i>difluprednate</i>	75
<i>refrigerated</i>	59	<i>digoxin</i>	32
<i>desogest-eth estrad & eth estrad tab</i>		<i>dihydroergotamine mesylate</i>	45
<i>0.15-0.02/0.01 mg(21/5)</i>	54	DILANTIN.....	40
<i>desogestrel & ethinyl estradiol tab 0.15</i>		DILANTIN INFATABS.....	40
<i>mg-30 mcg</i>	54	DILANTIN-125	40
<i>desvenlafaxine succinate</i>	34	<i>diltiazem hcl</i>	30
<i>dexamethasone</i>	58	<i>diltiazem hcl coated beads</i>	30
DEXAMETHASONE INTENSOL.....	58	<i>diltiazem hcl extended release beads</i> 30	
<i>dexamethasone sodium phosphate</i> ...	58	<i>dilt-xr</i>	30
<i>dexamethasone sodium phosphate</i>		DIP/TET PED INJ 25-5LFU	70
<i>(ophth)</i>	75	<i>diphenhydramine hcl</i>	77
<i>dexmethylphenidate hcl</i>	44	<i>diphenoxylate w/ atropine liq 2.5-0.025</i>	
<i>dextrose</i>	73, 74	<i>mg/5ml</i>	63
<i>dextrose 10% w/ sodium chloride</i>		<i>diphenoxylate w/ atropine tab 2.5-</i>	
<i>0.45%</i>	72	<i>0.025 mg</i>	63
<i>dextrose 2.5% w/ sodium chloride</i>		<i>dipyridamole</i>	67
<i>0.45%</i>	72	<i>disopyramide phosphate</i>	27
<i>dextrose 5% in lactated ringers</i>	72	<i>disulfiram</i>	48
<i>dextrose 5% w/ sodium chloride 0.2%</i>		<i>divalproex sodium</i>	40
.....	72	<i>docetaxel</i>	15
<i>dextrose 5% w/ sodium chloride</i>		DOCETAXEL.....	15
<i>0.225%</i>	72	<i>dofetilide</i>	27
<i>dextrose 5% w/ sodium chloride 0.3%</i>		<i>donepezil hydrochloride</i>	33
.....	72	DOPTELET	66
<i>dextrose 5% w/ sodium chloride 0.45%</i>		<i>dorzolamide hcl</i>	76
.....	72	<i>dorzolamide hcl-timolol maleate ophth</i>	
<i>dextrose 5% w/ sodium chloride 0.9%</i>		<i>soln 2-0.5%</i>	76
.....	72	<i>dotti</i>	57
DIACOMIT	40	DOVATO TAB 50-300MG	7
<i>diazepam</i>	40	<i>doxazosin mesylate</i>	25
<i>diazepam (anticonvulsant)</i>	40	<i>doxepin hcl</i>	34
<i>diazepam inj</i>	40	<i>doxepin hcl (sleep)</i>	45
<i>diazepam intensol</i>	40	<i>doxercalciferol</i>	61

<i>doxorubicin hcl</i>	13	<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	7
<i>doxorubicin hcl liposomal</i>	13	<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	8
DOXORUBICIN HYDROCHLORIDE	13	<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	8
<i>doxy 100</i>	12	EMTRIVA.....	6
<i>doxycycline (monohydrate)</i>	12	EMVERM	4
<i>doxycycline hyclate</i>	12	<i>emzahh</i>	54
DRIZALMA SPRINKLE.....	34	<i>enalapril maleate</i>	24
<i>dronabinol</i>	61	<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	24
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	54	<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	24
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	54	ENBREL.....	67
DROXIA	66	ENBREL MINI.....	67
<i>droxidopa</i>	32	ENBREL SURECLICK	67
DULERA AER 100-5MCG	80	ENDARI.....	66
DULERA AER 200-5MCG	80	<i>endocet tab 10-325mg</i>	2
DULERA AER 50-5MCG.....	80	<i>endocet tab 2.5-325mg</i>	2
<i>duloxetine hcl</i>	34	<i>endocet tab 5-325mg</i>	2
DUPIXENT	67	<i>endocet tab 7.5-325mg</i>	2
<i>dutasteride</i>	64	ENGERIX-B.....	70
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	64	<i>enilloring</i>	54
E		<i>enoxaparin sodium</i>	65
<i>e.e.s. 400</i>	10	<i>enpresse-28</i>	54
<i>ec-naproxen</i>	1	<i>enskyce</i>	54
EDARBI.....	27	ENSTILAR AER.....	82
EDARBYCLOR TAB 40-12.5	25	<i>entacapone</i>	36
EDARBYCLOR TAB 40-25MG	25	<i>entecavir</i>	8
EDURANT	6	ENTRESTO CAP 15-16MG	25
<i>efavirenz</i>	6	ENTRESTO CAP 6-6MG.....	25
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	7	ENTRESTO TAB 24-26MG	26
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	7	ENTRESTO TAB 49-51MG	26
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	7	ENTRESTO TAB 97-103MG	26
ELIGARD	14	<i>enulose</i>	63
<i>elinest</i>	54	EPCLUSA PAK 150-37.5	8
ELIQUIS.....	65	EPCLUSA PAK 200-50MG.....	8
ELIQUIS STARTER PACK.....	65	EPCLUSA TAB 200-50MG.....	8
ELLENCE	13	EPCLUSA TAB 400-100	8
<i>eluryng</i>	54	EPIDIOLEX	40
EMSAM	34	<i>epinephrine (anaphylaxis)</i>	32, 78
<i>emtricitabine</i>	6	<i>epitol</i>	40
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	7	<i>eplerenone</i>	25
		EPRONTIA	40
		<i>ergotamine w/ caffeine tab 1-100 mg</i>	45

ERIVEDGE	17
ERLEADA.....	14
<i>erlotinib hcl</i>	17
<i>errin</i>	54
<i>ertapenem sodium</i>	4
<i>ery</i>	81
<i>ery-tab</i>	10
ERYTHROCIN LACTOBIONATE	10
<i>erythromycin (acne aid)</i>	81
<i>erythromycin (ophth)</i>	74
<i>erythromycin base</i>	10
<i>erythromycin ethylsuccinate</i>	10
<i>erythromycin lactobionate</i>	10
<i>escitalopram oxalate</i>	34
<i>esomeprazole magnesium</i>	64
<i>estarylla</i>	54
<i>estradiol</i>	57
<i>estradiol & norethindrone acetate tab</i> <i>0.5-0.1 mg</i>	57
<i>estradiol & norethindrone acetate tab</i> <i>1-0.5 mg</i>	57
<i>estradiol vaginal</i>	57
<i>estradiol valerate</i>	57
<i>ethambutol hcl</i>	8
<i>ethosuximide</i>	40
<i>ethynodiol diacetate & ethinyl estradiol</i> <i>tab 1 mg-35 mcg</i>	54
<i>ethynodiol diacetate & ethinyl estradiol</i> <i>tab 1 mg-50 mcg</i>	54
<i>etodolac</i>	1
<i>etonogestrel-ethinyl estradiol va ring</i> <i>0.12-0.015 mg/24hr</i>	54
<i>etoposide</i>	16
<i>etravirine</i>	6
EULEXIN	14
<i>euthyrox</i>	60
<i>everolimus</i>	17
<i>everolimus (immunosuppressant)</i>	70
EVOTAZ TAB 300-150	8
<i>exemestane</i>	14
EYSUVIS	75
EZALLOR SPRINKLE.....	28
<i>ezetimibe</i>	28
<i>ezetimibe-simvastatin tab 10-10 mg</i>	29
<i>ezetimibe-simvastatin tab 10-20 mg</i>	29
<i>ezetimibe-simvastatin tab 10-40 mg</i>	29
<i>ezetimibe-simvastatin tab 10-80 mg</i>	29

F	
FABRAZYME.....	59
<i>falmina</i>	54
<i>famciclovir</i>	9
<i>famotidine</i>	62
<i>famotidine in nacl 0.9% iv soln 20</i> <i>mg/50ml</i>	62
FANAPT.....	37
FANAPT PAK	37
FARXIGA	48
FASENRA	78
FASENRA PEN	78
<i>febuxostat</i>	1
<i>felbamate</i>	40
<i>felodipine</i>	30
<i>fenofibrate</i>	28
<i>fenofibrate micronized</i>	28
<i>fentanyl</i>	1
<i>fentanyl citrate</i>	2
<i>fesoterodine fumarate</i>	64
FETZIMA	34
FETZIMA CAP TITRATIO	34
FIASP	51
FIASP FLEXTOUCH.....	51
FIASP PENFILL.....	51
FIASP PUMPCART	51
FINACEA	83
<i>finasteride</i>	64
<i>fingolimod hcl</i>	47
FINTEPLA	40
FIRMAGON	14
<i>flac</i>	76
FLAREX.....	75
FLEBOGAMMA DIF	69
<i>flecainide acetate</i>	27
<i>fluconazole</i>	5
<i>fluconazole in nacl 0.9% inj 200</i> <i>mg/100ml</i>	5
<i>fluconazole in nacl 0.9% inj 400</i> <i>mg/200ml</i>	5
<i>flucytosine</i>	5
<i>fludrocortisone acetate</i>	58
<i>flunisolide (nasal)</i>	79
<i>fluocinolone acetonide</i>	82, 83
<i>fluocinolone acetonide (otic)</i>	76
<i>fluocinonide</i>	83
<i>fluocinonide emulsified base</i>	83

<i>fluorometholone (ophth)</i>	75	<i>ganciclovir sodium</i>	9
<i>fluorouracil</i>	13	GARDASIL 9 INJ.....	70
<i>fluorouracil (topical)</i>	84	<i>gatifloxacin (ophth)</i>	74
<i>fluoxetine hcl</i>	34	GATTEX	63
<i>fluphenazine decanoate</i>	37	GAUZE PADS 2	51
<i>fluphenazine hcl</i>	37	<i>gavilyte-c</i>	63
<i>flurbiprofen</i>	1	<i>gavilyte-g</i>	63
<i>flurbiprofen sodium</i>	75	<i>gavilyte-n/flower pack</i>	63
<i>fluticasone propionate</i>	83	GAVRETO	18
<i>fluticasone propionate (nasal)</i>	79	<i>gefitinib</i>	18
<i>fluticasone-salmeterol aer powder ba</i> <i>100-50 mcg/act</i>	80	<i>gemcitabine hcl</i>	13
<i>fluticasone-salmeterol aer powder ba</i> <i>250-50 mcg/act</i>	80	<i>gemfibrozil</i>	28
<i>fluticasone-salmeterol aer powder ba</i> <i>500-50 mcg/act</i>	80	GEMTESA.....	64
<i>fluvastatin sodium</i>	28	<i>generlac</i>	63
<i>fluvoxamine maleate</i>	33	<i>gengraf</i>	70
<i>fondaparinux sodium</i>	65	GENOTROPIN.....	59
<i>formoterol fumarate</i>	78	GENOTROPIN MINIQUICK.....	59
FOSAMAX + D TAB 70-2800	52	<i>gentamicin in saline inj 0.8 mg/ml</i>	4
FOSAMAX + D TAB 70-5600	52	<i>gentamicin in saline inj 1 mg/ml</i>	4
<i>fosamprenavir calcium</i>	6	<i>gentamicin in saline inj 1.2 mg/ml</i>	4
<i>fosinopril sodium</i>	24	<i>gentamicin in saline inj 1.6 mg/ml</i>	4
<i>fosinopril sodium & hydrochlorothiazide</i> <i>tab 10-12.5 mg</i>	24	<i>gentamicin in saline inj 2 mg/ml</i>	4
<i>fosinopril sodium & hydrochlorothiazide</i> <i>tab 20-12.5 mg</i>	24	<i>gentamicin sulfate</i>	4
FOTIVDA	17	<i>gentamicin sulfate (ophth)</i>	74
FRUZAQLA.....	17	<i>gentamicin sulfate (topical)</i>	81
<i>fulvestrant</i>	14	GENVOYA TAB	8
<i>furosemide</i>	31	GILOTRIF	18
<i>furosemide inj</i>	31	<i>glatiramer acetate</i>	47
FUZEON	6	<i>glatopa</i>	47
<i>fyavolv tab 0.5mg-2.5mcg</i>	57	GLEOSTINE	13
<i>fyavolv tab 1mg-5mcg</i>	57	<i>glimepiride</i>	48
FYCOMPA	41	<i>glipizide</i>	49
G		<i>glipizide xl</i>	49
<i>gabapentin</i>	41	<i>glipizide-metformin hcl tab 2.5-250 mg</i>	49
<i>gabapentin (once-daily)</i>	46	<i>glipizide-metformin hcl tab 2.5-500 mg</i>	49
<i>galantamine hydrobromide</i>	33	<i>glipizide-metformin hcl tab 5-500 mg</i>	49
GAMASTAN INJ	69	<i>glycopyrrolate</i>	62
GAMMAGARD LIQUID.....	69	<i>glydo</i>	83
GAMMAGARD S/D IGA LESS TH.....	69	GLYXAMBI TAB 10-5 MG	49
GAMMAKED	69	GLYXAMBI TAB 25-5 MG	49
GAMMAPLEX	69	GRALISE	46
GAMUNEX-C	69	<i>granisetron hcl</i>	61
		<i>griseofulvin microsize</i>	5
		<i>griseofulvin ultramicrosize</i>	5
		<i>guanfacine hcl</i>	32

<i>guanfacine hcl (adhd)</i>	44
GVOKE HYPOPEN 2-PACK	58
GVOKE KIT	58
GVOKE PFS.....	58
H	
HAEGARDA	66
<i>hailey 1.5/30</i>	54
<i>halobetasol propionate</i>	83
<i>haloette</i>	54
<i>haloperidol</i>	37
<i>haloperidol decanoate</i>	37
<i>haloperidol lactate</i>	37
HARVONI PAK 33.75-150MG	9
HARVONI PAK 45-200MG	9
HARVONI TAB 45-200MG	9
HARVONI TAB 90-400MG	9
HAVRIX.....	70
<i>heather</i>	54
HEP SOD/D5W INJ 20000UNT	65
HEP SOD/D5W INJ 25000UNT	65
HEP SOD/NAACL INJ 12500UNT	65
HEP SOD/NAACL INJ 25000UNT	65
<i>heparin sodium (porcine)</i>	65
HEPARIN/NAACL INJ 25000UNT	65
HEPLISAV-B.....	70
HERCEP HYLEC SOL 60-10000	18
HERCEPTIN.....	18
HERZUMA.....	18
HIBERIX.....	70
HUMIRA	67
HUMIRA PEN.....	67
HUMIRA PEN KIT PS/UV	67
HUMIRA PEN-CD/UC/HS START	67
HUMIRA PEN-PEDIATRIC UC S	67
HUMULIN R U-500 (CONCENTRATE) ..	51
HUMULIN R U-500 KWIKPEN.....	51
<i>hydralazine hcl</i>	32
<i>hydrochlorothiazide</i>	31
<i>hydrocodone bitartrate</i>	2
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	2
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	2
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	2
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	2

<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	2
<i>hydrocortisone</i>	58
<i>hydrocortisone (intrarectal)</i>	62
<i>hydrocortisone (rectal)</i>	84
<i>hydrocortisone (topical)</i>	83
<i>hydromorphone hcl</i>	2
<i>hydroxychloroquine sulfate</i>	69
<i>hydroxyurea</i>	15
<i>hydroxyzine hcl</i>	77
<i>hydroxyzine pamoate</i>	77
HYSINGLA ER	2
I	
<i>ibandronate sodium</i>	52
IBRANCE.....	18
<i>ibu</i>	1
<i>ibuprofen</i>	1
<i>icatibant acetate</i>	66
<i>iclevia</i>	54
ICLUSIG.....	18
IDACIO (2 PEN)	67
IDACIO (2 SYRINGE)	67
IDACIO CROHN INJ DISEASE.....	67
IDACIO PLAQU INJ PSORIASIS.....	68
IDHIFA	18
<i>imatinib mesylate</i>	18
IMBRUVICA	18
<i>imipenem-cilastatin intravenous for soln 250 mg</i>	4
<i>imipenem-cilastatin intravenous for soln 500 mg</i>	4
<i>imipramine hcl</i>	35
<i>imiquimod</i>	84
IMOVAX RABIES (H.D.C.V.)	70
INBRIJA	36
<i>incassia</i>	54
INCRELEX	59
INCRUSE ELLIPTA	77
<i>indapamide</i>	31
INFANRIX INJ	70
INFLIXIMAB.....	68
INLYTA	18
INQOVI TAB 35-100MG	13
INREBIC.....	18
INSULIN PEN NEEDLES: BD/NOVO ...	51
INSULIN SAFETY NEEDLES	51
INSULIN SYRINGES: BD.....	51

INTELENCE.....	6	JENTADUETO TAB 2.5-1000.....	49
INTRALIPID	74	JENTADUETO TAB 2.5-500	49
<i>introvale</i>	54	JENTADUETO TAB 2.5-850	49
INVEGA HAFYERA.....	37	JENTADUETO TAB XR 2.5-1000MG ...	49
INVEGA SUSTENNA	37	JENTADUETO TAB XR 5-1000MG	49
INVEGA TRINZA	38	<i>jinteli</i>	58
IPOL INJ INACTIVE	71	<i>jolessa</i>	54
<i>ipratropium bromide</i>	77	<i>juleber</i>	54
<i>ipratropium bromide (nasal)</i>	77	JULUCA TAB 50-25MG.....	8
<i>ipratropium-albuterol nebu soln 0.5-</i> <i>2.5(3) mg/3ml</i>	77	<i>junel 1.5/30</i>	55
<i>irbesartan</i>	27	<i>junel 1/20</i>	55
<i>irbesartan-hydrochlorothiazide tab</i> <i>150-12.5 mg</i>	26	<i>junel fe 1.5/30</i>	55
<i>irbesartan-hydrochlorothiazide tab</i> <i>300-12.5 mg</i>	26	<i>junel fe 1/20</i>	55
<i>irinotecan hcl</i>	15	JYLAMVO.....	69
ISENTRESS.....	6	JYNNEOS.....	71
ISENTRESS HD	6	K	
<i>isibloom</i>	54	KADCYLA	18
ISOLYTE-P INJ /D5W	72	KALYDECO	78
ISOLYTE-S INJ	72	KANJINTI	18
ISOLYTE-S INJ PH 7.4.....	72	<i>kariva</i>	55
<i>isoniazid</i>	8	<i>kcl 10 meq/l (0.075%) in dextrose 5%</i> <i>& nacl 0.45% inj</i>	72
<i>isosorbide dinitrate</i>	32	<i>kcl 20 meq/l (0.149%) in nacl 0.45%</i> <i>inj</i>	72
<i>isosorbide mononitrate</i>	32	<i>kcl 20 meq/l (0.15%) in dextrose 5% &</i> <i>nacl 0.2% inj</i>	72
<i>isotretinoin</i>	81	<i>kcl 20 meq/l (0.15%) in dextrose 5% &</i> <i>nacl 0.45% inj</i>	72
<i>isradipine</i>	30	<i>kcl 20 meq/l (0.15%) in dextrose 5% &</i> <i>nacl 0.9% inj</i>	72
<i>itraconazole</i>	5	<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	72
<i>ivabradine hcl</i>	32	<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	72
<i>ivermectin</i>	4	<i>kcl 30 meq/l (0.224%) in dextrose 5%</i> <i>& nacl 0.45% inj</i>	72
IWILFIN	15	<i>kcl 40 meq/l (0.3%) in dextrose 5% &</i> <i>nacl 0.45% inj</i>	72
IXCHIQ INJ.....	71	<i>kcl 40 meq/l (0.3%) in dextrose 5% &</i> <i>nacl 0.9% inj</i>	72
IXIARO INJ	71	<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj</i> 72	
J		KCL/D5W/NACL INJ 0.3/0.9%.....	72
JAKAFI.....	18	<i>kelnor 1/35</i>	55
<i>jantoven</i>	65	<i>kelnor 1/50</i>	55
JANUMET TAB 50-1000	49	KERENDIA	25
JANUMET TAB 50-500MG	49	KESIMPTA	47
JANUMET XR TAB 100-1000.....	49	<i>ketoconazole</i>	5
JANUMET XR TAB 50-1000	49		
JANUMET XR TAB 50-500MG	49		
JANUVIA	49		
JARDIANCE.....	49		
<i>jasmiel</i>	54		
<i>javygtor</i>	59		
JAYPIRCA	18		

<i>ketoconazole (topical)</i>	81, 82	<i>latanoprost</i>	76
<i>ketorolac tromethamine (ophth)</i>	75	<i>leena</i>	55
KEVZARA	68	<i>leflunomide</i>	69
KEYTRUDA.....	18	<i>lenalidomide</i>	15
KINRIX INJ	71	LENVIMA 10 MG DAILY DOSE	19
<i>kionex</i>	53	LENVIMA 12MG DAILY DOSE	19
KISQALI 200 DOSE.....	18	LENVIMA 20 MG DAILY DOSE	19
KISQALI 200 PAK FEMARA.....	15	LENVIMA 4 MG DAILY DOSE	19
KISQALI 400 DOSE.....	19	LENVIMA 8 MG DAILY DOSE	19
KISQALI 400 PAK FEMARA.....	15	LENVIMA CAP 14 MG	19
KISQALI 600 DOSE.....	19	LENVIMA CAP 18 MG	19
KISQALI 600 PAK FEMARA.....	15	LENVIMA CAP 24 MG	19
<i>klayesta</i>	81	<i>lessina</i>	55
<i>klor-con</i>	73	<i>letrozole</i>	14
<i>klor-con 10</i>	73	<i>leucovorin calcium</i>	23
<i>klor-con 8</i>	73	LEUKERAN.....	13
<i>klor-con m10</i>	73	<i>leuprolide acetate</i>	14
<i>klor-con m15</i>	73	<i>levabuterol hcl</i>	78
<i>klor-con m20</i>	73	<i>levabuterol tartrate</i>	78
KORLYM	59	<i>levetiracetam</i>	41
KOSELUGO	19	<i>levetiracetam in sodium chloride iv soln</i>	
<i>kourzeq</i>	84	1000 mg/100ml	41
KRAZATI	19	<i>levetiracetam in sodium chloride iv soln</i>	
<i>kurvelo</i>	55	1500 mg/100ml	41
L		<i>levetiracetam in sodium chloride iv soln</i>	
<i>labetalol hcl</i>	29	500 mg/100ml	41
<i>lacosamide</i>	41	<i>levobunolol hcl</i>	76
<i>lacosamide oral</i>	41	<i>levocarnitine (metabolic modifiers)</i> ...59	
<i>lactated ringer's solution</i>	72	<i>levocetirizine dihydrochloride</i>	77
<i>lactic acid (ammonium lactate)</i>	84	<i>levofloxacin</i>	10
<i>lactulose</i>	63	<i>levofloxacin in d5w iv soln 250</i>	
<i>lactulose (encephalopathy)</i>	63	mg/50ml	10
<i>lamivudine</i>	6	<i>levofloxacin in d5w iv soln 500</i>	
<i>lamivudine (hbv)</i>	9	mg/100ml	11
<i>lamivudine-zidovudine tab 150-300 mg</i>		<i>levofloxacin in d5w iv soln 750</i>	
.....	8	mg/150ml	11
<i>lamotrigine</i>	41	<i>levonest</i>	55
<i>lanreotide acetate</i>	59	<i>levonorgestrel & ethinyl estradiol (91-</i>	
<i>lansoprazole</i>	64	<i>day) tab 0.15-0.03 mg</i>	55
<i>lanthanum carbonate</i>	60	<i>levonorgestrel & ethinyl estradiol tab</i>	
LANTUS	51	0.1 mg-20 mcg	55
LANTUS SOLOSTAR	51	<i>levonorgestrel & ethinyl estradiol tab</i>	
<i>lapatinib ditosylate</i>	19	0.15 mg-30 mcg	55
<i>larin 1.5/30</i>	55	<i>levonorgestrel-eth estra tab 0.05-</i>	
<i>larin 1/20</i>	55	30/0.075-40/0.125-30mg-mcg	55
<i>larin fe 1.5/30</i>	55	<i>levora 0.15/30-28</i>	55
<i>larin fe 1/20</i>	55	<i>levo-t</i>	60

<i>levothyroxine sodium</i>	61	<i>losartan potassium &</i>	
<i>levoxyl</i>	61	<i>hydrochlorothiazide tab 50-12.5 mg</i>	
<i>l-glutamine (sickle cell)</i>	66	.....	26
LIBERVANT.....	41	LOTEMAX	75
<i>lidocaine</i>	83	<i>loteprednol etabonate</i>	75
<i>lidocaine hcl</i>	83	<i>lovastatin</i>	28
<i>lidocaine hcl (local anesth.)</i>	3	<i>low-ogestrel</i>	55
<i>lidocaine hcl (mouth-throat)</i>	84	<i>loxapine succinate</i>	38
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	83	LUMAKRAS	19
<i>lidocan</i>	83	LUMIGAN	76
<i>linezolid</i>	4	LUMIZYME.....	59
LINEZOLID INJ 2MG/ML	4	LUPRON DEPOT (1-MONTH).....	14
LINZESS	63	LUPRON DEPOT (3-MONTH).....	14
<i>liothyronine sodium</i>	61	LUPRON DEPOT-PED (1-MONTH	59
<i>lisdexamfetamine dimesylate</i>	44	LUPRON DEPOT-PED (3-MONTH	59
<i>lisinopril</i>	25	LUPRON DEPOT-PED (6-MONTH	59
<i>lisinopril & hydrochlorothiazide tab 10-</i>		<i>lurasidone hcl</i>	38
<i>12.5 mg</i>	24	<i>lutera</i>	55
<i>lisinopril & hydrochlorothiazide tab 20-</i>		<i>lyleq</i>	55
<i>12.5 mg</i>	24	<i>lyllana</i>	58
<i>lisinopril & hydrochlorothiazide tab 20-</i>		LYNPARZA	19
<i>25 mg</i>	24	LYSODREN	14
<i>lithium</i>	46	LYTGOBI (12 MG DAILY DOSE)	19
<i>lithium carbonate</i>	46	LYTGOBI (16 MG DAILY DOSE)	19
<i>loestrin 1.5/30-21</i>	55	LYTGOBI (20 MG DAILY DOSE)	19
<i>loestrin 1/20-21</i>	55	<i>lyza</i>	55
<i>loestrin fe 1.5/30</i>	55	M	
<i>loestrin fe 1/20</i>	55	<i>magnesium sulfate</i>	72
LOKELMA	53	MAGNESIUM SULFATE	72
LONSURF TAB 15-6.14.....	13	<i>magnesium sulfate in dextrose 5% iv</i>	
LONSURF TAB 20-8.19.....	13	<i>soln 1 gm/100ml</i>	72
<i>loperamide hcl</i>	63	<i>malathion</i>	84
<i>lopinavir-ritonavir soln 400-100</i>		<i>maraviroc</i>	6
<i>mg/5ml (80-20 mg/ml)</i>	8	<i>marlissa</i>	55
<i>lopinavir-ritonavir tab 100-25 mg</i>	8	MARPLAN	35
<i>lopinavir-ritonavir tab 200-50 mg</i>	8	MATULANE	15
<i>lorazepam</i>	33	<i>matzim la</i>	30
<i>lorazepam intensol</i>	33	MAVYRET PAK 50-20MG	9
LORBRENA	19	MAVYRET TAB 100-40MG	9
<i>loryna</i>	55	<i>meclizine hcl</i>	61
<i>losartan potassium</i>	27	<i>medroxyprogesterone acetate</i>	60
<i>losartan potassium &</i>		<i>medroxyprogesterone acetate</i>	
<i>hydrochlorothiazide tab 100-12.5 mg</i>		<i>(contraceptive)</i>	55
.....	26	<i>mefloquine hcl</i>	6
<i>losartan potassium &</i>		<i>megestrol acetate</i>	14, 60
<i>hydrochlorothiazide tab 100-25 mg</i>	26	<i>megestrol acetate (appetite)</i>	60
		MEKINIST	19, 20

MEKTOVI.....	20	<i>mifepristone (hyperglycemia)</i>	59
<i>meloxicam</i>	1	<i>miglustat</i>	59
<i>memantine hcl</i>	33	<i>mili</i>	55
MENACTRA INJ.....	71	<i>mimvey</i>	58
MENQUADFI INJ	71	<i>minocycline hcl</i>	12
MENVEO INJ	71	<i>minoxidil</i>	32
MENVEO SOL	71	<i>mirtazapine</i>	35
<i>mercaptapurine</i>	13	<i>misoprostol</i>	63
<i>meropenem</i>	4	MITIGARE	1
<i>mesalamine</i>	62	M-M-R II INJ.....	71
<i>mesalamine w/ cleanser</i>	62	M-NATAL PLUS TAB	73
MESNEX	23	<i>modafinil</i>	47
<i>metformin hcl</i>	49	<i>moexipril hcl</i>	25
<i>methadone hcl</i>	2	<i>molindone hcl</i>	38
<i>methadone hydrochloride i</i>	2	<i>mometasone furoate</i>	83
<i>methazolamide</i>	31	<i>mometasone furoate (nasal)</i>	79
<i>methenamine hippurate</i>	4	MONJUVI.....	20
<i>methimazole</i>	61	<i>mono-lynyah</i>	55
<i>methotrexate sodium</i>	13, 69	<i>montelukast sodium</i>	78
<i>methsuximide</i>	41	<i>morphine sulfate</i>	2, 3
<i>methylphenidate hcl</i>	44	MORPHINE SULFATE.....	2
<i>methylprednisolone</i>	58	MORPHINE SULFATE/SODIUM C	3
<i>methylprednisolone acetate</i>	58	MOUNJARO.....	50
<i>methylprednisolone sod succ</i>	58	MOVANTIK	63
<i>methyltestosterone</i>	48	<i>moxifloxacin hcl</i>	11
<i>metoclopramide hcl</i>	61	<i>moxifloxacin hcl (ophth)</i>	74
<i>metolazone</i>	31	<i>moxifloxacin hcl 400 mg/250ml in</i> <i>sodium chloride 0.8% inj</i>	11
<i>metoprolol & hydrochlorothiazide tab</i> <i>100-25 mg</i>	29	MRESVIA.....	71
<i>metoprolol & hydrochlorothiazide tab</i> <i>100-50 mg</i>	29	MULTAQ.....	27
<i>metoprolol & hydrochlorothiazide tab</i> <i>50-25 mg</i>	29	<i>multiple electrolytes ph 5.5</i>	72
<i>metoprolol succinate</i>	29	<i>multiple electrolytes ph 7.4</i>	72
<i>metoprolol tartrate</i>	29, 30	<i>mupirocin</i>	81
<i>metronidazole</i>	4	<i>mycophenolate mofetil</i>	70
<i>metronidazole (topical)</i>	84	<i>mycophenolate sodium</i>	70
<i>metronidazole vaginal</i>	65	MYRBETRIQ.....	64
<i>metyrosine</i>	32	N	
MG SO4/D5W INJ 10MG/ML.....	72	<i>nabumetone</i>	1
<i>micafungin sodium</i>	5	<i>nadolol</i>	30
<i>microgestin 1.5/30</i>	55	<i>nafcillin sodium</i>	11
<i>microgestin 1/20</i>	55	NAGLAZYME	59
<i>microgestin fe 1.5/30</i>	55	<i>nalbuphine hcl</i>	3
<i>microgestin fe 1/20</i>	55	<i>naloxone hcl</i>	48
<i>midodrine hcl</i>	32	<i>naltrexone hcl</i>	48
MIEBO	76	NAMZARIC CAP 14-10MG	33
		NAMZARIC CAP 21-10MG	33
		NAMZARIC CAP 28-10MG	33

NAMZARIC CAP 7-10MG	33	NITRO-BID	32
NAMZARIC CAP PACK.....	34	<i>nitrofurantoin macrocrystal</i>	4
<i>naproxen</i>	1	<i>nitrofurantoin monohyd macro</i>	4
<i>naproxen dr</i>	1	<i>nitroglycerin</i>	32, 33
<i>naproxen sodium</i>	1	<i>nitroglycerin (intra-anal)</i>	84
<i>naratriptan hcl</i>	45	<i>nizatidine</i>	62
NATACYN	74	<i>nora-be</i>	56
<i>nateglinide</i>	50	<i>norelgestromin-ethinyl estradiol td</i>	
NATPARA.....	53	<i>ptwk 150-35 mcg/24hr</i>	56
NAYZILAM	41	<i>norethindrone (contraceptive)</i>	56
<i>nebivolol hcl</i>	30	<i>norethindrone ace & ethinyl estradiol</i>	
<i>necon 0.5/35-28</i>	55	<i>tab 1 mg-20 mcg</i>	56
<i>nefazodone hcl</i>	35	<i>norethindrone ace & ethinyl estradiol</i>	
<i>neomycin sulfate</i>	4	<i>tab 1.5 mg-30 mcg</i>	56
<i>neomycin-bacitrac zn-polymyx</i>		<i>norethindrone ace & ethinyl estradiol-fe</i>	
5(3.5)mg-400unt-10000unt op oin	74	<i>tab 1 mg-20 mcg</i>	56
<i>neomycin-polymy-gramicid op sol</i>		<i>norethindrone acetate</i>	60
1.75-10000-0.025mg-unt-mg/ml ..	74	<i>norethindrone acetate-ethinyl estradiol</i>	
<i>neomycin-polymyxin-dexamethasone</i>		<i>tab 0.5 mg-2.5 mcg</i>	58
<i>ophth oint 0.1%</i>	74	<i>norethindrone acetate-ethinyl estradiol</i>	
<i>neomycin-polymyxin-dexamethasone</i>		<i>tab 1 mg-5 mcg</i>	58
<i>ophth susp 0.1%</i>	74	<i>norethindrone ac-ethinyl estrad-fe tab</i>	
<i>neomycin-polymyxin-hc ophth susp</i> ..	74	1-20/1-30/1-35 mg-mcg	56
<i>neomycin-polymyxin-hc otic soln 1%</i>	76	<i>norgestimate & ethinyl estradiol tab</i>	
<i>neomycin-polymyxin-hc otic susp 3.5</i>		0.25 mg-35 mcg	56
mg/ml-10000 unit/ml-1%.....	76	<i>norgestimate-eth estrad tab 0.18-</i>	
<i>neo-polycin 5(3.5)mg-400unt-</i>		25/0.215-25/0.25-25 mg-mcg	56
10000unt op oin	74	<i>norgestimate-eth estrad tab 0.18-</i>	
<i>neo-polycin hc ophth oint 1%</i>	74	35/0.215-35/0.25-35 mg-mcg	56
NERLYNX.....	20	NORITATE	84
NEUPRO	36	<i>norlyroc</i>	56
<i>nevirapine</i>	6	NORPACE CR	27
NEXAVAR	20	<i>nortrel 0.5/35 (28)</i>	56
NEXLETOL	29	<i>nortrel 1/35 (21)</i>	56
NEXLIZET TAB 180/10MG.....	29	<i>nortrel 1/35 (28)</i>	56
<i>niacin (antihyperlipidemic)</i>	29	<i>nortrel 7/7/7</i>	56
<i>nicardipine hcl</i>	30	<i>nortriptyline hcl</i>	35
NICOTROL INHALER	48	NORVIR	7
NICOTROL NS	48	NOVOLIN INJ 70/30.....	51
<i>nifedipine</i>	30	NOVOLIN INJ 70/30 FP	51
<i>nikki</i>	56	NOVOLIN N	51
<i>nilutamide</i>	14	NOVOLIN N FLEXPEN	51
<i>nimodipine</i>	30	NOVOLIN R	51
NINLARO.....	20	NOVOLIN R FLEXPEN	51
<i>nisoldipine</i>	30	NOVOLOG	51
<i>nitazoxanide</i>	4	NOVOLOG FLEXPEN	51
<i>nitisinone</i>	59	NOVOLOG MIX INJ 70/30	51

NOVOLOG MIX INJ FLEXPEN	51	<i>olmesartan-amlodipine-</i>	
NOVOLOG PENFILL	51	<i>hydrochlorothiazide tab 40-10-25 mg</i>	
NUBEQA	14	.....	26
NUDEXTA CAP 20-10MG	46	<i>olmesartan-amlodipine-</i>	
NULOJIX	70	<i>hydrochlorothiazide tab 40-5-12.5</i>	
NUPLAZID	38	<i>mg</i>	26
NURTEC	45	<i>olmesartan-amlodipine-</i>	
NUTRILIPID	74	<i>hydrochlorothiazide tab 40-5-25 mg</i>	
NUZYRA	12	.....	26
<i>nyamyc</i>	81	<i>olopatadine hcl (nasal)</i>	77
<i>nylia 1/35</i>	56	<i>omega-3-acid ethyl esters cap 1 gm</i> .	29
<i>nylia 7/7/7</i>	56	<i>omeprazole</i>	64
NYMALIZE	30	OMNARIS	80
<i>nymyo</i>	56	OMNIPOD 5 DX KIT INT G7G6	51
<i>nystatin</i>	5	OMNIPOD 5 DX MIS POD G7G6	51
<i>nystatin (mouth-throat)</i>	84	OMNIPOD 5 G7 KIT INTRO	51
<i>nystatin (topical)</i>	81, 82	OMNIPOD 5 G7 MIS PODS	52
<i>nystop</i>	82	OMNIPOD DASH KIT INTRO.....	52
o		OMNIPOD DASH MIS PODS	52
<i>ocella</i>	56	OMNIPOD GO KIT 10UNT/DY	52
OCTAGAM	69	OMNIPOD GO KIT 15UNT/DY	52
<i>octreotide acetate</i>	59, 60	OMNIPOD GO KIT 20UNT/DY	52
ODEFSEY TAB	8	OMNIPOD GO KIT 25UNT/DY	52
ODOMZO.....	20	OMNIPOD GO KIT 30UNT/DY	52
OFEV	78	OMNIPOD GO KIT 35UNT/DY	52
<i>ofloxacin (ophth)</i>	74	OMNIPOD GO KIT 40UNT/DY	52
<i>ofloxacin (otic)</i>	76	OMNIPOD MIS CLASSIC	52
OGIVRI	20	<i>ondansetron</i>	61
OGSIVEO	20	<i>ondansetron hcl</i>	61
OJEMDA	20	ONTRUZANT	20
OJJAARA	20	ONUREG	13
<i>olanzapine</i>	38	OPSUMIT	33
<i>olmesartan medoxomil</i>	27	ORGOVYX.....	14
<i>olmesartan medoxomil-</i>		ORKAMBI GRA 100-125	78
<i>hydrochlorothiazide tab 20-12.5 mg</i>		ORKAMBI GRA 150-188	79
.....	26	ORKAMBI GRA 75-94MG	78
<i>olmesartan medoxomil-</i>		ORKAMBI TAB 100-125.....	79
<i>hydrochlorothiazide tab 40-12.5 mg</i>		ORKAMBI TAB 200-125	79
.....	26	ORSERDU.....	14
<i>olmesartan medoxomil-</i>		<i>oseltamivir phosphate</i>	9
<i>hydrochlorothiazide tab 40-25 mg</i> .	26	OTEZLA.....	68
<i>olmesartan-amlodipine-</i>		OTEZLA TAB 10/20.....	68
<i>hydrochlorothiazide tab 20-5-12.5</i>		OTEZLA TAB 10/20/30	68
<i>mg</i>	26	<i>oxacillin sodium</i>	11
<i>olmesartan-amlodipine-</i>		<i>oxaliplatin</i>	13
<i>hydrochlorothiazide tab 40-10-12.5</i>		<i>oxaprozin</i>	1
<i>mg</i>	26	<i>oxcarbazepine</i>	41

<i>oxybutynin chloride</i>	64	PENTACEL INJ	71
<i>oxycodone hcl</i>	3	<i>pentamidine isethionate inh</i>	4
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	3	<i>pentamidine isethionate inj</i>	4
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	3	<i>pentoxifylline</i>	66
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	3	<i>perindopril erbumine</i>	25
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	3	<i>perio gard</i>	84
OZEMPIC (0.25 OR 0.5 MG/DOSE)....	50	<i>permethrin</i>	84
OZEMPIC (0.25 OR 0.5MG/DOSE)	50	<i>perphenazine</i>	38
OZEMPIC (1MG/DOSE).....	50	PERSERIS	38
OZEMPIC (2MG/DOSE).....	50	<i>pfizerpen</i>	12
P		<i>phenelzine sulfate</i>	35
<i>pacerone</i>	27	<i>phenobarbital</i>	41
<i>paclitaxel</i>	16	<i>phenobarbital sodium</i>	42
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	16	<i>phenytek</i>	42
<i>paliperidone</i>	38	<i>phenytoin</i>	42
<i>pamidronate disodium</i>	53	<i>phenytoin sodium</i>	42
PAMIDRONATE DISODIUM.....	53	<i>phenytoin sodium extended</i>	42
PANRETIN	84	PHESGO SOL	20
<i>pantoprazole sodium</i>	64	<i>philith</i>	56
PANZYGA	69	PIFELTRO	7
<i>paraplatin</i>	13	<i>pilocarpine hcl</i>	76
<i>paricalcitol</i>	61	<i>pilocarpine hcl (oral)</i>	85
<i>paroxetine hcl</i>	35	<i>pimozide</i>	38
PAXLOVID TAB 150-100	9	<i>pimtrea</i>	56
PAXLOVID TAB 300-100	9	<i>pindolol</i>	30
<i>pazopanib hcl</i>	20	<i>pioglitazone hcl</i>	50
PEDIARIX INJ 0.5ML	71	<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	50
PEDVAX HIB	71	<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	50
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	63	<i>piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)</i>	12
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	63	<i>piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)</i>	12
PEGASYS.....	9	<i>piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)</i>	12
PEMAZYRE.....	20	<i>piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)</i>	12
<i>pemetrexed disodium</i>	13	<i>piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)</i>	12
PEN GK/DEXTR INJ 40000/ML.....	11	PIQRAY 200MG DAILY DOSE.....	20
PEN GK/DEXTR INJ 60000/ML.....	12	PIQRAY 250MG TAB DOSE.....	20
PENBRAYA INJ	71	PIQRAY 300MG DAILY DOSE.....	20
<i>penicillamine</i>	53	<i>pirfenidone</i>	79
<i>penicillin g potassium</i>	12	<i>piroxicam</i>	1
<i>penicillin g sodium</i>	12	<i>pitavastatin calcium</i>	28
<i>penicillin v potassium</i>	12	PLASMA-LYTE INJ -148	72

PLASMA-LYTE INJ -A.....	72	<i>primidone</i>	42
<i>plenamine</i>	74	PRIORIX INJ	71
PLENVU SOL	63	PRIVIGEN.....	69
<i>podofilox</i>	84	<i>probenecid</i>	1
<i>polycin ophth oint</i>	75	<i>prochlorperazine</i>	62
<i>polymyxin b-trimethoprim ophth soln</i> 10000 unit/ml-0.1%	75	<i>prochlorperazine edisylate</i>	62
POMALYST	15	<i>prochlorperazine maleate</i>	62
<i>portia-28</i>	56	PROCRIT	66
<i>posaconazole</i>	5, 6	<i>proctocort</i>	84
POT CHL 20MEQ/L IN NAACL 0.45% INJ	73	<i>procto-med hc</i>	84
POT CHL 20MEQ/L IN NAACL 0.9% INJ	73	<i>proctosol hc</i>	84
POT CHL 40MEQ/L IN NAACL 0.9% INJ	73	<i>proctozone-hc</i>	84
<i>potassium chloride</i>	73	<i>progesterone</i>	60
POTASSIUM CHLORIDE	73	PROGRAF	70
<i>potassium chloride 20 meq/l (0.15%)</i> <i>in dextrose 5% inj</i>	73	PROLASTIN-C	79
<i>potassium chloride microencapsulated</i> <i>crystals er</i>	73	PROLENSA.....	75
<i>potassium citrate (alkalinizer)</i>	64	PROLIA	53
PRADAXA	65	PROMACTA	66
<i>pramipexole dihydrochloride</i>	36	<i>promethazine hcl</i>	62
<i>prasugrel hcl</i>	67	<i>propafenone hcl</i>	27
<i>pravastatin sodium</i>	28	<i>proparacaine hcl</i>	76
<i>praziquantel</i>	4	<i>propranolol hcl</i>	30
<i>prazosin hcl</i>	25	<i>propylthiouracil</i>	61
<i>prednisolone</i>	58	PROQUAD INJ	71
<i>prednisolone acetate (ophth)</i>	75	PROSOL INJ 20%	74
PREDNISOLONE SODIUM PHOSP	75	<i>protriptyline hcl</i>	35
<i>prednisolone sodium phosphate</i>	58	PULMOZYME	79
<i>prednisone</i>	58	PURIXAN	13
PREDNISONE INTENSOL.....	58	<i>pyrazinamide</i>	8
<i>pregabalin</i>	42	<i>pyridostigmine bromide</i>	46
PREHEVBRIO	71	Q	
PREMASOL SOL 10%	74	QINLOCK	20
PRENATAL TAB 27-1MG.....	73	QUADRACEL INJ.....	71
PRENATAL TAB PLUS.....	73	QUADRACEL INJ 0.5ML	71
<i>prevalite</i>	29	<i>quetiapine fumarate</i>	38
PREVYMIS	9	<i>quinapril hcl</i>	25
PREZCOBIX TAB 800-150	8	<i>quinidine sulfate</i>	28
PREZISTA.....	7	<i>quinine sulfate</i>	6
PRIFTIN	8	QULIPTA	45
<i>primaquine phosphate</i>	6	R	
PRIMAQUINE PHOSPHATE	6	RABAVERT INJ	71
		<i>rabeprazole sodium</i>	64
		<i>raloxifene hcl</i>	60
		<i>ramipril</i>	25
		<i>ranolazine</i>	32
		<i>rasagiline mesylate</i>	36
		RAYALDEE	61

<i>reclipsen</i>	56	RYDAPT	21
RECOMBIVAX HB.....	71	S	
RECTIV	84	<i>sajazir</i>	66
REGRANEX	84	SANDIMMUNE.....	70
RELENZA DISKHALER	9	SANTYL.....	84
RELISTOR	63	<i>sapropterin dihydrochloride</i>	60
REMICADE.....	68	SAVELLA	46
RENFLEXIS	68	SAVELLA MIS TITR PAK.....	46
<i>repaglinide</i>	50	SCSEMBLIX	21
REPATHA.....	29	<i>scopolamine</i>	62
REPATHA PUSHTRONEX SYSTEM	29	SECUADO.....	39
REPATHA SURECLICK.....	29	<i>selegiline hcl</i>	36
RESTASIS	76	<i>selenium sulfide</i>	82
RESTASIS MULTIDOSE.....	76	SELZENTRY	7
RETEVMO	20, 21	SEREVENT DISKUS.....	78
REVLIMID.....	15	<i>sertraline hcl</i>	35
REXULTI.....	38	<i>setlakin</i>	56
REYATAZ.....	7	<i>sevelamer carbonate</i>	60
REZLIDHIA	21	<i>sharobel</i>	56
REZUROCK	70	SHINGRIX	71
RHOPRESSA	76	SIGNIFOR	60
<i>ribavirin (hepatitis c)</i>	9	<i>sildenafil citrate</i>	80
<i>rifabutin</i>	8	<i>sildenafil citrate (pulmonary</i> <i>hypertension)</i>	33
<i>rifampin</i>	8	<i>silodosin</i>	64
<i>riluzole</i>	46	<i>silver sulfadiazine</i>	81
<i>rimantadine hydrochloride</i>	9	SIMBRINZA SUS 1-0.2%.....	76
RINVOQ	68	<i>simliya</i>	56
RINVOQ LQ	68	<i>simvastatin</i>	28
<i>risedronate sodium</i>	53	<i>sirolimus</i>	70
<i>risperidone</i>	38	SIRTURO.....	8
<i>risperidone microspheres</i>	38	SIVEXTRO	4
<i>ritonavir</i>	7	SKYRIZI.....	68
<i>rivastigmine</i>	34	SKYRIZI PEN	68
<i>rivastigmine tartrate</i>	34	<i>sod sulfate-pot sulf-mg sulf oral sol</i> <i>17.5-3.13-1.6 gm/177ml</i>	63
<i>rizatriptan benzoate</i>	45	<i>sodium chloride</i>	73
ROCKLATAN DRO	76	<i>sodium chloride (gu irrigant)</i>	84
<i>roflumilast</i>	79	<i>sodium fluoride chew; tab; 1.1 (0.5 f)</i> <i>mg/ml soln</i>	73
<i>ropinirole hydrochloride</i>	36	SODIUM OXYBATE.....	47
<i>rosuvastatin calcium</i>	28	<i>sodium phenylbutyrate</i>	60
ROTARIX SUS	71	<i>sodium polystyrene sulfonate powder</i>	53
ROTATEQ SOL.....	71	<i>solifenacin succinate</i>	65
<i>roweepra</i>	42	SOLIQUA INJ 100/33	52
ROZLYTREK.....	21	SOLTAMOX.....	14
RUBRACA	21		
<i>rufinamide</i>	42		
RUKOBIA.....	7		
RYBELSUS	50		

SOLU-CORTEF.....	58	SYNAREL.....	57
SOMATULINE DEPOT.....	60	SYNJARDY TAB 12.5-1000MG	50
SOMAVERT	60	SYNJARDY TAB 12.5-500.....	50
<i>sorafenib tosylate</i>	21	SYNJARDY TAB 5-1000MG.....	50
<i>sorine</i>	28	SYNJARDY TAB 5-500MG.....	50
<i>sotalol hcl</i>	28	SYNJARDY XR TAB 10-1000.....	50
<i>sotalol hcl (afib/afI)</i>	28	SYNJARDY XR TAB 12.5-1000	50
<i>spironolactone</i>	25	SYNJARDY XR TAB 25-1000.....	50
<i>spironolactone & hydrochlorothiazide</i>		SYNJARDY XR TAB 5-1000MG	50
<i>tab 25-25 mg</i>	31	SYNTHROID.....	61
<i>sprintec 28</i>	56	T	
SPRITAM	42	TABLOID	13
SPRYCEL	21	TABRECTA.....	21
<i>sps</i>	53	<i>tacrolimus</i>	70
<i>sronyx</i>	56	<i>tacrolimus (topical)</i>	84
<i>ssd</i>	81	<i>tadalafil</i>	81
STELARA	68	TAFINLAR.....	21
STIVARGA	21	TAGRISSE.....	21
<i>streptomycin sulfate</i>	4	TALTZ.....	68
STRIBILD TAB.....	8	TALZENNA.....	21
<i>subvenite</i>	42	<i>tamoxifen citrate</i>	14
<i>sucralfate</i>	63	<i>tamsulosin hcl</i>	64
<i>sulfacetamide sodium (acne)</i>	81	<i>tarina fe 1/20 eq</i>	56
<i>sulfacetamide sodium (ophth)</i>	75	TASIGNA.....	21
<i>sulfacetamide sodium-prednisolone</i>		<i>tasimelteon</i>	45
<i>ophth soln 10-0.23(0.25)%</i>	74	<i>tazarotene</i>	82
<i>sulfadiazine</i>	4	<i>tazicef</i>	10
<i>sulfamethoxazole-trimethoprim iv soln</i>		TAZORAC	82
<i>400-80 mg/5ml</i>	5	TAZVERIK	22
<i>sulfamethoxazole-trimethoprim susp</i>		TDVAX INJ 2-2 LF.....	71
<i>200-40 mg/5ml</i>	5	TECENTRIQ	22
<i>sulfamethoxazole-trimethoprim tab</i>		TEFLARO	10
<i>400-80 mg</i>	5	<i>telmisartan</i>	27
<i>sulfamethoxazole-trimethoprim tab</i>		<i>telmisartan-amlodipine tab 40-10 mg</i>	
<i>800-160 mg</i>	5	.....	26
SULFAMYLON.....	81	<i>telmisartan-amlodipine tab 40-5 mg</i>	26
<i>sulfasalazine</i>	62	<i>telmisartan-amlodipine tab 80-10 mg</i>	
<i>sulindac</i>	1	.....	26
<i>sumatriptan</i>	45	<i>telmisartan-amlodipine tab 80-5 mg</i>	26
<i>sumatriptan succinate</i>	45	<i>telmisartan-hydrochlorothiazide tab 40-</i>	
<i>sunitinib malate</i>	21	<i>12.5 mg</i>	26
SUNLENCA	7	<i>telmisartan-hydrochlorothiazide tab 80-</i>	
<i>syeda</i>	56	<i>12.5 mg</i>	26
SYMDEKO TAB 100-150	79	<i>telmisartan-hydrochlorothiazide tab 80-</i>	
SYMDEKO TAB 50-75MG	79	<i>25 mg</i>	26
SYMPAZAN	42	<i>temazepam</i>	45
SYMTUZA TAB.....	8	TENIVAC INJ 5-2LF.....	71

<i>tenofovir disoproxil fumarate</i>	7	<i>tramadol-acetaminophen tab 37.5-325</i>	
TEPMETKO.....	22	<i>mg</i>	3
<i>terazosin hcl</i>	25	<i>trandolapril</i>	25
<i>terbinafine hcl</i>	6	<i>tranexamic acid</i>	66
<i>terbutaline sulfate</i>	78	<i>tranylcypromine sulfate</i>	35
<i>terconazole vaginal</i>	65	TRAVASOL INJ 10%.....	74
TERIPARATIDE	53	<i>travoprost</i>	76
<i>testosterone</i>	48	TRAZIMERA	22
<i>testosterone cypionate</i>	48	<i>trazodone hcl</i>	35
<i>testosterone enanthate</i>	48	TRECATOR	8
<i>tetrabenazine</i>	46	TRELEGY AER ELLIPTA 100-62.5-25	
<i>tetracycline hcl</i>	12	<i>MCG</i>	77
THALOMID.....	15	TRELEGY AER ELLIPTA 200-62.5-25	
THEO-24	79	<i>MCG</i>	77
<i>theophylline</i>	79	TREMFYA.....	68
<i>thioridazine hcl</i>	39	<i>treprostinil</i>	33
<i>thiothixene</i>	39	TRESIBA	52
<i>tiadylt er</i>	30	TRESIBA FLEXTOUCH.....	52
<i>tiagabine hcl</i>	42	<i>tretinoin</i>	81
TIBSOVO.....	22	<i>tretinoin (chemotherapy)</i>	15
TICOVAC	71	TREXALL	69
<i>tigecycline</i>	12	<i>triamcinolone acetonide (mouth)</i>	85
<i>tilia fe</i>	56	<i>triamcinolone acetonide (topical)</i>	83
<i>timolol maleate</i>	30	<i>triamterene & hydrochlorothiazide cap</i>	
<i>timolol maleate (ophth)</i>	76	<i>37.5-25 mg</i>	31
<i>tinidazole</i>	5	<i>triamterene & hydrochlorothiazide tab</i>	
TIVICAY	7	<i>37.5-25 mg</i>	31
TIVICAY PD	7	<i>triamterene & hydrochlorothiazide tab</i>	
<i>tizanidine hcl</i>	47	<i>75-50 mg</i>	31
TOBRADEX OIN 0.3-0.1%	74	<i>tridacaine ii</i>	83
TOBRADEX ST SUS 0.3-0.05	74	<i>trientine hcl</i>	53
<i>tobramycin</i>	5	<i>tri-estarylla</i>	56
<i>tobramycin (ophth)</i>	75	<i>trifluoperazine hcl</i>	39
<i>tobramycin sulfate</i>	5	<i>trifluridine</i>	75
<i>tobramycin-dexamethasone ophth susp</i>		<i>trihexyphenidyl hcl</i>	36
<i>0.3-0.1%</i>	74	TRIJARDY XR TAB ER 24HR 10-5-	
<i>tolterodine tartrate</i>	65	<i>1000MG</i>	50
<i>topiramate</i>	42	TRIJARDY XR TAB ER 24HR 12.5-2.5-	
<i>toremifene citrate</i>	14	<i>1000MG</i>	50
<i>torpenz</i>	22	TRIJARDY XR TAB ER 24HR 25-5-	
<i>torse mide</i>	31	<i>1000MG</i>	50
TOUJEO MAX SOLOSTAR	52	TRIJARDY XR TAB ER 24HR 5-2.5-	
TOUJEO SOLOSTAR	52	<i>1000MG</i>	50
TPN ELECTROL INJ	73	TRIKAFTA PAK 59.5MG	79
TRADJENTA	50	TRIKAFTA PAK 75MG	79
<i>tramadol hcl</i>	3	TRIKAFTA TAB 100-50-75MG & 150MG	
		.....	79

TRIKAFTA TAB 50-25-37.5MG & 75MG		<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	27
.....	79	<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	27
<i>tri-legest fe</i>	56	<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	27
<i>tri-linyah</i>	56	<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	26
<i>tri-lo-estarylla</i>	57	VALTOCO 10 MG DOSE	42
<i>tri-lo-marzia</i>	57	VALTOCO 15 MG DOSE	42
<i>tri-lo-mili</i>	57	VALTOCO 20 MG DOSE	42
<i>tri-lo-sprintec</i>	57	VALTOCO 5 MG DOSE	42
<i>trimethoprim</i>	5	<i>vancomycin hcl</i>	5
<i>tri-mili</i>	57	VANCOMYCIN HYDROCHLORIDE	5
<i>trimipramine maleate</i>	35	VANCOMYCIN INJ 1 GM.....	5
TRINTELLIX	35	VANCOMYCIN INJ 500MG	5
<i>tri-nymyo</i>	57	VANCOMYCIN INJ 750MG	5
<i>tri-sprintec</i>	57	VANFLYTA	22
TRIUMEQ PD TAB	8	VAQTA	71
TRIUMEQ TAB	8	<i>vardenafil hcl</i>	81
<i>trivora-28</i>	57	<i>varenicline tartrate</i>	48
<i>tri-vylibra</i>	57	<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	48
<i>tri-vylibra lo</i>	57	VARIVAX	71
TRIZIVIR TAB	8	VASCEPA.....	29
TROGARZO.....	7	VAXCHORA SUS	71
TROPHAMINE INJ 10%.....	74	<i>velivet</i>	57
<i>trosipium chloride</i>	65	VELPHORO	60
TRULICITY	50	VELTASSA	53
TRUMENBA INJ	71	VEMLIDY	9
TRUQAP	22	VENCLEXTA	22
TRUXIMA.....	22	VENCLEXTA TAB START PK.....	22
TUKYSA	22	<i>venlafaxine hcl</i>	35
TURALIO	22	VENTAVIS	33
<i>turqoz</i>	57	VENTOLIN HFA.....	78
TWINRIX INJ	71	VENTOLIN HFA (INSTITUTIONAL PACK)	78
TYBOST.....	7	.....	78
TYPHIM VI	71	<i>verapamil hcl</i>	30, 31
TYRVAYA.....	76	VERQUVO.....	32
U		VERSACLOZ.....	39
UBRELVY	45	VERZENIO	22
<i>unithroid</i>	61	<i>vestura</i>	57
<i>ursodiol</i>	63	V-GO 20 KIT.....	52
V		V-GO 30 KIT.....	52
<i>valacyclovir hcl</i>	9	V-GO 40 KIT.....	52
VALCHLOR.....	84	<i>vienva</i>	57
<i>valganciclovir hcl</i>	9	<i>vigabatrin</i>	42, 43
<i>valproate sodium</i>	42		
<i>valproic acid</i>	42		
<i>valsartan</i>	27		
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	27		

<i>vigadrone</i>	43	XIFAXAN	63
VIGAFYDE	43	XIGDUO XR TAB 10-1000.....	50
<i>vigoder</i>	43	XIGDUO XR TAB 10-500MG	50
<i>vilazodone hcl</i>	35	XIGDUO XR TAB 2.5-1000.....	50
<i>vincristine sulfate</i>	16	XIGDUO XR TAB 5-1000MG	50
<i>vinorelbine tartrate</i>	16	XIGDUO XR TAB 5-500MG	50
<i>viorele</i>	57	XIIDRA	76
VIRACEPT.....	7	XOLAIR.....	79
VIREAD.....	7	XOSPATA	23
VITRAKVI	22	XPOVIO 100 MG ONCE WEEKLY	23
VIVITROL	48	XPOVIO 40 MG ONCE WEEKLY	23
VIZIMPRO	22	XPOVIO 40 MG TWICE WEEKLY	23
VONJO	22	XPOVIO 60 MG ONCE WEEKLY	23
<i>voriconazole</i>	6	XPOVIO 60 MG TWICE WEEKLY	23
VOSEVI TAB	9	XPOVIO 80 MG ONCE WEEKLY	23
VRAYLAR.....	39	XPOVIO 80 MG TWICE WEEKLY	23
VRAYLAR CAP 1.5-3MG	39	XTANDI.....	14
<i>vyfemla</i>	57	<i>xulane</i>	57
<i>vylibra</i>	57	XULTOPHY INJ 100/3.6	52
VYVANSE	44	Y	
VYZULTA.....	76	<i>yargesa</i>	60
W		YF-VAX INJ.....	71
<i>warfarin sodium</i>	65	<i>yuvaferm</i>	58
<i>water for irrigation, sterile irrigation</i> <i>soln</i>	84	Z	
WELIREG.....	15	<i>zafemy</i>	57
<i>wera</i>	57	<i>zafirlukast</i>	78
<i>wixela inhub</i>	80	ZARXIO.....	66
X		ZEJULA	23
XALKORI	22, 23	ZELBORAF	23
XARELTO.....	65	ZEMAIRA.....	79
XARELTO STAR TAB 15/20MG.....	65	<i>zenatane</i>	81
XATMEP	69	ZENPEP CAP 10000UNT.....	64
XCOPRI.....	43	ZENPEP CAP 15000UNT.....	64
XCOPRI PAK 100-150	43	ZENPEP CAP 20000UNT.....	64
XCOPRI PAK 12.5-25	43	ZENPEP CAP 25000UNT.....	64
XCOPRI PAK 150-200MG (MAINTENANCE).....	43	ZENPEP CAP 3000UNIT	63
XCOPRI PAK 150-200MG (TITRATION)	43	ZENPEP CAP 40000UNT.....	64
XCOPRI PAK 50-100MG	43	ZENPEP CAP 5000UNIT	64
XDEMVY.....	75	ZENPEP CAP 60000UNT.....	64
XELJANZ	68	ZERVIAE	75
XELJANZ XR	69	<i>zidovudine</i>	7
XERMELO	63	ZIEXTENZO	66
XGEVA.....	53	<i>ziprasidone hcl</i>	39
XHANCE	80	<i>ziprasidone mesylate</i>	39
		ZIRABEV	23
		ZIRGAN	75
		<i>zoledronic acid</i>	53

ZOLINZA.....	23	ZURZUVAE	35
<i>zolpidem tartrate</i>	45	ZYCLARA PUMP	84
ZONISADE.....	43	ZYDELIG	23
<i>zonisamide</i>	43	ZYKADIA.....	23
<i>zovia 1/35</i>	57	ZYLET SUS 0.5-0.3%.....	74
ZTALMY.....	43	ZYPITAMAG	28
<i>zumandimine</i>	57	ZYPREXA RELPREVV	39

Notice of Nondiscrimination

Mount Carmel MediGold Health Plan complies with applicable Federal civil rights laws and does not discriminate on age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law.

Mount Carmel MediGold does not exclude people or treat them differently because of age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law. Mount Carmel MediGold:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
 - Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Member Services.

If you believe that Mount Carmel MediGold has failed to provide these services or discriminated in any other way on the basis of age, racial or ethnic background, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex (including sex at birth and legal sex), pregnancy, sexual stereotypes, sexual orientation, or gender (which includes gender identity and gender expression), veteran status, or any category protected by law, you can file a grievance with: Daniel Hayes, Member Services Manager, 3100 Easton Square Place, Third Floor - Health Plan, Columbus, OH 43219, 1-800-240-3851 (TTY 711), 1-833-802-2200 fax, HealthPlanAppeals@trinity-health.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, Daniel Hayes, Member Services Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/complaints/index.html.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-240-3851 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-240-3851 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-240-3851 (TTY 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-240-3851 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-240-3851 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-240-3851 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-240-3851 (TTY 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-240-3851 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-240-3851 (TTY 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-240-3851 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-240-3851 (TTY 711).. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुझे दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-240-3851 (TTY 711) पर फ़ोन करें। कोई भी जो हिंदी बोलता है आपकी मदद कर सकता है। यह एक मुझे सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande

sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-240-3851 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-240-3851 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-240-3851 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-240-3851 (TTY 711).. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがあります。通訳をご用命になるには、1-800-240-3851 (TTY 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Somali: Waxaan leenahay adeegyo turjumaan oo lacag la'aan ah si aan uga jawaabno su'aalo kasta oo aad ka qabtid caafimaadkayaga ama qorshahayaga daawo ahaaneed. Si aad u hesho turjumaan, kaliya naga soo wac 1-800-240-3851 (TTY 711). Qof ku hadla luuqada Soomaliga ayaa ku caawin kara. Adeegani waa lacag la'aan.

Form Approved OMB# 0938-1421
Form CMS-10802 (Expires 12/31/25)



3100 Easton Square Place, Third Floor - Health Plan, Columbus, Ohio 43219

<https://www.thpmedicare.org/mount-carmel/>

Members, please contact 1-800-240-3851 (TTY 711) 8 a.m. – 8 p.m., 7 days a week. Prospective Members, please contact 1-800-964-4525 (TTY 711) 8 a.m. – 8 p.m., 7 days a week. From October 1 to March 31, we are open daily from 8 a.m. to 8 p.m., 7 days a week. From April 1 through September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. On certain holidays and weekends from April 1 through September 30, your call will be handled by our automated phone system.

This formulary was updated on 11/1/2024. For more recent information or other questions, please contact Member Services at 1-800-240-3851 or, for TTY users, 711, 8 a.m. – 8 p.m., 7 days a week, or visit <https://www.thpmedicare.org/mount-carmel/>.

Updated 11/2024

24_MS_OH_FRMNEW_00634