Search Tip:
This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

SISC - Book of Business Drug List
Alphabetical Index
Last Updated 11/1/2026

Drug Name	Special Code	Tier	Category
abacavir soln (ZIAGEN equiv)	-	G	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	G	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	G	ANTIVIRALS
ABILIFY MYCITE PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ABILIFY MYCITE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day)	LMSP-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABRILADA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ABRYSVO INJ (QL= 1 dose/lifetime)	QL-VAC	$0	VACCINES
ABSORICA CAP	-	NC	DERMATOLOGICALS
ABSORICA LD CAP	-	NC	DERMATOLOGICALS
ABSTRAL SL TAB	-	NC	ANALGESICS - OPIOID
acamprosate calcium DR tab (CAMPRAL equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	G	ANTIDIABETICS
ACCRUFER CAP	-	NC	HEMATOPOIETIC AGENTS
ACCU-CHEK GUIDE CARE METER	OTC	$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE ME KIT	OTC	$0	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
acebutolol cap (SECTRAL equiv)	-	G	BETA BLOCKERS
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC	ANALGESICS - OPIOID
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	G	ANALGESICS - OPIOID
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC	MIGRAINE PRODUCTS
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC	MIGRAINE PRODUCTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	G	DIURETICS
acetazolamide tab	-	G	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	G	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	G	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	G	COUGH/COLD/ALLERGY
ACIPHEX SPRINKLE CAP	-	NC	ULCER DRUGS
ACIPHEX TAB	-	NC	ULCER DRUGS
acitretin cap (SORIATANE equiv)	-	G	DERMATOLOGICALS
ACTEMRA ACTPEN INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA IV INJ	MSP-PA	B	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA SC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ACTHAR GEL AUTO-INJECTOR	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ACTHIB INJ, HIBERIX INJ	VAC	$0	VACCINES
ACTICLATE TAB 75MG, 150MG	-	NC	TETRACYCLINES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B	ANTINEOPLASTICS
ACTIQ LOZENGE	-	NC	ANALGESICS - OPIOID
ACTIVE OB	-	NC	MULTIVITAMINS
ACTIVITE TAB	-	NC	MULTIVITAMINS
ACTOPLUS MET TAB	-	NC	ANTIDIABETICS
ACULAR (LS) OPHTH SOLN 0.4%	-	B	OPHTHALMIC AGENTS
ACUVAIL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	G	ANTIVIRALS
acyclovir cream (ZOVIRAX equiv)	-	NC	DERMATOLOGICALS
acyclovir oint (ZOVIRAX OINT equiv)	-	G	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	G	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	G	ANTIVIRALS
ADACEL/BOOSTRIX INJ	VAC	$0	TOXOIDS
ADAGEN INJ	MSP-PA	B	BIOLOGICALS MISC
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT (YUFLYMA equiv) (QL= 1 kit/fill; 1 fill/plan year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ INJ 10/0.1ML	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-ADAZ PFS INJ (HYRIMOZ equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML (QL= 2 inj/2 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ADALIMUMAB-RYVK INJ (SIMLANDI equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ADAPALENE SOLN	-	NC	DERMATOLOGICALS
adapalene cream (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
adapalene gel 0.3% (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	G	DERMATOLOGICALS
ADAPALENE PAD	-	NC	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	G	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC	DERMATOLOGICALS
ADASUVE INHALER	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ADAZIN CREAM	-	NC	DERMATOLOGICALS
ADBRY INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
ADBRY INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
ADCIRCA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ADDERALL XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ADDYI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
adefovir dipivoxil tab (HEPSERA equiv)	-	G	ANTIVIRALS
ADEMPAS TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ADLARITY PATCH	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ADMELOG INJ, HUMALOG INJ	-	NC	ANTIDIABETICS
ADMELOG SOLOSTAR, HUMALOG TEMPO PEN	-	NC	ANTIDIABETICS
ADOXA CAP 150MG	-	NC	TETRACYCLINES
ADQUEY OINT	-	NC	DERMATOLOGICALS
ADRENACLICK INJ, EPINEPHRINE INJ	-	NC	VASOPRESSORS
ADRENALIN SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
ADVAIR DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVATE, KOVALTRY INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ADVICOR TAB	-	NC	ANTIHYPERLIPIDEMICS
ADYNOVATE INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ADZENYS ER SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ADZENYS XR ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
AEMCOLO TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
AEROCHAMBER	OTC	B	MEDICAL DEVICES AND SUPPLIES
AFINITOR DISPERZ TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days)	QL-VAC	$0	VACCINES
AFSTYLA KIT	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
AGAMREE SUSP	-	NC	CORTICOSTEROIDS
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	B	MIGRAINE PRODUCTS
AIRDUO POWDER INHALER W/SENSOR	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AIRDUO RESPICLICK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AIRSUPRA INH	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	B	MIGRAINE PRODUCTS
AKEEGA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AKLIEF CREAM	-	NC	DERMATOLOGICALS
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	B	ANTIEMETICS
ALA-SCALP LOTION	-	NC	DERMATOLOGICALS
albuterol HFA (18gm) inhaler (VENTOLIN equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol HFA (6.7gm, 8.5gm) inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL NEBULIZER SOLN	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALCLOMETASONE CREAM	-	G	DERMATOLOGICALS
alclometasone cream (ACLOVATE equiv)	-	G	DERMATOLOGICALS
ALCLOMETASONE OINT	-	G	DERMATOLOGICALS
alclometasone oint (ACLOVATE OINT equiv)	-	G	DERMATOLOGICALS
ALCOHOL SWABS	OTC	NC	MEDICAL DEVICES AND SUPPLIES
ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv)	-	NC	DERMATOLOGICALS
ALDURAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALECENSA CAP (QL= 8 caps/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
alendronate sodium oral soln (FOSAMAX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
alendronate tab (FOSAMAX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALENDRONATE TAB 40MG	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALEVICYN SOLN DERMAL	-	NC	DERMATOLOGICALS
alfuzosin SR tab (UROXATRAL equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
ALHEMO INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
aliskiren tab (TEKTURNA equiv)	-	G	ANTIHYPERTENSIVES
ALKINDI SPRINKLE CAP	-	NC	CORTICOSTEROIDS
ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	B	CORTICOSTEROIDS
ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	B	CORTICOSTEROIDS
allopurinol tab (ZYLOPRIM equiv)	-	G	GOUT AGENTS
allopurinol tab 200mg	-	NC	GOUT AGENTS
ALLZITAL TAB	-	NC	ANALGESICS - NONNARCOTIC
almotriptan tab (AXERT equiv)	-	NC	MIGRAINE PRODUCTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ALOCRIL OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ALOGLIPTIN TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN TAB, NESINA TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN-METFORMIN TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN-PIOGILTAZONE TAB	-	NC	ANTIDIABETICS
ALOQUIN GEL	-	NC	DERMATOLOGICALS
ALORA PATCH	-	NC	ESTROGENS
alosetron tab (LOTRONEX equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN 0.15%	-	NC	OPHTHALMIC AGENTS
ALPHANATE, HUMATE-P INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ALPHANINE SD/MONONINE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
alprazolam ER tab (XANAX XR equiv)	-	G	ANTIANXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	G	ANTIANXIETY AGENTS
alprazolam tab (XANAX equiv)	-	G	ANTIANXIETY AGENTS
ALPROLIX INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ALREX OPHTH SUSP	-	B	OPHTHALMIC AGENTS
ALREX OPHTH SUSP 0.2%	-	B	OPHTHALMIC AGENTS
ALTABAX OINT	-	NC	DERMATOLOGICALS
ALTAFRIN OPHTH SOLN	-	G	OPHTHALMIC AGENTS
ALTOPREV TAB	-	NC	ANTIHYPERLIPIDEMICS
ALTRENO LOTION	-	NC	DERMATOLOGICALS
ALTUVIIIO INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ALUNBRIG PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALVAIZ TAB	-	NC	HEMATOPOIETIC AGENTS
ALVESCO INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
alvimopan cap (ENTEREG equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
ALYFTREK TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
ALYFTREK TAB 4-20-50MG (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
ALZAIR NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
amantadine cap (SYMMETREL equiv)	-	G	ANTIPARKINSON AGENTS
amantadine soln (AMANTADINE equiv)	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
amantadine tab	-	G	ANTIPARKINSON AGENTS
AMBIEN CR TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
AMCINONIDE CREAM 0.1%	-	NC	DERMATOLOGICALS
AMCINONIDE LOTION	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AMCINONIDE OINTMENT	-	NC	DERMATOLOGICALS
amethyst tab (LYBREL equiv)	-	$0	CONTRACEPTIVES
amiloride tab (MIDAMOR equiv)	-	G	DIURETICS
AMILORIDE/HCTZ TAB	-	G	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	G	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	G	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	G	HEMOSTATICS
amiodarone tab (CORDARONE equiv)	-	G	ANTIARRHYTHMICS
AMITIZA CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
amitriptyline tab (ELAVIL equiv)	-	G	ANTIDEPRESSANTS
AMJEVITA AUTO-INJECTOR (adalimumab-atto)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AMJEVITA INJ (adalimumab-atto)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
amlodipine tab (NORVASC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
amlodipine/atorvastatin tab (CADUET equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
amlodipine/benazepril cap (LOTREL equiv)	-	G	ANTIHYPERTENSIVES
amlodipine/olmesartan tab (AZOR equiv)	-	NC	ANTIHYPERTENSIVES
amlodipine/valsartan tab (EXFORGE equiv)	-	G	ANTIHYPERTENSIVES
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	NC	ANTIHYPERTENSIVES
ammonium lactate cream (LAC-HYDRIN equiv) (Rx Only)	-	G	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv) (Rx Only)	-	G	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	G	DERMATOLOGICALS
amoxapine tab (AMOXAPINE equiv)	-	G	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	G	PENICILLINS
AMOXICILLIN CHEW	-	G	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	G	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	G	PENICILLINS
AMOXICILLIN/CLAVULANATE CHEW TAB	-	B	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	G	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	G	PENICILLINS
amoxicillin/k clavulanate er tab (AMOXICILLIN/CLAVULANATE equiv)	-	G	PENICILLINS
amphetamine er odt (ADZENYS XR equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
AMPHETAMINE ER SUSP, DYANAVEL XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine tab (EVEKEO equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ampicillin cap (AMPICILLIN equiv)	-	G	PENICILLINS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AMZEEQ FOAM	-	NC	DERMATOLOGICALS
anagrelide cap (AGRYLIN equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM HC CREAM 2.5-1%	-	B	ANORECTAL AND RELATED PRODUCTS
ANALPRAM HC CREAM 2.5-1%	-	G	ANORECTAL AND RELATED PRODUCTS
ANALPRAM-E KIT	-	B	ANORECTAL AGENTS
ANALPRAM-HC CREAM	-	B	ANORECTAL AND RELATED PRODUCTS
ANAPROX TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ANASTIA LOTION	-	NC	DERMATOLOGICALS
anastrozole tab (ARIMIDEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDEMBRY INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
ANDROGEL 1% 25MG	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1% 50MG, TESTIM GEL 1%	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 1.25GM	-	NC	ANDROGENS-ANABOLIC
ANDROGEL 1.62% 2.5GM	-	NC	ANDROGENS-ANABOLIC
ANGELIQ TAB	-	NC	ESTROGENS
ANNOVERA RING	-	NC	CONTRACEPTIVES
ANORO ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ANTARA CAP, FENOFIBRATE MICRONIZED CAP	-	NC	ANTIHYPERLIPIDEMICS
ANTARA CAP, LOFIBRA CAP	-	NC	ANTIHYPERLIPIDEMICS
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC	OTIC AGENTS
ANUCORT-HC SUPP 25MG	-	G	ANORECTAL AND RELATED PRODUCTS
ANUCORT-HC SUPP 30MG	-	G	ANORECTAL AND RELATED PRODUCTS
anusol-HC supp	-	NC	ANORECTAL AGENTS
ANZEMET TAB (QL= 9 tabs/fill)	QL	B	ANTIEMETICS
ANZUPGO CREAM	-	NC	DERMATOLOGICALS
APADAZ TAB	-	NC	ANALGESICS - OPIOID
APAP/CODEINE SOLN	-	B	ANALGESICS - OPIOID
APEXICON E CREAM (PSORCON E equiv)	-	NC	DERMATOLOGICALS
APIDRA INJ	-	NC	ANTIDIABETICS
APIDRA SOLOSTAR INJ	-	NC	ANTIDIABETICS
APLENZIN TAB	-	NC	ANTIDEPRESSANTS
APOKYN INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
apomorphine inj (APOKYN equiv)	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
APRACLONIDINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
apraclonidine ophth soln (IOPIDINE equiv)	-	G	OPHTHALMIC AGENTS
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	G	ANTIEMETICS
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	G	ANTIEMETICS
APRETUDE SUSP (QL= 7 inj/year)	PA-QL	$0	ANTIVIRALS
APRISO CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
APRIZIO PAK KIT	-	NC	DERMATOLOGICALS
APTENSIO XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
APTIOM TAB	-	NC	ANTICONVULSANTS
APTIVUS CAP	-	B	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AQNEURSA PACKET FOR SUSPENSION (QL= 4 packets/day; Only available through CurantHealth 866-437-8040)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AQVESME TAB 100MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
ARAKODA TAB	-	NC	ANTIMALARIALS
ARALAST/PROLASTIN/ZEMAIRA INJ (Only available through Walgreens 888-347-3416)	LD-PA	B	RESPIRATORY AGENTS - MISC.
ARANELLE TAB	-	$0	CONTRACEPTIVES
ARANESP INJ	-	NC	HEMATOPOIETIC AGENTS
ARAZLO LOTION	-	NC	DERMATOLOGICALS
ARBLI SUSP (QL= 330mL/30 days; Prior Authorization required for members age 9 years and older)	PA-QL	B	ANTIHYPERTENSIVES
ARCALYST INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AREXVY INJ (QL= 1 dose/lifetime)	QL-VAC	$0	VACCINES
arformoterol tartrate neb soln (BROVANA equiv) (Step Therapy requires trial of PERFOROMIST)	ST	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	B	AMINOGLYCOSIDES
aripiprazole ODT (ABILIFY equiv)	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ARIXTRA INJ	-	NC	ANTICOAGULANTS
ARMLUPEG INJ	-	NC	HEMATOPOIETIC AGENTS
armodafanil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMOUR THYROID TAB, NATURE THYROID TAB	-	NC	THYROID AGENTS
ARNUITY ELLIPTA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARTHROTEC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ARYNTA SOLN	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ASACOL HD TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
ASACOL HD TAB, MESALAMINE TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day; Step Therapy requires trial of aripiprazole or quetiapine ER)	QL-ST	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	$0	CONTRACEPTIVES
ASMANEX HFA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ASMANEX INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
aspirin chew tab 81mg (Covered for female members only age 59 years and younger)	OTC	$0	ANALGESICS - NONNARCOTIC
aspirin EC tab 325mg	OTC	NC	ANALGESICS - NONNARCOTIC

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
aspirin ec tab 81mg (Covered for female members only age 59 years and younger)	OTC	$0	ANALGESICS - NONNARCOTIC
aspirin tab 325mg	OTC	NC	ANALGESICS - NONNARCOTIC
aspirin/dipyridamole cap (AGGRENOX equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
ASPIRIN/OMEPRAZOLE ER TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
ASPRUZYO SPRINKLE GRANULES	-	NC	ANTIANGINAL AGENTS
ASTAGRAF XL CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ASTAMED MYO CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ASTEPRO NASAL SPRAY (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	B	NASAL AGENTS - SYSTEMIC AND TOPICAL
ATACAND TAB	-	NC	ANTIHYPERTENSIVES
atazanavir cap (REYATAZ equiv)	-	G	ANTIVIRALS
ATEBRIOZ TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
atenolol tab (TENORMIN equiv)	-	G	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	G	ANTIHYPERTENSIVES
ATMEKSI SUSP	-	NC	MUSCULOSKELETAL THERAPY AGENTS
atomoxetine cap (STRATTERA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ATONCY SOLN, ATOMOXETINE HCL SOLN	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ATORVALIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	B	ANTIHYPERLIPIDEMICS
atorvastatin tab (LIPITOR equiv)	-	$0	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
atovaquone/proguanil tab (MALARONE equiv)	-	G	ANTIMALARIALS
ATRALIN GEL 0.05%	-	NC	DERMATOLOGICALS
ATRIPLA TAB	-	NC	ANTIVIRALS
atropine ophth oint	-	G	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	G	OPHTHALMIC AGENTS
ATROPINE SUL SOLN 1% OPHTH	-	G	OPHTHALMIC AGENTS
ATROPINE SULFATE OPHTH OINT	-	G	OPHTHALMIC AGENTS
ATROVENT HFA AERO	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ATTRUBY PACK (QL= 4 tabs/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
AUBAGIO TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUGTYRO CAP (QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AUGTYRO CAP 160MG (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AURANOFIN CAP, RIDAURA CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
AURYXIA TAB (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B	GASTROINTESTINAL AGENTS - MISC.
AUSTEDO TAB (QL= 4 tabs/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO TITRATION PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUSTEDO XR TITRATION PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUVELITY TAB	-	NC	ANTIDEPRESSANTS
AUVELITY TAB TITRATION PACK	-	NC	ANTIDEPRESSANTS
AUVI-Q INJ	-	NC	VASOPRESSORS
avanafil tab (STENDRA equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
AVAR AEROSOL FOAM	-	NC	DERMATOLOGICALS
AVAR CLEANSE LIQ 10-5%	-	G	DERMATOLOGICALS
AVAR PAD	-	NC	DERMATOLOGICALS
AVAR-E EMOLL CREAM	-	NC	DERMATOLOGICALS
AVAR-E LS CREAM 10-2%	-	NC	DERMATOLOGICALS
AVASTIN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AVERI TAB	-	NC	CONTRACEPTIVES
AVMAPKI FAKZYNJA CO-PACK (QL= 1 pack/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AVONEX INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AVSOLA INJ	MSP-PA	B	GASTROINTESTINAL AGENTS - MISC.
AVTOZMA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
AWIQLI FLEX INJ	-	NC	ANTIDIABETICS
AXERT TAB	-	NC	MIGRAINE PRODUCTS
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
azacitidine inj (VIDAZA equiv)	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AZASITE SOLN	-	B	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	G	ASSORTED CLASSES
azathioprine tab 100mg (AZASAN equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
azathioprine tab 75mg (AZASAN equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
azelaic acid gel (FINACEA equiv)	-	G	DERMATOLOGICALS
azelastine nasal spray 0.1% (ASTELIN equiv)	-	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine nasal spray 0.15% (ASTEPRO equiv) (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
azelastine ophth soln (OPTIVAR equiv)	-	G	OPHTHALMIC AGENTS
azelastine/fluticasone nasal spray (DYMISTA equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZELEX CREAM	-	NC	DERMATOLOGICALS
AZENASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
AZESCHEW TAB	-	NC	MULTIVITAMINS
AZESCO TAB	-	NC	MULTIVITAMINS
azilsartan medoxomil tab (EDARBI equiv)	-	NC	ANTIHYPERTENSIVES
azithromycin susp (ZITHROMAX equiv)	-	G	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	G	MACROLIDES
AZOPT OPHTH SUSP	-	B	OPHTHALMIC AGENTS
AZOR TAB	-	NC	ANTIHYPERTENSIVES
AZSTARYS CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BACIT/POLYMY OPHTH OINT	-	G	OPHTHALMIC AGENTS
BACITRACIN OPHTH OINT	-	B	OPHTHALMIC AGENTS
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	G	OPHTHALMIC AGENTS
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	G	OPHTHALMIC AGENTS
BACLOFEN CREAM COMPOUND KIT	-	B	DERMATOLOGICALS
BACLOFEN ORAL SOLN 10MG/5ML (Prior Authorization required for members age 9 years and older)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
baclofen oral soln 10mg/5ml (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older)	PA	G	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN ORAL SOLN 5 MG/5ML	-	NC	MUSCULOSKELETAL THERAPY AGENTS
baclofen oral soln 5mg/5ml (Prior Authorization required for members age 9 years and older)	PA	G	MUSCULOSKELETAL THERAPY AGENTS
baclofen susp (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older)	PA	G	MUSCULOSKELETAL THERAPY AGENTS
baclofen tab (BACLOFEN equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
baclofen tab 15mg	-	NC	MUSCULOSKELETAL THERAPY AGENTS
BACTROBAN CREAM	-	NC	DERMATOLOGICALS
BAFIERTAM CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BALCOLTRA TAB	-	NC	CONTRACEPTIVES
balsalazide cap (COLAZAL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BANZEL SUSP	-	NC	ANTICONVULSANTS
BANZEL TAB	-	NC	ANTICONVULSANTS
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	B	ANTIDIABETICS
BARACLUDE SOLN (Prior Authorization required for members age 9 years and older)	PA	B	ANTIVIRALS
BASAGLAR INJ, INSULIN GLARGINE SOLOSTAR INJ	-	NC	ANTIDIABETICS
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	B	FLUOROQUINOLONES
BAXFENDY TAB	-	NC	ANTIHYPERTENSIVES
BCG INJ	VAC	EXC	VACCINES
B-D INSULIN SYRINGE	--OTC	G	MEDICAL DEVICES AND SUPPLIES
B-D PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
b-donna tab (DONNATAL equiv)	-	NC	ULCER DRUGS
BECONASE AQ NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
BELBUCA FILM	-	NC	ANALGESICS - OPIOID
BELLADONNA ALKALOID/OPIUM SUPP	-	B	ULCER DRUGS
BELSOMRA TAB	-	NC	HYPNOTICS
benazepril tab (LOTENSIN equiv)	-	G	ANTIHYPERTENSIVES
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	G	ANTIHYPERTENSIVES
bendamustine hcl for iv soln (TREANDA equiv)	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BENEFIX INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
BENICAR HCT TAB	-	NC	ANTIHYPERTENSIVES
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BENLYSTA INJ (QL= 4 inj/28 day)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
BENTIVITE TAB	-	NC	HEMATOPOIETIC AGENTS
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	B	ANTHELMINTICS
benzonatate cap (TESSALON equiv)	-	G	COUGH/COLD/ALLERGY
BENZONATATE CAP 150MG	-	NC	COUGH/COLD/ALLERGY
benzonatate cap 150mg (ZONATUSS equiv)	-	NC	COUGH/COLD/ALLERGY
BENZOYL PEROXIDE LOTION	-	NC	DERMATOLOGICALS
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC	DERMATOLOGICALS
benzphetamine tab	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS
benztropine tab	-	G	ANTIPARKINSON AGENTS
bepotastine ophth soln (BEPREVE equiv)	-	NC	OPHTHALMIC AGENTS
BEQALZI TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BEQALZI TAB STARTER PACK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BERINERT INJ (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
BESER KIT 0.05%	-	NC	DERMATOLOGICALS
BESIFLOXACIN OPHTH SUSP, BESIVANCE OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
BESREMI INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BESREMI PEN INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
betaine powder for oral solution (CYSTADANE equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BETAMETH VALERATE LOTION	-	G	DERMATOLOGICALS
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	G	DERMATOLOGICALS
BETAMETHASONE AUGMENTED GEL	-	B	DERMATOLOGICALS
betamethasone augmented gel	-	NC	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	G	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	G	DERMATOLOGICALS
betamethasone diproprionate cream (DIPROSONE CREAM equiv)	-	G	DERMATOLOGICALS
betamethasone diproprionate lotion	-	G	DERMATOLOGICALS
betamethasone diproprionate oint (DIPROSONE OINT equiv)	-	G	DERMATOLOGICALS
betamethasone valerate cream	-	G	DERMATOLOGICALS
betamethasone valerate foam (LUXIQ equiv)	-	NC	DERMATOLOGICALS
betamethasone valerate lotion	-	G	DERMATOLOGICALS
betamethasone valerate oint	-	G	DERMATOLOGICALS
BETASERON INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BETAXOLOL OPHTH SOLN	-	G	OPHTHALMIC AGENTS
betaxolol ophth soln (BETOPTIC-S equiv)	-	G	OPHTHALMIC AGENTS
betaxolol tab (KERLONE equiv)	-	G	BETA BLOCKERS
bethanechol tab (URECHOLINE equiv)	-	G	URINARY ANTISPASMODICS
BETIMOL OPHTH SOLN 0.25%	-	B	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	B	OPHTHALMIC AGENTS
BEVESPI AEROSPHERE INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
bexarotene cap (TARGRETIN equiv) (QL= 10 caps/day)	LMSP-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bexarotene gel (TARGRETIN equiv) (QL= 60 grams/30 days)	LMSP-PA-QL	G	DERMATOLOGICALS
BEXSERO INJ	VAC	$0	VACCINES
BEYFORTUS INJ	VAC	$0	PASSIVE IMMUNIZING AND TREATMENT AGENTS
BIAFINE EMULSION	-	NC	DERMATOLOGICALS
bicalutamide tab (CASODEX equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIDIL TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
BIFERARX TAB	-	NC	HEMATOPOIETIC AGENTS
BIJUVA CAP	-	NC	ESTROGENS
BIKTARVY TAB	-	B	ANTIVIRALS
BILTRICIDE TAB	-	B	ANTHELMINTICS
bimatoprost ophth soln (LATISSE equiv)	-	EXC	DERMATOLOGICALS
BIMATOPROST OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
bimatoprost ophth soln (LUMIGAN equiv)	-	NC	OPHTHALMIC AGENTS
BIMZELX INJ (QL= 1 mL/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
BIMZELX INJ 320MG/2ML (QL= 2 mL/56 days)	LMSP-PA-QL	B	DERMATOLOGICALS
BIMZELX SYRINGE (QL= 1 mL/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
BIMZELX SYRINGE 320MG/2ML (QL= 2 mL/56 days)	LMSP-PA-QL	B	DERMATOLOGICALS
BINOSTO TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
bismuth/metro/tetra cap (PYLERA equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
BISOPROLOL FUMARATE TAB	-	NC	BETA BLOCKERS
bisoprolol tab (ZEBETA equiv)	-	G	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	G	ANTIHYPERTENSIVES
BIXLENVO TAB	-	B	ANTIVIRALS
BIXLENVO/SUNLENCA STARTER PACK	-	NC	ANTIVIRALS
BLANCHE CREAM	-	EXC	DERMATOLOGICALS
BLUJEPA TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
BONSITY INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BORTEZOMIB INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bortezomib inj (VELCADE equiv)	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
bosentan tab for oral susp (TRACLEER equiv) (QL= 4 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
BOSULIF CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOSULIF TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
bosutinib tab (BOSULIF equiv)	MSP-PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOTOX INJ	MSP-PA	B	NEUROMUSCULAR AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
BP 10-1 EMU	-	NC	DERMATOLOGICALS
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREKIYA INJ	-	NC	MIGRAINE PRODUCTS
BRENZAVVY TAB	-	NC	ANTIDIABETICS
BREO ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREO ELLIPTA INHALER 50-25 MCG/ACT	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BREXAFEMME TAB	-	NC	ANTIFUNGALS
BREZTRI AEROSPHERE INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BRILINTA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	G	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	G	OPHTHALMIC AGENTS
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	G	OPHTHALMIC AGENTS
brimonidine/timolol ophth soln (COMBIGAN OPHTH SOLN equiv)	-	G	OPHTHALMIC AGENTS
BRINSUPRI TAB (QL= 1 tab/day; Only available through Maxor Pharmacy 800-658-6046 or Amber Specialty Pharmacy 888-370-1724)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
brinzolamide ophth susp (AZOPT equiv)	-	G	OPHTHALMIC AGENTS
BRISDELLE CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
brivaracetam inj (BRIVIACT equiv)	-	NC	ANTICONVULSANTS
brivaracetam oral soln 10mg/ml (BRIVIACT equiv)	-	NC	ANTICONVULSANTS
brivaracetam tab (BRIVIACT equiv)	-	NC	ANTICONVULSANTS
BRIVIACT INJ	-	NC	ANTICONVULSANTS
BRIVIACT SOLN 10MG/ML	-	NC	ANTICONVULSANTS
BRIVIACT TAB	-	NC	ANTICONVULSANTS
bromfenac ophth soln (BROMDAY equiv)	-	G	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	G	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	G	ANTIPARKINSON AGENTS
BRONCHITOL CAP	-	NC	RESPIRATORY AGENTS - MISC.
BRUKINSA CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRUKINSA TAB (QL= 2 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRYHALI LOTION	-	NC	DERMATOLOGICALS
BRYNOVIN SOLN	-	NC	ANTIDIABETICS
B-SERENE PAD	-	NC	HEMATOPOIETIC AGENTS
BUCAPSOL CAP	-	NC	ANTIANXIETY AGENTS
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	G	CORTICOSTEROIDS
budesonide inh susp (PULMICORT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
budesonide nasal spray (RHINOCORT AQUA equiv)	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
budesonide rectal foam (UCERIS RECTAL FOAM equiv)	-	B	ANORECTAL AND RELATED PRODUCTS
budesonide SR cap (ENTOCORT EC equiv)	-	G	CORTICOSTEROIDS
budesonide/formoterol inhaler (SYMBICORT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
bumetanide tab (BUMEX equiv)	-	G	DIURETICS
BUNAVAIL FILM	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
bupap tab	-	NC	ANALGESICS - NONNARCOTIC
buprenorphine hcl buccal film (BELBUCA equiv)	-	NC	ANALGESICS - OPIOID
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	G	ANALGESICS - OPIOID
buprenorphine SL tab (SUBUTEX equiv)	-	G	ANALGESICS - OPIOID
buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv)	-	G	ANALGESICS - OPIOID
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	G	ANALGESICS - OPIOID
bupropion ER tab (WELLBUTRIN equiv)	-	G	ANTIDEPRESSANTS
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
bupropion tab (WELLBUTRIN equiv)	-	G	ANTIDEPRESSANTS
bupropion XL tab (WELLBUTRIN XL equiv)	-	G	ANTIDEPRESSANTS
BUPROPION XL TAB, FORFIVO XL TAB	-	NC	ANTIDEPRESSANTS
buspirone tab (BUSPAR equiv)	-	G	ANTIANXIETY AGENTS
BUSPIRONE TAB	-	NC	ANTIANXIETY AGENTS
buspirone tab 30mg (BUSPAR equiv)	-	NC	ANTIANXIETY AGENTS
butalbital/acetaminophen cap	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen tab 50-325mg (PHRENILIN equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine cap (FIORICET equiv)	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine soln	-	NC	ANALGESICS - NONNARCOTIC
butalbital/acetaminophen/caffeine tab (FIORICET equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
butalbital/aspirin/caffeine cap (FIORINAL equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC	ANALGESICS - NONNARCOTIC
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	G	ANALGESICS - OPIOID
BYDUREON BCISE AUTO INJ	-	NC	ANTIDIABETICS
BYDUREON INJ	-	NC	ANTIDIABETICS
BYDUREON PEN INJ	-	NC	ANTIDIABETICS
BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
BYNFEZIA PEN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BYQLOVI OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
BYQLOVI SUSP	-	NC	OPHTHALMIC AGENTS
BYSANTI TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
BYSANTI TITRATION PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
BYSTOLIC TAB	-	NC	BETA BLOCKERS
BYVALSON TAB	-	NC	ANTIHYPERTENSIVES
CABENUVA IM SUSP (QL= 1 kit/30 days)	LMSP-QL	B	ANTIVIRALS
CABENUVA SUSP 600MG-900MG/3ML (QL= 1 kit/30 days)	LMSP-QL	B	ANTIVIRALS
cabergoline tab (DOSTINEX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CABLIVI INJ KIT (QL= 1 vial/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAFCIT INJ	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB	-	NC	MIGRAINE PRODUCTS
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB 1-100MG	-	NC	MIGRAINE PRODUCTS
caffeine citrate soln (CAFCIT equiv) (Covered for members age 11 months and younger)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	G	DERMATOLOGICALS
calcipotriene cream (TRIONEX equiv)	-	NC	DERMATOLOGICALS
CALCIPOTRIENE FOAM	-	NC	DERMATOLOGICALS
CALCIPOTRIENE FOAM, SORILUX FOAM	-	NC	DERMATOLOGICALS
calcipotriene oint	-	G	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	G	DERMATOLOGICALS
CALCIPOTRIENE SOLN 0.005%	-	G	DERMATOLOGICALS
calcipotriene/betamethasone dipropionate susp (TACLONEX equiv)	-	NC	DERMATOLOGICALS
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC	DERMATOLOGICALS
calcitonin inj (MIACALCIN equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitonin nasal spray (MIACALCIN equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcitriol cap (ROCALTROL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CALCITRIOL OINT	-	NC	DERMATOLOGICALS
calcitriol soln (ROCALTROL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
calcium acetate cap (PHOSLO equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
CALIBRATION LIQUID	OTC	G	MEDICAL DEVICES AND SUPPLIES
CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CALSODORE PAK	-	NC	DERMATOLOGICALS
CAMBIA POWDER	-	NC	MIGRAINE PRODUCTS
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
candesartan tab (ATACAND equiv)	-	NC	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	NC	ANTIHYPERTENSIVES
capecitabine tab (XELODA equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPEX SHAMPOO	-	NC	DERMATOLOGICALS
CAPLYTA CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CAPRELSA TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAPRELSA TAB 300MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
capsaicin/menthol topical patch (SINELEE equiv)	-	NC	DERMATOLOGICALS
captopril tab (CAPOTEN equiv)	-	G	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CAPVAXIVE INJ	VAC	$0	VACCINES
CARAC CREAM	-	NC	DERMATOLOGICALS
CARBAGLU TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
carbamazepine chew tab (TEGRETOL equiv)	-	G	ANTICONVULSANTS
CARBAMAZEPINE CHEW TAB	-	NC	ANTICONVULSANTS
carbamazepine ER cap (CARBATROL equiv)	-	G	ANTICONVULSANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	G	ANTICONVULSANTS
carbamazepine susp (TEGRETOL equiv)	-	G	ANTICONVULSANTS
carbamazepine tab (TEGRETOL equiv)	-	G	ANTICONVULSANTS
carbidopa tab (LODOSYN equiv)	-	G	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA CAP, RYTARY CAP	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	G	ANTIPARKINSON AGENTS
carbidopa/levodopa ODT (PARCOPA equiv)	-	G	ANTIPARKINSON AGENTS
carbidopa/levodopa tab (SINEMET equiv)	-	G	ANTIPARKINSON AGENTS
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	B	ANTIPARKINSON AGENTS
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
carbinoxamine maleate tab 6mg	-	NC	ANTIHISTAMINES
CARBINOXAMINE SOLN	-	G	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	G	ANTIHISTAMINES
CARBZAH SOLN 4MG/5ML	-	NC	ANTIHISTAMINES
CARDAMYST NASAL SPRAY	-	NC	CALCIUM CHANNEL BLOCKERS
CARDURA XL TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CARIMUNE INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
carisoprodol tab (SOMA equiv) (QL= 90 tabs/90 days)	QL	G	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol tab 250mg (SOMA equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CARMOL LOTION	-	NC	DERMATOLOGICALS
CARTEOLOL OPHTH SOLN	-	G	OPHTHALMIC AGENTS
carteolol ophth soln (OCUPRESS equiv)	-	G	OPHTHALMIC AGENTS
carvedilol phosphate ER cap (COREG CR equiv)	-	NC	BETA BLOCKERS
carvedilol tab (COREG equiv)	-	G	BETA BLOCKERS
CATAPRES-TTS PATCH	-	B	ANTIHYPERTENSIVES
CAVERJECT INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B	CARDIOVASCULAR AGENTS - MISC.
CAVHANZA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTI-INFECTIVE AGENTS - MISC.
CEFACLOR CAP	-	G	CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	G	CEPHALOSPORINS
CEFACLOR ER TAB	-	B	CEPHALOSPORINS
CEFACLOR SUSP	-	B	CEPHALOSPORINS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
cefadroxil cap (DURICEF equiv)	-	G	CEPHALOSPORINS
cefadroxil susp (DURICEF equiv)	-	G	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	G	CEPHALOSPORINS
CEFADROXIL TAB	-	NC	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	G	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	G	CEPHALOSPORINS
cefixime cap (SUPRAX equiv)	-	G	CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	G	CEPHALOSPORINS
CEFIXIME TAB	-	NC	CEPHALOSPORINS
CEFPODOXIME PROXETIL SUSP	-	G	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	G	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	G	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	G	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	G	CEPHALOSPORINS
CELEBREX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap (CELEBREX equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
CENTANY OINT	-	NC	DERMATOLOGICALS
cephalexin cap (KEFLEX equiv)	-	G	CEPHALOSPORINS
cephalexin cap 750mg (KEFLEX equiv)	-	NC	CEPHALOSPORINS
cephalexin susp (KEFLEX equiv)	-	G	CEPHALOSPORINS
cephalexin tab	-	NC	CEPHALOSPORINS
CEQUA OPHTH SOLN (Restricted to Ophthalmology or Optometry Specialist; Step Therapy requires trial of cyclosporine ophth emulsion)	QL-RS-ST	B	OPHTHALMIC AGENTS
CEQUR SIMPLICITY	-	NC	MEDICAL DEVICES AND SUPPLIES
CERDELGA CAP (QL= 2 caps/day)	LMSP-PA-QL	B	HEMATOPOIETIC AGENTS
CEREZYME INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
CERVICAL CAP	-	$0	MEDICAL DEVICES AND SUPPLIES
cetrorelix acetate for inj kit (CETROTIDE equiv)	INF	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETROTIDE KIT	INF	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CETYLEV TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
cevimeline cap (EVOXAC equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
CHANTIX STARTER PACK	SMKG	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	B	ANTIDOTES
CHENODAL TAB, CTEXLI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
chlordiazepoxide cap (LIBRIUM equiv)	-	G	ANTIANXIETY AGENTS
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHLORDIAZEPOXIDE/CLIDINIUM CAP	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	G	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
CHLOROQUINE TAB	-	G	ANTIMALARIALS
chloroquine tab (ARALEN equiv)	-	G	ANTIMALARIALS
CHLORPROMAZINE CONC	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
chlorpromazine hcl conc	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
chlorpromazine tab (THORAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
chlorthalidone tab	-	G	DIURETICS
chlorzoxazone tab	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
chlorzoxazone tab 500mg	-	G	MUSCULOSKELETAL THERAPY AGENTS
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	B	GASTROINTESTINAL AGENTS - MISC.
cholestyramine lite powder (QUESTRAN LITE equiv)	-	G	ANTIHYPERLIPIDEMICS
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	G	ANTIHYPERLIPIDEMICS
cholestyramine powder (QUESTRAN equiv)	-	G	ANTIHYPERLIPIDEMICS
cholestyramine powder pack (QUESTRAN equiv)	-	G	ANTIHYPERLIPIDEMICS
CIBINQO TAB (QL= 1 tab/day)	LMSP-PA-QL	B	DERMATOLOGICALS
CICLODAN KIT	-	NC	DERMATOLOGICALS
ciclopirox cream (LOPROX CREAM equiv)	-	G	DERMATOLOGICALS
ciclopirox gel (LOPROX equiv)	-	NC	DERMATOLOGICALS
ciclopirox nail soln (PENLAC equiv)	-	G	DERMATOLOGICALS
ciclopirox shampoo (LOPROX equiv) (Step Therapy requires trial of ketoconazole shampoo)	ST	G	DERMATOLOGICALS
ciclopirox topical susp (LOPROX equiv)	-	NC	DERMATOLOGICALS
cilostazol tab (PLETAL equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
CILOXAN OPHTH OINT	-	B	OPHTHALMIC AGENTS
CIMDUO TAB	-	B	ANTIVIRALS
cimetidine soln (CIMETIDINE equiv)	-	G	ULCER DRUGS
cimetidine tab (TAGAMET equiv) (Rx Only)	-	G	ULCER DRUGS
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
CIMZIA INJ 200MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
cinacalcet tab (SENSIPAR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
CIPRO HC OTIC SUSP (Step Therapy requires trial of CIPRODEX)	ST	B	OTIC AGENTS
CIPRO SUSP	-	B	FLUOROQUINOLONES
CIPROFLOXACIN 100MG TAB	-	B	FLUOROQUINOLONES
ciprofloxacin hcl otic soln (CETRAXAL equiv)	-	G	OTIC AGENTS
ciprofloxacin ophth soln (CILOXAN equiv)	-	G	OPHTHALMIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	G	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	G	FLUOROQUINOLONES
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	G	OTIC AGENTS
ciprofloxacin-hydrocortisone otic susp (CIPRO HC equiv) (Step Therapy requires trial of CIPRODEX)	ST	G	OTIC AGENTS
CITALOPRAM CAP	-	NC	ANTIDEPRESSANTS
citalopram hydrobromide cap	-	NC	ANTIDEPRESSANTS
citalopram soln (CELEXA equiv)	-	G	ANTIDEPRESSANTS
citalopram tab (CELEXA equiv)	-	G	ANTIDEPRESSANTS
CITRANATAL 90 DHA, CITRANATAL ASSURE	-	NC	MULTIVITAMINS
CITRANATAL B CALM	-	NC	MULTIVITAMINS
CITRANATAL BLOOM	-	NC	MULTIVITAMINS
CITRANATAL CAP MEDLEY	-	NC	MULTIVITAMINS
CITRANATAL HARMONY	-	NC	MULTIVITAMINS
CITRANATAL RX	-	NC	MULTIVITAMINS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CITRULLINE EASY TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
cladribine tab therapy pack (MAVENCLAD equiv)	LMSP-PA	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CLARINEX SYRUP	-	EXC	ANTIHISTAMINES
CLARINEX TAB	-	EXC	ANTIHISTAMINES
CLARINEX-D TAB	-	EXC	COUGH/COLD/ALLERGY
CLARITHROMYC SUSP	-	B	MACROLIDES
clarithromycin ER tab (BIAXIN XL equiv)	-	NC	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	G	MACROLIDES
CLARITIN CAP	OTC	EXC	ANTIHISTAMINES
CLARITIN CHEW TAB	OTC	EXC	ANTIHISTAMINES
CLEMASTINE SYRUP	-	NC	ANTIHISTAMINES
CLEMASTINE TAB	-	NC	ANTIHISTAMINES
CLEMASTINE TAB, CLEMASZ TAB	-	NC	ANTIHISTAMINES
CLENIA PLUS SUSP	-	NC	DERMATOLOGICALS
CLENPIQ SOLN	-	NC	LAXATIVES
CLEOCIN VAGINAL SUPP	-	NC	VAGINAL PRODUCTS
CLIMARA PATCH	-	NC	ESTROGENS
CLIMARA PRO PATCH	-	NC	ESTROGENS
CLINDACIN KIT	-	NC	DERMATOLOGICALS
clindamycin cap (CLEOCIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
clindamycin cap 300mg (CLEOCIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
clindamycin foam (EVOCLIN equiv)	-	NC	DERMATOLOGICALS
clindamycin gel (CLEOCIN GEL equiv)	-	G	DERMATOLOGICALS
clindamycin gel 1% (CLEOCIN GEL equiv)	-	NC	DERMATOLOGICALS
clindamycin lotion (CLEOCIN- T equiv)	-	G	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	G	DERMATOLOGICALS
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv)	-	NC	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	G	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	G	VAGINAL PRODUCTS
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	G	DERMATOLOGICALS
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	NC	DERMATOLOGICALS
clindamycin/tretinoin gel (ZIANA equiv)	-	NC	DERMATOLOGICALS
CLINDAVIX KIT	-	NC	DERMATOLOGICALS
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	B	VAGINAL AND RELATED PRODUCTS
CLINISTIX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
clobazam susp (ONFI equiv) (Prior Authorization required for members age 9 years and older)	PA	G	ANTICONVULSANTS
clobazam tab (ONFI equiv)	PA	G	ANTICONVULSANTS
clobetasol E foam (OLUX E equiv)	-	NC	DERMATOLOGICALS
clobetasol foam (OLUX equiv)	PA	G	DERMATOLOGICALS
clobetasol lotion (CLOBEX equiv)	PA	G	DERMATOLOGICALS
clobetasol propionate cream (TEMOVATE equiv)	-	G	DERMATOLOGICALS
CLOBETASOL PROPIONATE CREAM, IMPOYZ CREAM	-	NC	DERMATOLOGICALS
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	G	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	G	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	G	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
clobetasol propionate soln (TEMOVATE equiv)	-	G	DERMATOLOGICALS
clobetasol shampoo (CLOBEX equiv)	-	G	DERMATOLOGICALS
clobetasol spray (CLOBEX equiv)	-	G	DERMATOLOGICALS
CLOBETAVIX KIT	-	NC	DERMATOLOGICALS
CLOBEX LOTION	-	NC	DERMATOLOGICALS
CLOBEX SHAMPOO	-	NC	DERMATOLOGICALS
CLOCORTOLONE CREAM	-	NC	DERMATOLOGICALS
CLODERM CREAM	-	NC	DERMATOLOGICALS
clomiphene citrate tab (CLOMID equiv)	INF	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CLOMIPHENE TAB	INF	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
clomipramine cap (ANAFRANIL equiv)	-	G	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	G	ANTICONVULSANTS
clonazepam tab (KLONOPIN equiv)	-	G	ANTICONVULSANTS
CLONAZEPAM TAB	-	NC	ANTICONVULSANTS
clonidine ER tab (KAPVAY equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
clonidine hcl tab 0.05mg	-	NC	ANTIHYPERTENSIVES
clonidine patch (CATAPRES-TTS equiv)	-	G	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	G	ANTIHYPERTENSIVES
clopidogrel tab 75mg (PLAVIX equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
CLOPIDOGREL THERAPY PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
clorazepate tab (TRANXENE-T equiv)	-	G	ANTIANXIETY AGENTS
CLOTIC SOLN	-	NC	OTIC AGENTS
clotrimazole cream (LOTRIMIN AF equiv)	-	NC	DERMATOLOGICALS
clotrimazole soln	-	NC	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
clotrimazole/betamethasone cream (LOTRISONE equiv)	-	NC	DERMATOLOGICALS
CLOTRIMAZOLE/BETAMETHASONE LOTION	-	NC	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE equiv)	-	NC	DERMATOLOGICALS
clozapine odt tab (CLOZAPINE, FAZACLO equiv)	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CLOZAPINE ODT, FAZACLO ODT	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
clozapine tab (CLOZARIL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
COAGADEX INJ (Only available through CVS/Caremark 800-237-2767 or OptionCare 877-686-2622)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
COBENFY CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
COBENFY CAP STARTER PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
COCAINE HCL SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
CODEINE SULFATE TAB	-	G	ANALGESICS - OPIOID
colchicine cap (MITIGARE equiv)	-	NC	GOUT AGENTS
colchicine tab (COLCRYS equiv)	-	G	GOUT AGENTS
colchicine/probenecid tab (COL-BENEMID equiv)	-	G	GOUT AGENTS
COLCRYS TAB	-	NC	GOUT AGENTS
colesevelam pack (WELCHOL equiv)	-	G	ANTIHYPERLIPIDEMICS
colesevelam tab (WELCHOL equiv)	-	G	ANTIHYPERLIPIDEMICS
colestipol granule (COLESTID equiv)	-	G	ANTIHYPERLIPIDEMICS
colestipol powder packet (COLESTID equiv)	-	G	ANTIHYPERLIPIDEMICS
colestipol tab (COLESTID equiv)	-	G	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
colistimethate inj (COLY-MYCIN M equiv)	LMSP	B	ANTI-INFECTIVE AGENTS - MISC.
COLLANEX EXTERNAL POWDER	-	NC	DERMATOLOGICALS
COLY-MYCIN S OTIC SUSP	-	B	OTIC AGENTS
COMBIGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
COMBIPATCH	-	NC	ESTROGENS
COMBIVENT RESPIMAT INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
COMBOGESIC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	$0	VACCINES
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	$0	VACCINES
COMPLERA TAB	-	B	ANTIVIRALS
COMPLETE NATAL DHA	-	G	MULTIVITAMINS
CONCEPT DHA CAP	-	G	MULTIVITAMINS
CONDYLOX GEL	-	B	DERMATOLOGICALS
CONJUPRI TAB, LEVAMLODIPINE TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONSENSI TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONTRACEPTIVE GEL	OTC	$0	VAGINAL PRODUCTS
CONTRACEPTIVE SUPP	OTC	$0	VAGINAL PRODUCTS
COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CORDRAN CREAM 0.025%	-	NC	DERMATOLOGICALS
CORDRAN OINTMENT	-	NC	DERMATOLOGICALS
CORDRAN TAPE	-	NC	DERMATOLOGICALS
CORIFACT KIT	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
CORLANOR SOLN (Prior Authorization required for members age 9 years and older)	PA	B	CARDIOVASCULAR AGENTS - MISC.
CORLANOR TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
CORPHENA ORAL SOLN, RYCLORA ORAL SOLN	-	NC	ANTIHISTAMINES
CORTANE-B OTIC SOLN	-	NC	OTIC AGENTS
CORTEF TAB	-	NC	CORTICOSTEROIDS
CORTIC-ND DROPS	-	NC	OTIC AGENTS
CORTIFOAM	-	B	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	B	CORTICOSTEROIDS
CORTROPHIN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CORTROPHIN INJ GEL	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
CORVITA 150 TAB	-	NC	HEMATOPOIETIC AGENTS
COSENTYX INJ (1-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ (2-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ 300MG/2ML	-	NC	DERMATOLOGICALS
COSENTYX UNO INJ	-	NC	DERMATOLOGICALS
COTELLIC TAB (QL= 3 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COTEMPLA XR TAB, METHYLPHENIDATE ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
COVARYX HS TAB	-	G	ESTROGENS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
COVID-19 TEST	OTC	EXC	DIAGNOSTIC PRODUCTS
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	$0	VACCINES
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	$0	VACCINES
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	$0	VACCINES
COXANTO CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
CRENESSITY CAP (QL= 2 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CRENESSITY SOLN (QL= 2ml/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CREON CAP	-	B	DIGESTIVE AIDS
CRESEMBA CAP	-	NC	ANTIFUNGALS
CRESTOR TAB	-	NC	ANTIHYPERLIPIDEMICS
CREXONT CAP	-	NC	ANTIPARKINSON AGENTS
CRINONE GEL	PA	B	VAGINAL PRODUCTS
cromolyn conc (GASTROCROM equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
cromolyn neb soln (INTAL equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
cromolyn ophth soln (CROLOM equiv)	-	G	OPHTHALMIC AGENTS
CROMOLYN SODIUM OPHTH SOLN	-	G	OPHTHALMIC AGENTS
CROTAN LOTION	-	NC	DERMATOLOGICALS
cryselle tab	-	$0	CONTRACEPTIVES
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC	DIAGNOSTIC PRODUCTS
CUE HEALTH MONITOR	OTC	EXC	DIAGNOSTIC PRODUCTS
CUTAQUIG INJ	-	NC	PASSIVE IMMUNIZING AND TREATMENT AGENTS
CUTIVATE LOTION	-	NC	DERMATOLOGICALS
CUVITRU INJ	-	NC	PASSIVE IMMUNIZING AGENTS
CUVRIOR TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
cyanocobalamin inj	-	G	HEMATOPOIETIC AGENTS
cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv)	-	NC	HEMATOPOIETIC AGENTS
CYCLOBENZAPRINE COMPOUND KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine ER cap (AMRIX equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab (FLEXERIL equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CYCLOGYL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
CYCLOMYDRIL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	G	OPHTHALMIC AGENTS
cyclophosphamide cap	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOPHOSPHAMIDE TAB	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CYCLOSERINE CAP	-	NC	ANTIMYCOBACTERIAL AGENTS
CYCLOSET TAB	-	B	ANTIDIABETICS
cyclosporine cap (SANDIMMUNE equiv)	-	G	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	G	ASSORTED CLASSES
cyclosporine modified soln (NEORAL equiv)	-	G	ASSORTED CLASSES
cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days)	PA-QL	G	OPHTHALMIC AGENTS
CYCLOSPORINE OPHTH EMULSION 0.1%	-	NC	OPHTHALMIC AGENTS
CYFOLEX CAP	-	NC	HEMATOPOIETIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
CYLTEZO AUTO-INJECTOR KIT (adalimumab-adbm)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
CYLTEZO INJ (adalimumab-adbm)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
cyproheptadine syrup	-	G	ANTIHISTAMINES
cyproheptadine tab	-	G	ANTIHISTAMINES
CYSTADANE POWDER	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CYSTADANE POWDER (Only available through AnovoRx 844-288-5007)	LD	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
CYSTADROPS SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	B	OPHTHALMIC AGENTS
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	B	GENITOURINARY AGENTS - MISCELLANEOUS
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B	OPHTHALMIC AGENTS
CYTRA K CRYSTALS	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
CYTRA-3 SYRUP	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	G	ANTICOAGULANTS
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist)	LMSP-QL-RS	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DALIRESP TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
danazol cap (DANOCRINE equiv)	-	G	ANDROGENS-ANABOLIC
dantrolene cap (DANTRIUM equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
DANZITEN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
dapagliflozin tab (FARXIGA equiv) (QL= 1 tab/day)	QL	G	ANTIDIABETICS
dapagliflozin-metformin er tab (XIGDUO XR equiv) (QL= 1 tab/day)	QL	G	ANTIDIABETICS
dapagliflozin-metformin er tab 5-1000MG (XIGDUO XR equiv) (QL= 2 tabs/day)	QL	G	ANTIDIABETICS
dapsone gel (ACZONE equiv)	-	NC	DERMATOLOGICALS
dapsone gel 5% (ACZONE equiv)	-	B	DERMATOLOGICALS
dapsone tab	-	G	ANTI-INFECTIVE AGENTS - MISC.
DAPTACEL INJ, INFANRIX INJ	VAC	$0	TOXOIDS
darifenacin SR tab (ENABLEX equiv)	-	NC	URINARY ANTISPASMODICS
DARTISLA ODT TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
darunavir tab (PREZISTA equiv)	-	G	ANTIVIRALS
dasatinib tab (SPRYCEL equiv)	LMSP-PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DAURISMO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DAWNZERA INJ (QL= 1 inj/28 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
DAYBUE STIX POWDER (QL= 4 packets/day; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B	NEUROMUSCULAR AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DAYBUE STIX POWDER 8000MG (QL= 2 packets/day; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
DAYVIGO TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
DAZOMON GEL	-	EXC	DERMATOLOGICALS
deferasirox granules packet (JADENU equiv)	LMSP	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (JADENU equiv)	LMSP	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab for oral susp (EXJADE equiv)	LMSP	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
deflazacort susp (EMFLAZA equiv)	-	NC	CORTICOSTEROIDS
deflazacort tab (EMFLAZA equiv)	-	NC	CORTICOSTEROIDS
DEGLUDEC FLEXTOUCH INJ	-	NC	ANTIDIABETICS
DEGLUDEC INJ	-	NC	ANTIDIABETICS
DELESTROGEN INJ	-	NC	ESTROGENS
DELSTRIGO TAB	-	B	ANTIVIRALS
DELZICOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
demeclocycline tab (DECLOMYCIN equiv)	-	NC	TETRACYCLINES
DEMSER CAP	-	NC	ANTIHYPERTENSIVES
DENAVIR CREAM	-	NC	DERMATOLOGICALS
DENGVAXIA SUSP	VAC	$0	VACCINES
DENTA 5000 CREAM PLUS ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	$0	MOUTH/THROAT/DENTAL AGENTS
DEPACON INJ	-	NC	ANTICONVULSANTS
DEPLIN CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
DEPO-ESTRADIOL IM	-	NC	ESTROGENS
DEPO-MEDROL INJ	-	NC	CORTICOSTEROIDS
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	NC	CORTICOSTEROIDS
DEPO-PROVERA INJ	-	NC	CONTRACEPTIVES
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	$0	CONTRACEPTIVES
DERMACINRX CREAM	-	NC	DERMATOLOGICALS
DERMACINRX KIT	-	NC	DERMATOLOGICALS
DERMACINRX TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEI CS
DERMALID PAK	-	NC	DERMATOLOGICALS
DERMASORB XM KIT	-	B	DERMATOLOGICALS
DESCOVY TAB	PA	$0	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	G	ANTIDEPRESSANTS
DESLORATADINE ODT	-	EXC	ANTIHISTAMINES
DESLORATADINE SOLN	-	EXC	ANTIHISTAMINES
desloratadine tab (CLARINEX equiv)	-	EXC	ANTIHISTAMINES
DESMODA SOLN	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate nasal spray (DDAVP equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
desmopressin acetate tab (DDAVP equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DESMOPRESSIN NASAL SOLN 1.5MG/ML	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESMOPRESSIN NASAL SPRAY	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
DESONATE GEL	-	NC	DERMATOLOGICALS
desonide cream (DESOWEN equiv)	-	G	DERMATOLOGICALS
desonide gel	-	NC	DERMATOLOGICALS
desonide lotion (DESOWEN equiv)	-	NC	DERMATOLOGICALS
desonide oint (DESOWEN equiv)	-	G	DERMATOLOGICALS
DESOWEN CREAM	-	NC	DERMATOLOGICALS
DESOWEN CREAM KIT	-	NC	DERMATOLOGICALS
DESOWEN LOTION	-	NC	DERMATOLOGICALS
DESOWEN LOTION KIT	-	NC	DERMATOLOGICALS
DESOWEN OINT	-	NC	DERMATOLOGICALS
DESOWEN OINT KIT	-	NC	DERMATOLOGICALS
desoximetasone cream (TOPICORT CREAM equiv)	-	NC	DERMATOLOGICALS
desoximetasone cream 0.05% (TOPICORT equiv)	-	NC	DERMATOLOGICALS
DESOXIMETASONE GEL	-	NC	DERMATOLOGICALS
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC	DERMATOLOGICALS
desoximetasone oint 0.25% (TOPICORT equiv)	-	G	DERMATOLOGICALS
desvenlafaxine ER tab (PRISTIQ equiv)	-	G	ANTIDEPRESSANTS
DESVENLAFAXINE ER TAB	-	NC	ANTIDEPRESSANTS
DETROL LA CAP	-	NC	URINARY ANTISPASMODICS
DEXAMETHASONE CONC	-	G	CORTICOSTEROIDS
dexamethasone elixir	-	G	CORTICOSTEROIDS
dexamethasone pak (DEXPAK equiv)	-	NC	CORTICOSTEROIDS
DEXAMETHASONE PHOSPHATE INJ	-	G	CORTICOSTEROIDS
dexamethasone sodium phosphate inj	-	G	CORTICOSTEROIDS
DEXAMETHASONE SOLN	-	G	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	G	CORTICOSTEROIDS
DEXAMETHASONE TAB	-	NC	CORTICOSTEROIDS
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G7 SENSOR (15-DAY) (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
DEXILANT DR CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
dexlansoprazole DR cap (DEXILANT equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dexmethylphenidate tab (FOCALIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
DEXPAK TAB	-	NC	CORTICOSTEROIDS
DEXTENZA OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine sulfate tab 15mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine sulfate tab 20mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine sulfate tab 30mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
dextromethorphan hbr-quinidine sulfate cap (NUEDEXTA equiv) (QL= 2 caps/day)	PA-QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DHIVY TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
DIABETIC METER (all other diabetic meters)	OTC	NC	MEDICAL DEVICES AND SUPPLIES
DIACOMIT CAP (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B	ANTICONVULSANTS
DIACOMIT POWDER PACK (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B	ANTICONVULSANTS
DIALYVITE TAB	-	G	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	NC	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	G	MULTIVITAMINS
DIAPHRAGM	-	$0	MEDICAL DEVICES AND SUPPLIES
DIASTAT ACDL GEL	-	NC	ANTICONVULSANTS
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 4 doses/fill)	QL	B	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	G	ANTIANXIETY AGENTS
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	G	ANTIANXIETY AGENTS
diazepam rectal gel (QL= 4 doses/fill)	QL	G	ANTICONVULSANTS
diazepam tab (VALIUM equiv)	-	G	ANTIANXIETY AGENTS
diazoxide susp (PROGLYCEM equiv)	-	G	ANTIDIABETICS
dichlorphenamide tab (KEVEYIS equiv)	-	NC	DIURETICS
DICLOFENAC CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	G	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv)	-	NC	DERMATOLOGICALS
DICLOFENAC PATCH, FLECTOR PATCH	-	NC	DERMATOLOGICALS
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	NC	MIGRAINE PRODUCTS
diclofenac potassium cap (ZIPSOR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
diclofenac potassium tab (CATAFLAM equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac potassium tab 25mg (DICLOFENAC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
diclofenac sodium EC tab (VOLTAREN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium gel kit (VENNGEL equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium ophth soln (VOLTAREN equiv)	-	G	OPHTHALMIC AGENTS
diclofenac sodium soln 2% (PENNSAID SOLN equiv)	-	NC	DERMATOLOGICALS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac soln 1.5% (PENNSAID equiv)	-	G	DERMATOLOGICALS
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
DICLONA GEL	-	NC	DERMATOLOGICALS
DICLOTREX PAK	-	NC	DERMATOLOGICALS
dicloxacillin cap (DYNAPEN equiv)	-	G	PENICILLINS
dicyclomine cap (BENTYL equiv)	-	G	ULCER DRUGS
dicyclomine soln (BENTYL equiv)	-	G	ULCER DRUGS
dicyclomine tab (BENTYL equiv)	-	G	ULCER DRUGS
DICYCLOMINE TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINER CS
DIETHYLPROPION ER TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
diethylpropion tab	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
DIFICID SUSP (QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	B	MACROLIDES
DIFICID TAB	-	NC	MACROLIDES
DIFLORASONE CREAM	-	NC	DERMATOLOGICALS
DIFLORASONE CREAM, PSORCON CREAM	-	NC	DERMATOLOGICALS
diflorasone oint	-	NC	DERMATOLOGICALS
diflunisal tab (DOLOBID equiv)	-	G	ANALGESICS - NONNARCOTIC
difluprednate ophth emulsion (DUREZOL equiv)	-	G	OPHTHALMIC AGENTS
digoxin soln (LANOXIN equiv)	-	G	CARDIOTONICS
DIGOXIN SOLN 0.05MG/ML	-	G	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	G	CARDIOTONICS
digoxin tab 62.5mcg (LANOXIN equiv)	-	NC	CARDIOTONICS
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC	MIGRAINE PRODUCTS
dihydroergotamine mesylate nasal spray (MIGRANAL equiv) (QL= 8 sprays/fill, 2 fills/30 days)	PA-QL	G	MIGRAINE PRODUCTS
DILANTIN CAP 30MG	-	B	ANTICONVULSANTS
diltiazem ER cap (CARDIZEM CD equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (CARDIZEM SR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (DILACOR XR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap (TIAZAC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem ER cap 120mg (CARDIZEM SR equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
diltiazem ER tab (CARDIZEM LA equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
DILTIAZEM HCL COATED BEADS CAP ER 24HR 120MG	-	G	CALCIUM CHANNEL BLOCKERS
DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 120MG	-	G	CALCIUM CHANNEL BLOCKERS
diltiazem tab (CARDIZEM equiv)	-	G	CALCIUM CHANNEL BLOCKERS
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DIOVAN TAB	-	NC	ANTIHYPERTENSIVES
DIPENTUM CAP	-	B	GASTROINTESTINAL AGENTS - MISC.
DIPHENHYDRAMINE ELIXIR	-	NC	ANTIHISTAMINES
diphenhydramine inj (BENADRYL equiv)	-	G	ANTIHISTAMINES
DIPHENOXYLATE/ATROPINE LIQUID	-	B	ANTIDIARRHEAL/PROBIOTIC AGENTS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	G	ANTIDIARRHEALS
DIPTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	$0	TOXOIDS
dipyridamole tab (PERSANTINE equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
DISKETS TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
disopyramide cap (NORPACE equiv)	-	G	ANTIARRHYTHMICS
disulfiram tab (ANTABUSE equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
disulfiram tab 500mg	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIURIL SUSP	-	B	DIURETICS
divalproex ER tab (DEPAKOTE ER equiv)	-	G	ANTICONVULSANTS
divalproex sodium DR tab (DEPAKOTE equiv)	-	G	ANTICONVULSANTS
divalproex sprinkle cap (DEPAKOTE equiv)	-	G	ANTICONVULSANTS
DIVIGEL GEL, ESTROGEL GEL	-	NC	ESTROGENS
dofetilide cap (TIKOSYN equiv)	-	G	ANTIARRHYTHMICS
DOJOLVI ORAL LIQUID	-	NC	NUTRIENTS
DOLGIC PLUS TAB	-	NC	ANALGESICS - NONNARCOTIC
DOLOBID TAB	-	NC	ANALGESICS - NONNARCOTIC
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DONNATAL ELIXIR, PB-BELLADONNA ELIXIR	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
DONNATAL TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
DOPTELET SPRINKLE CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
DORYX MPC TAB	-	NC	TETRACYCLINES
dorzolamide ophth soln (TRUSOPT equiv)	-	G	OPHTHALMIC AGENTS
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	G	OPHTHALMIC AGENTS
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
DOVATO TAB	-	B	ANTIVIRALS
doxazosin tab (CARDURA equiv)	-	G	ANTIHYPERTENSIVES
doxepin cap (SINEQUAN equiv)	-	G	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	G	ANTIDEPRESSANTS
DOXEPIN HCL CAP	-	G	ANTIDEPRESSANTS
DOXEPIN HCL CONC	-	G	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
doxepin hcl cream	-	NC	DERMATOLOGICALS
doxepin tab (SILENOR equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
DOXERCALCIFEROL CAP	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxercalciferol cap (HECTOROL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
doxycycline (rosacea) cap delayed release (ORACEA equiv)	-	NC	DERMATOLOGICALS
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	G	TETRACYCLINES
DOXYCYCLINE HYCLATE CAP	-	NC	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	-	NC	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	G	TETRACYCLINES
doxycycline hyclate tab (TARGADOX equiv)	-	NC	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg	-	NC	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv)	-	G	TETRACYCLINES
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate tab (ADOXA equiv)	-	G	TETRACYCLINES
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate tab 75mg (ADOXA equiv)	-	NC	TETRACYCLINES
doxycycline susp (VIBRAMYCIN equiv)	-	G	TETRACYCLINES
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC	ANTIEMETICS
DRIZALMA DR CAP	-	NC	ANTIDEPRESSANTS
dronabinol cap (MARINOL equiv)	PA	G	ANTIEMETICS
DRONABINOL SOLN, SYNDROS SOLN	-	NC	ANTIEMETICS
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	NC	CONTRACEPTIVES
DROXIA CAP	-	B	HEMATOPOIETIC AGENTS
droxidopa cap (NORTHERA equiv)	-	NC	VASOPRESSORS
DRYSOL SOLN	-	G	DERMATOLOGICALS
DSUVIA SL TAB	-	NC	ANALGESICS - OPIOID
DUAKLIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
DUAVEE TAB	-	B	ESTROGENS
DUET	-	NC	MULTIVITAMINS
DUET DHA 400, DUET DHA BALANCED	-	NC	MULTIVITAMINS
DUETACT TAB	-	NC	ANTIDIABETICS
DULERA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
duloxetine cap 40mg (IRENKA equiv)	-	NC	ANTIDEPRESSANTS
DULOXETINE DR CAP	-	NC	ANTIDEPRESSANTS
duloxetine EC cap (CYMBALTA equiv)	-	G	ANTIDEPRESSANTS
DULOXICAINE PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DUOBRII LOTION	-	NC	DERMATOLOGICALS
DUOPA ENTERAL SUSP	-	NC	ANTIPARKINSON AGENTS
DUOVISC KIT	-	NC	OPHTHALMIC AGENTS
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
DUPIXENT PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
DURAVENT PE TAB	-	NC	COUGH/COLD/ALLERGY
DUROLANE INJ	LMSP-PA	B	MUSCULOSKELETAL THERAPY AGENTS
dutasteride cap (AVODART equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
dutasteride/tamsulosin cap (JALYN equiv)	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
DUTOPROL TAB	-	NC	ANTIHYPERTENSIVES
DUVYZAT ORAL SUSP	-	NC	NEUROMUSCULAR AGENTS
DUZALLO TAB	-	NC	GOUT AGENTS
DXEVO 11-DAY PAK	-	NC	CORTICOSTEROIDS
DYANAVEL XR CHEW	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
DYRENIUM CAP	-	B	DIURETICS
DYSPORT INJ	MSP-PA	B	NEUROMUSCULAR AGENTS
E.E.S. TAB	-	NC	MACROLIDES
EBGLYSS INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
EBGLYSS PEN INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
EB-N3 DR CAP	-	NC	MULTIVITAMINS
ECONASIL KIT	-	NC	DERMATOLOGICALS
econazole cream (SPECTAZOLE equiv) (QL= 30gm/30 days)	QL	G	DERMATOLOGICALS
ECONAZOLE NITRATE FOAM, ECOZA FOAM	-	NC	DERMATOLOGICALS
ECOZA FOAM	-	NC	DERMATOLOGICALS
EDARBI TAB	-	NC	ANTIHYPERTENSIVES
EDARBYCLOR TAB	-	NC	ANTIHYPERTENSIVES
EDECRIN TAB	-	NC	DIURETICS
EDEX INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B	CARDIOVASCULAR AGENTS - MISC.
EDLUAR SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
EDURANT PED TAB	-	B	ANTIVIRALS
EDURANT TAB	-	B	ANTIVIRALS
efavirenz tab (SUSTIVA equiv)	-	G	ANTIVIRALS
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	G	ANTIVIRALS
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	G	ANTIVIRALS
EFAVIRENZ/LAMIVUDINE/TENOFOVIR TAB	-	G	ANTIVIRALS
EFFER-K TAB	-	G	MINERALS & ELECTROLYTES
EFFEXOR XR CAP	-	NC	ANTIDEPRESSANTS
EGATEN TAB	-	NC	ANTHELMINTICS
EGRIFTA INJ	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
EGRIFTA WR KIT	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
EKTERLY TAB (QL= 8 tabs/fill; Only available through Accredo 800-803-2523 or Optum 877-445-6874)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
ELAPRASE INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELEPSIA XR TAB	-	NC	ANTICONVULSANTS
ELESTRIN GEL	-	NC	ESTROGENS
eletriptan tab (RELPAX equiv)	-	NC	MIGRAINE PRODUCTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ELIGEN B12 TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ELIQUIS SPRINKLE CAP	-	B	ANTICOAGULANTS
ELIQUIS TAB FOR ORAL SUSP	-	B	ANTICOAGULANTS
ELIQUIS TAB, ELIQUIS STARTER PACK	-	B	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	$0	CONTRACEPTIVES
ELMIRON CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
ELOCTATE INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
eltrombopag olamine powder pack for susp (PROMACTA equiv) (QL= 1 packet/day)	LMSP-PA-QL	G	HEMATOPOIETIC AGENTS
eltrombopag olamine tab (PROMACTA equiv) (QL= 1 tab/day)	LMSP-PA-QL	G	HEMATOPOIETIC AGENTS
eltrombopag olamine tab 50MG (PROMACTA equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G	HEMATOPOIETIC AGENTS
eltrombopag olamine tab 75MG (PROMACTA equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G	HEMATOPOIETIC AGENTS
eluryng vaginal ring (NUVARING equiv)	-	$0	CONTRACEPTIVES
ELYXYB SOLN	-	NC	MIGRAINE PRODUCTS
EMBECTA INSULIN SYRINGE	--OTC	G	MEDICAL DEVICES AND SUPPLIES
EMBECTA PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
EMCITATE TAB	-	NC	THYROID AGENTS
EMEND CAP	-	NC	ANTIEMETICS
EMEND SUSP	-	NC	ANTIEMETICS
EMFLAZA SUSP	-	NC	CORTICOSTEROIDS
EMFLAZA TAB	-	NC	CORTICOSTEROIDS
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	B	MIGRAINE PRODUCTS
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
EMROSI CAP	-	NC	DERMATOLOGICALS
EMSAM PATCH	-	B	ANTIDEPRESSANTS
emtricitabine cap (EMTRIVA equiv)	-	G	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	$0	ANTIVIRALS
emtricitabine-rilpivirine-tenofovir df tab (COMPLERA equiv)	-	G	ANTIVIRALS
EMTRIVA CAP	-	B	ANTIVIRALS
EMTRIVA SOLN	-	B	ANTIVIRALS
EMVERM TAB	-	NC	ANTHELMINTICS
enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 years and older)	PA	G	ANTIHYPERTENSIVES
enalapril tab (VASOTEC equiv)	-	G	ANTIHYPERTENSIVES
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	G	ANTIHYPERTENSIVES
ENBRACE HR	-	NC	MULTIVITAMINS
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ENBUMYST SOLN 0.5MG/0.1ML (QL= 12 devices/fill; Only available through Carepoint Pharmacy 855-237-9112)	LD-QL	B	DIURETICS
ENDARI POWDER PACKET	-	NC	HEMATOPOIETIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ENDOMETRIN INSERT	-	NC	VAGINAL PRODUCTS
ENDOMETRIN SUPP	-	NC	VAGINAL AND RELATED PRODUCTS
ENFLONSIA INJ	VAC	$0	PASSIVE IMMUNIZING AND TREATMENT AGENTS
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	$0	VACCINES
enoxaparin inj (LOVENOX equiv)	-	G	ANTICOAGULANTS
enpresse tab (TRI-LEVELEN equiv)	-	$0	CONTRACEPTIVES
ENSACOVE CAP (QL= 1 cap/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ENSACOVE CAP 100MG (QL= 2 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
ENSTILAR FOAM	-	NC	DERMATOLOGICALS
entacapone tab (COMTAN equiv)	-	G	ANTIPARKINSON AGENTS
ENTADFI CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	G	ANTIVIRALS
ENTEREG CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ENTRESTO CAP	-	NC	CARDIOVASCULAR AGENTS - MISC.
ENTRESTO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ENTYVIO SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
ENVARSUS XR TAB	-	NC	ASSORTED CLASSES
EOHILIA SUSP	-	NC	CORTICOSTEROIDS
EPCLUSA PAK	-	NC	ANTIVIRALS
EPCLUSA TAB	-	NC	ANTIVIRALS
EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553)	LD-PA	B	ANTICONVULSANTS
EPIDUO FORTE GEL 0.3-2.5%	-	NC	DERMATOLOGICALS
EPIDUO GEL 0.1-2.5%	-	NC	DERMATOLOGICALS
EPIFOAM AEROSOL	-	B	DERMATOLOGICALS
epinastine ophth soln (ELESTAT equiv)	-	G	OPHTHALMIC AGENTS
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	G	VASOPRESSORS
EPIPEN (JR) INJ	-	NC	VASOPRESSORS
EPIQUIN MICRO CREAM	-	NC	DERMATOLOGICALS
eplerenone tab (INSPRA equiv)	-	G	ANTIHYPERTENSIVES
EPRONTIA SOLN	-	NC	ANTICONVULSANTS
EPSOLAY CREAM	-	NC	DERMATOLOGICALS
EQUETRO CAP	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ERGOCAL CAP	-	NC	VITAMINS
ERGOLOID MESYLATES TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ERGOMAR SL TAB	-	NC	MIGRAINE PRODUCTS
ERIVEDGE CAP (QL= 1 cap/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB (QL= 4 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB 240MG (QL= 1 tab/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
erlotinib tab (TARCEVA equiv) (QL= 1 tab/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tabs/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERMEZA SOLN 150 MCG/5ML	-	NC	THYROID AGENTS
ERTACZO CREAM	-	NC	DERMATOLOGICALS
ERY PAD	-	NC	DERMATOLOGICALS
ERYPED SUSP	-	NC	MACROLIDES
ERYTHROMYCIN CAP DR (Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	B	MACROLIDES
erythromycin DR cap (Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	G	MACROLIDES
ERYTHROMYCIN EC CAP (Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	B	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv) (Step Therapy requires trial of azithromycin or clarithromycin)	ST	G	MACROLIDES
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	NC	MACROLIDES
erythromycin gel	-	G	DERMATOLOGICALS
erythromycin ophth oint	-	G	OPHTHALMIC AGENTS
ERYTHROMYCIN OPHTH OINT	-	NC	OPHTHALMIC AGENTS
erythromycin pad	-	G	DERMATOLOGICALS
erythromycin soln	-	G	DERMATOLOGICALS
erythromycin tab (ERY-TAB equiv) (Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg)	ST	G	MACROLIDES
erythromycin tab (ERYTHROMYCIN equiv) (Step Therapy require trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	G	MACROLIDES
erythromycin/benzoyl peroxide gel	-	G	DERMATOLOGICALS
ESBRIET CAP	-	NC	RESPIRATORY AGENTS - MISC.
ESBRIET TAB	-	NC	RESPIRATORY AGENTS - MISC.
ESCITALOPRAM CAP	-	NC	ANTIDEPRESSANTS
escitalopram soln (LEXAPRO equiv)	-	G	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	G	ANTIDEPRESSANTS
ESKATA SOLN	-	NC	DERMATOLOGICALS
eslicarbazepine acetate tab (APTIOM equiv)	-	NC	ANTICONVULSANTS
esomeprazole cap (NEXIUM equiv) (Rx Only)	PA	G	ULCER DRUGS
esomeprazole DR granule pack (NEXIUM equiv) (Prior Authorization required for members age 9 years and older)	PA	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
ESPEROCT INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
estazolam tab (PROSOM equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	G	ESTROGENS
ESTRACE VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
estradiol cream (ESTRACE equiv)	-	G	VAGINAL PRODUCTS
estradiol gel 0.06% (ESTROGEL equiv)	-	NC	ESTROGENS
estradiol patch (CLIMARA equiv)	-	G	ESTROGENS
estradiol patch (VIVELLE-DOT, MINIVELLE equiv)	-	G	ESTROGENS
estradiol tab (ESTRACE equiv)	-	G	ESTROGENS
estradiol td gel (DIVIGEL, ESTROGEL equiv) (QL= 1 packet/day)	QL	G	ESTROGENS
estradiol td gel 1.25mg (DIVIGEL equiv) (QL= 1 packet/day)	QL	G	ESTROGENS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill)	QL	G	VAGINAL PRODUCTS
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	G	ESTROGENS
estradiol/norethindrone tab (ACTIVELLA equiv)	-	G	ESTROGENS
ESTRING (3 copays per Rx)	-	B	VAGINAL PRODUCTS
estrogens, conjugated tab (PREMARIN equiv)	-	G	ESTROGENS
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ETCAMAH TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ethacrynic tab (EDECRIN equiv)	-	NC	DIURETICS
ethambutol tab (MYAMBUTOL equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
ethosuximide cap (ZARONTIN equiv)	-	G	ANTICONVULSANTS
ethosuximide soln (ZARONTIN equiv)	-	G	ANTICONVULSANTS
etodolac cap (LODINE equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
etodolac ER tab (LODINE XL equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
etodolac tab	-	G	ANALGESICS - ANTI-INFLAMMATORY
etoposide cap (VEPESID equiv)	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
etravirine tab (INTELENCE equiv)	-	G	ANTIVIRALS
EUCRISA OINT	-	NC	DERMATOLOGICALS
EULEXIN CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EURAX CREAM	-	NC	DERMATOLOGICALS
EVAMIST SPRAY	-	B	ESTROGENS
EVEKEO ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab (ZORTRESS equiv)	PA	G	MISCELLANEOUS THERAPEUTIC CLASSES
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EVIVO LIQUID	-	NC	ANTIDIARRHEALS
EVOCLIN FOAM	-	NC	DERMATOLOGICALS
EVOTAZ TAB	-	B	ANTIVIRALS
EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
EVRYSDI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
EVZIO INJ	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
EVZIO INJ	-	NC	ANTIDOTES
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC	DERMATOLOGICALS
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC	DERMATOLOGICALS
exemestane tab (AROMASIN equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXENATIDE INJ (BYETTA INJ EQUIV)	-	NC	ANTIDIABETICS
EXTAVIA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EXXUA TAB/EXXUA TITRATION PACK	-	NC	ANTIDEPRESSANTS
EYSUVIS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
EZALLOR SPRINKLE CAP (Prior Authorization required for members age 9 years and older)	PA	B	ANTIHYPERLIPIDEMICS
ezetimibe tab (ZETIA equiv)	-	G	ANTIHYPERLIPIDEMICS
EZETIMIBE/ATORVASTATIN TAB	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (ezetimibe/simvastatin 10-80 mg is not covered)	-	NC	ANTIHYPERLIPIDEMICS
FABHALTA CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
FABIOR AEROSOL FOAM	-	NC	DERMATOLOGICALS
FABRAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
FACTIVE TAB	-	NC	FLUOROQUINOLONES
FALESSA TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	G	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	G	ULCER DRUGS
famotidine tab (PEPCID equiv) (Rx Only)	-	G	ULCER DRUGS
FANAPT TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANAPT TITRATION PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANAPT TITRATION PACK 1MG/2MG/6MG/8MG	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FARXIGA TAB	-	NC	ANTIDIABETICS
FASENRA PEN INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST	G	GOUT AGENTS
FEIBA INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
felbamate susp (FELBATOL equiv)	-	G	ANTICONVULSANTS
felbamate tab (FELBATOL equiv)	-	G	ANTICONVULSANTS
FELBATOL TAB	-	NC	ANTICONVULSANTS
felodipine ER tab (PLENDIL equiv)	-	G	CALCIUM CHANNEL BLOCKERS
FEM PH GEL	-	B	VAGINAL PRODUCTS
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	$0	MEDICAL DEVICES AND SUPPLIES
FEMHRT TAB	-	NC	ESTROGENS
FEMLYV TAB	-	NC	CONTRACEPTIVES
FEMRING (3 copays per Rx)	-	B	VAGINAL PRODUCTS
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	G	ANTIHYPERLIPIDEMICS
FENOFIBRATE CAP, LIPOFEN CAP	-	NC	ANTIHYPERLIPIDEMICS
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC	ANTIHYPERLIPIDEMICS
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	G	ANTIHYPERLIPIDEMICS
fenofibric acid DR cap (TRILIPIX equiv)	-	G	ANTIHYPERLIPIDEMICS
FENOFIBRIC TAB	-	NC	ANTIHYPERLIPIDEMICS
FENOFIBRIC TAB, FIBRICOR TAB	-	NC	ANTIHYPERLIPIDEMICS
fenoprofen calcium cap (NALFON equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN CAP, NAFLON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPRON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENTANYL BUCCAL TAB	-	NC	ANALGESICS - OPIOID
FENTANYL CITRATE LOLLIPOP	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
fentanyl citrate lollipop (ACTIQ equiv)	-	NC	ANALGESICS - OPIOID
fentanyl patch (DURAGESIC equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC	ANALGESICS - OPIOID
FENTORA TAB	-	NC	ANALGESICS - OPIOID
FEONYX TAB	-	NC	HEMATOPOIETIC AGENTS
FERIVA 21/7 TAB	-	NC	HEMATOPOIETIC AGENTS
FEROTRINSIC CAP	-	G	HEMATOPOIETIC AGENTS
ferrex 150 forte cap	-	G	HEMATOPOIETIC AGENTS
ferric citrate tab (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B	GASTROINTESTINAL AGENTS - MISC.
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B	ANTIDOTES
FERRO-PLEX TAB	-	NC	HEMATOPOIETIC AGENTS
ferrous sulfate elixir	OTC	NC	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID	OTC	NC	HEMATOPOIETIC AGENTS
ferrous sulfate soln	OTC	NC	HEMATOPOIETIC AGENTS
FESILTY INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	G	URINARY ANTISPASMODICS
FETZIMA CAP	-	NC	ANTIDEPRESSANTS
FETZIMA TITRATION PACK	-	NC	ANTIDEPRESSANTS
FIASP FLEXTOUCH INJ	-	NC	ANTIDIABETICS
FIASP INJ	-	NC	ANTIDIABETICS
FIASP PENFILL INJ, FIASP PUMP CARTRIDGE	-	NC	ANTIDIABETICS
FIBRIK CAP	-	NC	MULTIVITAMINS
FIBRYGA INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
fidaxomicin tab (DIFICID equiv) (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	G	MACROLIDES
FILKRI INJ	-	NC	HEMATOPOIETIC AGENTS
FILSPARI TAB (QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B	GENITOURINARY AGENTS - MISCELLANEOUS
FILSUVEZ GEL 10%	MSP-PA	B	DERMATOLOGICALS
FINACEA FOAM	-	B	DERMATOLOGICALS
finasteride tab (PROPECIA equiv)	-	EXC	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
fingolimod hcl cap 0.5mg (GILENYA equiv) (QL= 1 cap/day)	LMSP-QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ANTICONVULSANTS
FIRAZYR INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	B	ANTIMYASTHENIC/CHOLINERGIC AGENTS
FIRMAGON INJ	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FIRST METRONIDAZOLE SUSP	-	B	ANTI-INFECTIVE AGENTS - MISC.
FIRST MOUTHWASH BLM	-	B	MOUTH/THROAT/DENTAL AGENTS
FIRST OMEPRAZOLE SUSP	PA	B	ULCER DRUGS
FIRST PANTOPRAZOLE SUSP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
FIRVANQ SOLN 25MG/ML	-	G	ANTI-INFECTIVE AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FIRVANQ SOLN 50MG/ML	-	G	ANTI-INFECTIVE AGENTS - MISC.
FLAREX OPHTH SUSP	-	B	OPHTHALMIC AGENTS
flavoxate tab (URISPAS equiv)	-	G	URINARY ANTISPASMODICS
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
flecainide tab (TAMBOCOR equiv)	-	G	ANTIARRHYTHMICS
FLOLIPID SUSP (Prior Authorization required for members age 9 years and older)	PA	B	ANTIHYPERLIPIDEMICS
FLONASE SENSIMIST NASAL SPRAY	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
FLO-PRED SUSP	-	NC	CORTICOSTEROIDS
FLORIVA CHEW TAB	-	NC	MULTIVITAMINS
FLORIVA PLUS DROPS	-	NC	MULTIVITAMINS
FLOVENT DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUAD INJ (QL= 1 inj/28 days)	QL-VAC	$0	VACCINES
FLUBLOK INJ (QL= 1 inj/28 days)	QL-VAC	$0	VACCINES
FLUCELVAX INJ (QL= 1 inj/28 days)	QL-VAC	$0	VACCINES
fluconazole susp (DIFLUCAN equiv)	-	G	ANTIFUNGALS
fluconazole tab (DIFLUCAN equiv)	-	G	ANTIFUNGALS
flucytosine cap (ANCOBON equiv)	-	G	ANTIFUNGALS
fludrocortisone tab (FLORINEF equiv)	-	G	CORTICOSTEROIDS
FLULAVAL INJ, FLUARIX INJ (QL= 1 inj/28 days)	QL-VAC	$0	VACCINES
FLUMIST NASAL (QL= 1 dose/28 days)	QL-VAC	$0	VACCINES
flunisolide nasal soln (QL= 2 bottles/fill)	QL	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluocinolone acetonide cream	-	G	DERMATOLOGICALS
fluocinolone acetonide oil	-	G	DERMATOLOGICALS
fluocinolone acetonide oint	-	G	DERMATOLOGICALS
fluocinolone acetonide soln	-	G	DERMATOLOGICALS
fluocinolone otic oil (DERMOTIC equiv)	-	G	OTIC AGENTS
fluocinonide cream 0.05% (LIDEX equiv)	-	G	DERMATOLOGICALS
fluocinonide cream 0.1%	-	NC	DERMATOLOGICALS
fluocinonide emollient cream	-	G	DERMATOLOGICALS
fluocinonide gel	-	G	DERMATOLOGICALS
fluocinonide oint	-	G	DERMATOLOGICALS
fluocinonide soln	-	G	DERMATOLOGICALS
FLUOPAR KIT	-	NC	DERMATOLOGICALS
FLUORABON SOLN ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	$0	MINERALS & ELECTROLYTES
FLUORAC CREAM	-	NC	DERMATOLOGICALS
FLUORIDE CHW 0.25MG ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0	MINERALS & ELECTROLYTES
FLUORIDEX SENSITIVITY PASTE	-	G	MOUTH/THROAT/DENTAL AGENTS
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	G	OPHTHALMIC AGENTS
fluorouracil cream (EFUDEX CREAM equiv)	-	G	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	NC	DERMATOLOGICALS
FLUOROURACIL SOLN	-	B	DERMATOLOGICALS
fluorouracil soln (FLUOROURACIL equiv)	-	G	DERMATOLOGICALS
FLUOVIX PAK	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
fluoxetine cap (PROZAC equiv)	-	G	ANTIDEPRESSANTS
FLUOXETINE CAP (PMDD)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
fluoxetine soln (PROZAC equiv)	-	G	ANTIDEPRESSANTS
fluoxetine tab (PROZAC equiv)	-	G	ANTIDEPRESSANTS
fluoxetine tab 60mg	-	NC	ANTIDEPRESSANTS
fluoxetine weekly cap (PROZAC equiv)	-	NC	ANTIDEPRESSANTS
fluphenazine tab (PROLIXIN equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FLURANDRENOL LOTION	-	NC	DERMATOLOGICALS
flurandrenolide cream (CORDRAN equiv)	-	NC	DERMATOLOGICALS
flurandrenolide oint (CORDRAN equiv)	-	NC	DERMATOLOGICALS
FLURAZEPAM CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
FLURBIPROFEN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
FLURBIPROFEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
flurbiprofen tab (ANSAID equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FLUTAMIDE CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
flutamide cap (EULEXIN equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FLUTICASONE DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100MCG/AC	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200MCG/AC	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE LOTION	-	NC	DERMATOLOGICALS
fluticasone nasal spray (FLONASE equiv)	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	G	DERMATOLOGICALS
fluticasone propionate hfa inhal aero (FLUTICASONE equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone propionate lotion (CUTIVATE equiv)	-	NC	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	G	DERMATOLOGICALS
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 115-21 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 230-21 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-SALMETEROL INHALER 45-21 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv)	-	NC	ANTIHYPERLIPIDEMICS
fluvastatin ER tab (LESCOL XL equiv)	-	NC	ANTIHYPERLIPIDEMICS
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	G	ANTIDEPRESSANTS
fluvoxamine tab (LUVOX equiv)	-	G	ANTIDEPRESSANTS
FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days)	QL-VAC	$0	VACCINES
FML FORTE OPHTH SUSP	-	B	OPHTHALMIC AGENTS
FOCALIN XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
FOLBEE PLUS CZ TAB	-	G	MULTIVITAMINS
folbee tab (FOLGARD RX equiv)	-	NC	HEMATOPOIETIC AGENTS
FOLET ONE	-	NC	MULTIVITAMINS
FOLGARD RX TAB	-	NC	HEMATOPOIETIC AGENTS
folic acid tab 1mg ($0 copay for female members only; All other members covered at generic copay)	-	$0	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for female members only)	OTC	$0	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for female members only)	OTC	$0	HEMATOPOIETIC AGENTS
FOLIKA-V TAB	-	NC	MULTIVITAMINS
FOLITE TAB	-	NC	HEMATOPOIETIC AGENTS
FOLTANX TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
FOLVITE-FE TAB	-	NC	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	-	G	ANTICOAGULANTS
formoterol fumarate neb soln (PERFOROMIST equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FORTAMET TAB	-	NC	ANTIDIABETICS
FORTEO INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FORZINITY INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX+D TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
fosamprenavir tab (LEXIVA equiv)	-	G	ANTIVIRALS
fosfomycin tromethamine powder pack (MONUROL equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
fosinopril tab (MONOPRIL equiv)	-	G	ANTIHYPERTENSIVES
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	G	ANTIHYPERTENSIVES
FOSRENOL CHEW TAB	-	B	GASTROINTESTINAL AGENTS - MISC.
FOSRENOL POWDER PACK	-	B	GASTROINTESTINAL AGENTS - MISC.
FOTIVDA CAP (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FOUNDAYO TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
FRAGMIN INJ	-	B	ANTICOAGULANTS
FRAICHE 5000 SENSITIVE GEL	-	NC	MOUTH/THROAT/DENTAL AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
FREESTYLE FREEDOM LITE METER	OTC	$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE INSULINX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 3-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE METER	OTC	$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LITE TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
FREESTYLE PRECISION NEO METER	OTC	$0	MEDICAL DEVICES AND SUPPLIES
FREESTYLE PRECISION NEO TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
FREESTYLE TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
FROVA TAB	-	NC	MIGRAINE PRODUCTS
frovatriptan tab (FROVA equiv)	-	NC	MIGRAINE PRODUCTS
FRUZAQLA CAP 1MG (QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FRUZAQLA CAP 5MG (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FULPHILA INJ	LMSP	B	HEMATOPOIETIC AGENTS
FULVICIN P/G TAB	-	NC	ANTIFUNGALS
FULVICIN P/G TAB, GRISEOFULVIN ULTRA MICRO TAB	-	NC	ANTIFUNGALS
FUROSCIX KIT	-	NC	DIURETICS
FUROSCIX READYFLOW INJ	-	NC	DIURETICS
FUROSEMIDE SOLN	-	G	DIURETICS
furosemide soln (LASIX equiv)	-	G	DIURETICS
furosemide tab (LASIX equiv)	-	G	DIURETICS
FUZEON INJ	-	NC	ANTIVIRALS
FYCOMPA SUSP	-	B	ANTICONVULSANTS
FYCOMPA TAB	-	B	ANTICONVULSANTS
FYLNETRA INJ	-	NC	HEMATOPOIETIC AGENTS
gabapentin (once-daily) tab (GRALISE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
gabapentin cap 100mg (NEURONTIN equiv) (QL= 9 caps/day)	QL	G	ANTICONVULSANTS
gabapentin cap 200mg (RELGAABI equiv)	-	NC	ANTICONVULSANTS
gabapentin cap 300mg (NEURONTIN equiv) (QL= 6 caps/day)	QL	G	ANTICONVULSANTS
gabapentin cap 400mg (NEURONTIN equiv) (QL= 4 caps/day)	QL	G	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	G	ANTICONVULSANTS
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	G	ANTICONVULSANTS
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	G	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
GABARONE TAB	-	NC	ANTICONVULSANTS
GALAFOLD CAP (QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
galantamine ER cap (RAZADYNE ER equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALANTAMINE SOLN	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
galantamine tab (RAZADYNE equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GALZIN CAP	-	NC	MINERALS & ELECTROLYTES
GAMASTAN S/D INJ	MSP-PA	B	PASSIVE IMMUNIZING AND TREATMENT AGENTS
GAMUNEX INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
GANCICLOVIR INJ	MSP	B	ANTIVIRALS
ganciclovir inj (CYTOVENE equiv)	MSP	B	ANTIVIRALS
GARDASIL 9 INJ	VAC	$0	VACCINES
gatifloxacin ophth soln (ZYMAXID equiv)	-	G	OPHTHALMIC AGENTS
GATTEX KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
GAVILYTE-C SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	$0	LAXATIVES
GAVRETO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GEAMETDRAY GEL	-	NC	DERMATOLOGICALS
gefitinib tab (IRESSA equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GELCLAIR GEL	-	B	MOUTH/THROAT/DENTAL AGENTS
gemfibrozil tab (LOPID equiv)	-	G	ANTIHYPERLIPIDEMICS
GEMTESA TAB	-	NC	URINARY ANTISPASMODICS
GEN7T LOTION	-	NC	DERMATOLOGICALS
GEN7T PAD 3.5%	-	NC	DERMATOLOGICALS
GEN7T PLUS LOTION	-	NC	DERMATOLOGICALS
GEN7T PLUS PAD	-	NC	DERMATOLOGICALS
GENOTROPIN INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENOTROPIN INJ 5MG	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENOTROPIN MINIQUICK INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPHTH OINT	-	G	OPHTHALMIC AGENTS
gentamicin ophth soln (GARAMYCIN equiv)	-	G	OPHTHALMIC AGENTS
gentamicin sulfate cream	-	G	DERMATOLOGICALS
gentamicin sulfate oint	-	G	DERMATOLOGICALS
GENVISC 850 INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
GENVOYA TAB	-	B	ANTIVIRALS
GIALAX KIT	-	NC	LAXATIVES
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	$0	CONTRACEPTIVES
GILENYA CAP 0.25MG (QL= 1 cap/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GILENYA CAP 0.5MG	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GIMOTI NASAL SPRAY	-	NC	GASTROINTESTINAL AGENTS - MISC.
GLASSIA INJ	MSP-PA	B	RESPIRATORY AGENTS - MISC.
glatiramer inj (COPAXONE equiv)	LMSP-PA	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEOSTINE CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	G	ANTIDIABETICS
GLIMEPIRIDE TAB	-	NC	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	G	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	G	ANTIDIABETICS
GLIPIZIDE TAB	-	NC	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	G	ANTIDIABETICS
GLOPERBA SOLN (Prior Authorization required for members age 9 years and older)	PA	B	GOUT AGENTS
glucagon (rdna) for inj kit (QL= 2 inj/fill)	QL	G	ANTIDIABETICS
GLUCAGON DIAGNOSTIC INJ	-	NC	DIAGNOSTIC PRODUCTS
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUMETZA TAB 1000MG	-	NC	ANTIDIABETICS
GLUMETZA TAB 500MG	-	NC	ANTIDIABETICS
GLYBURID MCR TAB	-	G	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	G	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	G	ANTIDIABETICS
GLYCATE TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC	ULCER DRUGS
glycerol phenylbutyrate liquid (RAVICTI equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
glycopyrrolate oral soln (CUVPOSA equiv)	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
glycopyrrolate tab (ROBINUL equiv)	-	G	ULCER DRUGS
GLYGEST PAK	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
GLYXAMBI TAB	-	NC	ANTIDIABETICS
GOCOVRI CAP	-	NC	ANTIPARKINSON AGENTS
GOLYTELY SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	$0	LAXATIVES
GOMEKLI CAP (QL= 84 caps/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GOMEKLI CAP 1MG (QL= 168 caps/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GOMEKLI TAB FOR ORAL SUSP (QL= 168 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GONITRO POWDER	-	NC	ANTIANGINAL AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
GRALISE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	G	ANTIEMETICS
GRANISOL ORAL SOLN	-	NC	ANTIEMETICS
GRANIX INJ	-	NC	HEMATOPOIETIC AGENTS
GRASTEK SL TAB	-	NC	BIOLOGICALS MISC
griseofulvin micro tab (GRIFULVIN V equiv)	-	G	ANTIFUNGALS
griseofulvin susp (GRIFULVIN equiv)	-	G	ANTIFUNGALS
griseofulvin tab (GRIS-PEG equiv)	-	G	ANTIFUNGALS
GUAIFENESEN SYRUP	-	NC	COUGH/COLD/ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	G	COUGH/COLD/ALLERGY
guaifenesin-DM oral liquid (ROBITUSSIN equiv)	-	NC	COUGH/COLD/ALLERGY
guanfacine ER tab (INTUNIV equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
guanfacine IR tab (TENEX equiv)	-	G	ANTIHYPERTENSIVES
GVOKE INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GVOKE INJ KIT (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GVOKE PFS INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GWYN LO PATCH	-	NC	CONTRACEPTIVES
HADLIMA INJ (adalimumab-bwwd)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HADLIMA PUSH INJ (adalimumab-bwwd)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HAEGARDA INJ (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
halcinonide cream (HALOG equiv)	-	NC	DERMATOLOGICALS
HALCINONIDE SOLN	-	NC	DERMATOLOGICALS
halcinonide soln (HALOG equiv)	-	NC	DERMATOLOGICALS
HALOBETASOL AER	-	NC	DERMATOLOGICALS
HALOBETASOL AERO	-	NC	DERMATOLOGICALS
halobetasol propionate cream (ULTRAVATE equiv)	-	G	DERMATOLOGICALS
halobetasol propionate oint (ULTRAVATE equiv)	-	G	DERMATOLOGICALS
HALOG CREAM	-	NC	DERMATOLOGICALS
HALOG OINT	-	NC	DERMATOLOGICALS
HALOG SOLN	-	NC	DERMATOLOGICALS
halonate pac kit (ULTRAVATE KIT equiv)	-	NC	DERMATOLOGICALS
haloperidol lactate conc (HALDOL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
haloperidol tab (HALDOL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
HARLIKU TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HARVONI PELLET PAK	-	NC	ANTIVIRALS
HARVONI TAB	-	NC	ANTIVIRALS
HAVRIX INJ, VAQTA INJ	VAC	$0	VACCINES
HC BUTYRATE CREAM	-	NC	DERMATOLOGICALS
HC BUTYRATE SOLN	-	NC	DERMATOLOGICALS
HC PRAMOXINE CREAM 1-2.5%	-	G	DERMATOLOGICALS
HC/IODOQUIN CREAM	-	NC	DERMATOLOGICALS
HC/PRAMOXINE CREAM 1-2.35%	-	NC	DERMATOLOGICALS
HC-LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
HELIDAC PACK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINER CS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HELIXATE/KOGENATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEMADY TAB	-	NC	CORTICOSTEROIDS
HEMANGEOL ORAL SOLN (QL= 9.6mL/day; 1750mL/365 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B	BETA BLOCKERS
HEMANGEOL SOLN (QL= 9.6mL/day; 1750mL/365 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B	BETA BLOCKERS
HEMLIBRA INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEMOFIL M, KOATE INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEPCLUDEX INJ	-	NC	ANTIVIRALS
HEPLISAV-B INJ	VAC	$0	VACCINES
HERCEPTIN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HERNEXEOS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HETLIOZ CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
HETLIOZ SUSP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
HIXDEFRIMA SOLN	-	NC	DERMATOLOGICALS
HIZENTRA INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
HOMATROPINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
HORIZANT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HULIO INJ (adalimumab-fkjp)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HULIO KIT (adalimumab-fkjp)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMALOG JR KWIKPEN INJ	-	B	ANTIDIABETICS
HUMALOG KWIKPEN INJ	-	B	ANTIDIABETICS
HUMALOG MIX INJ	-	B	ANTIDIABETICS
HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN	-	B	ANTIDIABETICS
HUMALOG PEN INJ	-	B	ANTIDIABETICS
HUMALOG TEMPO PEN	-	B	ANTIDIABETICS
HUMATIN CAP	-	NC	AMINOGLYCOSIDES
HUMATROPE INJ, ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HUMIRA INJ 10MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 20MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 40MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 80MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC UC STARTER PACK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN MIX INJ	OTC	B	ANTIDIABETICS
HUMULIN MIX PEN INJ	OTC	B	ANTIDIABETICS
HUMULIN N INJ	OTC	B	ANTIDIABETICS
HUMULIN N PEN INJ	OTC	B	ANTIDIABETICS
HUMULIN R INJ	OTC	B	ANTIDIABETICS
HUMULIN R INJ U-500	-	B	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HUMULIN R U-500 KWIKPEN INJ	-	B	ANTIDIABETICS
HURRISEAL MIS SNAP	-	NC	MEDICAL DEVICES AND SUPPLIES
HYALGAN INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
HYCAMTIN CAP	LMSP-PA	B	ANTINEOPLASTICS
HYCLODEX SOLN	-	NC	DERMATOLOGICALS
HYCODAN SYRUP	-	B	COUGH/COLD/ALLERGY
HYCOFENIX SOLN	-	NC	COUGH/COLD/ALLERGY
HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	G	COUGH/COLD/ALLERGY
hydralazine tab (APRESOLINE equiv)	-	G	ANTIHYPERTENSIVES
hydrochlorothiazide cap (MICROZIDE equiv)	-	G	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	G	DIURETICS
HYDROCODONE BITARTRATE ER CAP (QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	B	ANALGESICS - OPIOID
HYDROCODONE BITARTRATE ER TAB (QL= 1 tab/day; Step Therapy require step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	G	ANALGESICS - OPIOID
hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab (LORTAB equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	G	COUGH/COLD/ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	G	COUGH/COLD/ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	G	ANALGESICS - OPIOID
HYDROCODONE/IBUPROFEN TAB 10-200MG	-	B	ANALGESICS - OPIOID
HYDROCORTISONE ACETATE CREAM, MICORT-HC CREAM	-	NC	DERMATOLOGICALS
HYDROCORTISONE ACETATE/PRAMOXINE CREAM	-	G	ANORECTAL AND RELATED PRODUCTS
hydrocortisone butyrate cream (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE BUTYRATE LIPO CREAM	-	NC	DERMATOLOGICALS
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE BUTYRATE OINT	-	NC	DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE CREAM	-	G	ANORECTAL AND RELATED PRODUCTS
hydrocortisone cream (PROCTOCORT equiv)	-	G	DERMATOLOGICALS
hydrocortisone enema (CORTENEMA equiv)	-	G	ANORECTAL AGENTS
hydrocortisone lotion (HYTONE equiv)	-	G	DERMATOLOGICALS
hydrocortisone lotion (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone lotion 2% (ALA SCALP equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE LOTION 2.5%	-	G	DERMATOLOGICALS
hydrocortisone oint	-	G	DERMATOLOGICALS
HYDROCORTISONE PAK	-	NC	DERMATOLOGICALS
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	G	DERMATOLOGICALS
hydrocortisone succinate inj 100mg (SOLU-CORTEF equiv) (QL= 2 vials/fill)	QL	G	CORTICOSTEROIDS
hydrocortisone supp (ANUSOL HC equiv)	-	G	ANORECTAL AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
hydrocortisone tab (CORTEF equiv)	-	G	CORTICOSTEROIDS
hydrocortisone valerate cream (WESTCORT equiv)	-	NC	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	NC	DERMATOLOGICALS
HYDROCORTISONE/PRAMOXINE SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
hydromorphone ER tab (EXALGO TAB equiv)	-	NC	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	NC	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	G	ANALGESICS - OPIOID
hydroquinone cream/sunscreen (LUSTRA ULTRA equiv)	-	NC	DERMATOLOGICALS
hydroquinone micro cream (EPIQUIN MICRO equiv)	-	NC	DERMATOLOGICALS
HYDROXYCHLOROQUINE TAB	-	G	ANTIMALARIALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	G	ANTIMALARIALS
HYDROXYM GEL	-	NC	DERMATOLOGICALS
HYDROXYPROGESTERONE CAPROATE INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyurea cap (HYDREA equiv)	-	G	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	G	ANTIANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	G	ANTIANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	G	ANTIANXIETY AGENTS
HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	DERMATOLOGICALS
HYLAMEND GEL FIRST AID	-	NC	ANTISEPTICS & DISINFECTANTS
HYLINATE LOTION	-	NC	DERMATOLOGICALS
HYMOVIS INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
HYMPAVZI INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
HYOPHEN TAB	-	B	ANTI-INFECTIVE AGENTS - MISC.
hyophen tab (PROSED DS equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
HYOSCYAMINE ELXIR	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
HYOSCYAMINE INJ	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	G	ULCER DRUGS
HYOSCYAMINE SULFATE ER TAB	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	G	ULCER DRUGS
HYOSCYAMINE SULFATE SL TAB	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	G	ULCER DRUGS
HYOSCYAMINE TAB	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
hyoscyamine tab (LEVSIN equiv)	-	G	ULCER DRUGS
HYPER-SAL NEB SOLN 7%	-	B	COUGH/COLD/ALLERGY
HYQVIA INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
HYRIMOZ INJ (adalimumab-adaz)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
HYRIMOZ PFS INJ (adalimumab-adaz)	-	NC	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
HYRNUO TAB (QL= 4 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
IBRANCE CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBRANCE TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBSRELA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
IBTROZI CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBU 600-EZS KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab	-	G	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen tab ((RX only))	-	G	ANALGESICS - ANTI-INFLAMMATORY
IBUPROFEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ibuprofen-famotidine tab (DUEXIS equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ICAR-C PLUS TAB 100-250-0.025-1 MG	-	B	HEMATOPOIETIC AGENTS
icatibant inj (FIRAZYR equiv)	LMSP-PA	G	HEMATOLOGICAL AGENTS - MISC.
ICLUSIG TAB (QL= 1 tab/day; Only available through AcariaHealth 800-511-5144)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
icosapent ethyl cap (VASCEPA equiv) (QL= 4 caps/day)	QL	G	ANTIHYPERLIPIDEMICS
ICOTYDE TAB	-	NC	DERMATOLOGICALS
IDACIO INJ (adalimumab-aacf)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
IDELVION INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IDVYNSO TAB	-	NC	ANTIVIRALS
IHEEZO GEL	-	NC	OPHTHALMIC AGENTS
ILEVRO OPHTH SUSP	-	B	OPHTHALMIC AGENTS
imatinib tab (GLEEVEC equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 140MG (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 140MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 280MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA TAB 420MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
imipramine pamoate cap (TOFRANIL PM equiv)	-	G	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	G	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	G	DERMATOLOGICALS
IMIQUIMOD CREAM 3.75%	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
imiquimod cream 3.75% (IMIQUIMOD equiv)	-	NC	DERMATOLOGICALS
IMITREX 4MG INJ, ZEMBRACE INJ	-	NC	MIGRAINE PRODUCTS
IMITREX INJ	-	NC	MIGRAINE PRODUCTS
IMITREX TAB	-	NC	MIGRAINE PRODUCTS
IMKELDI SOLUTION	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMOVAX INJ	VAC	EXC	VACCINES
IMPAVIDO CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
IMPEKLO LOTION	-	NC	DERMATOLOGICALS
IMPOYZ CREAM	-	NC	DERMATOLOGICALS
IMULDOSA SYRINGE	-	NC	DERMATOLOGICALS
IMVEXXY SUPP	-	NC	VAGINAL PRODUCTS
INBRIJA INH POWDER (QL= 10 caps/day; Only available through Sterling 888-618-4126 or Walgreens 888-347-3416)	LD-PA-QL	B	ANTIPARKINSON AND RELATED THERAPY AGENTS
INCRELEX INJ (Only available through AnovoRx 844-288-5007)	LD	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
INCRUSE ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
indapamide tab (LOZOL equiv)	-	G	DIURETICS
INDERAL XL CAP, INNOPRAN XL CAP	-	NC	BETA BLOCKERS
INDOCIN SUPP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INDOCIN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin cap (INDOCIN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
INDOMETHACIN CAP, TIVORBEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin CR cap (INDOCIN SR equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
indomethacin suppository (INDOCIN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
indomethacin susp (INDOCIN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INFLATHERM PAK	-	NC	ANALGESICS - ANTI-INFLAMMATORY
INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INGREZZA PACK 40-80MG (QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INGREZZA SPRINKLE CAP (QL= 1 cap/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INLURIYO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Orsini 800-410-8575)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INLYTA TAB (QL=4 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INLYTA TAB 1MG (QL= 8 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INPEFA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
INPEN INSULIN INJECTION DEVICE	-	NC	MEDICAL DEVICES AND SUPPLIES
INQOVI TAB (QL= 5 tabs/28 days)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INREBIC CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	NC	ANTIDIABETICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
INSULIN ASPART PENFILL INJ	-	NC	ANTIDIABETICS
INSULIN GLARGINE INJ	-	NC	ANTIDIABETICS
INSULIN GLARGINE SOLN PEN-INJ	-	B	ANTIDIABETICS
INSULIN GLARGINE-YFGN (SINGLE PEN)	-	NC	ANTIDIABETICS
INSULIN GLARGINE-YFGN PEN (CIVICA) 100UNIT/ML	-	NC	ANTIDIABETICS
INSULIN LISPRO INJ (HUMALOG equiv)	-	G	ANTIDIABETICS
INSULIN LISPRO JR KWIKPEN INJ	-	B	ANTIDIABETICS
INSULIN LISPRO KWIKPEN INJ	-	B	ANTIDIABETICS
INSULIN SYRINGE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	B	ANTIVIRALS
INTENSE COUGH LIQUID	-	NC	COUGH/COLD/ALLERGY
INTERMEZZO SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
INTRAROSA SUPP	-	NC	VAGINAL PRODUCTS
INVEGA TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVELTYS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
INVOKAMET TAB	-	NC	ANTIDIABETICS
INVOKAMET XR TAB	-	NC	ANTIDIABETICS
INVOKANA TAB	-	NC	ANTIDIABETICS
INZIRQO SUSP (Prior Authorization required for members age 9 years and older)	PA	B	DIURETICS
IODOFLEX PAD	-	NC	ANTISEPTICS & DISINFECTANTS
IODOQUINOL/HC ALOE GEL	-	NC	DERMATOLOGICALS
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	NC	DERMATOLOGICALS
IODOQUINOL-HYDROCORTISONE CREAM	-	NC	DERMATOLOGICALS
iohexol inj (OMNIPAQUE equiv)	-	NC	DIAGNOSTIC PRODUCTS
IOPIDINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
IPOL INJ	VAC	$0	VACCINES
ipratropium bromide hfa inhaler aerosol (ATROVENT equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ipratropium nasal spray (ATROVENT equiv)	-	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
ipratropium neb soln (ATROVENT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
IQIRVO TAB (QL= 1 tab/day; Only available through Caremark/CVS Specialty 800-378-0695 or Walgreens 888-347-3416)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
irbesartan tab (AVAPRO equiv)	-	G	ANTIHYPERTENSIVES
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	G	ANTIHYPERTENSIVES
ISENTRESS (HD) TAB	-	B	ANTIVIRALS
ISENTRESS CHEW TAB	-	B	ANTIVIRALS
ISENTRESS POWDER PACK	-	B	ANTIVIRALS
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	$0	CONTRACEPTIVES
isoniazid syrup (ISONIAZID equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
isoniazid tab	-	G	ANTIMYCOBACTERIAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
isosorbide mononitrate ER tab (IMDUR equiv)	-	G	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	G	ANTIANGINAL AGENTS
isotretinoin cap 25mg (ABSORICA equiv)	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
isotretinoin cap 35mg (ABSORICA equiv)	-	NC	DERMATOLOGICALS
isradipine cap (DYNACIRC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
ISTURISA TAB (QL= 12 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ITOVEBI TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
itraconazole cap (SPORANOX equiv)	-	G	ANTIFUNGALS
itraconazole soln (SPORANOX equiv)	PA	G	ANTIFUNGALS
ivabradine hcl tab (CORLANOR equiv)	PA	G	CARDIOVASCULAR AGENTS - MISC.
IVERMECTIN TAB	-	NC	ANTHELMINTICS
IVERMECTIN CREAM	-	NC	DERMATOLOGICALS
ivermectin cream (SOOLANTRA equiv)	-	NC	DERMATOLOGICALS
IVERMECTIN LOTION	-	NC	DERMATOLOGICALS
ivermectin tab (STROMECTOL equiv)	-	G	ANTHELMINTICS
IWILFIN TAB (QL= 8 tabs/day; Only available through CurantHealth 866-437-8040)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IXCHIQ INJ	-	EXC	VACCINES
IXIARO INJ	VAC	EXC	VACCINES
IXINITY INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
IYUZEH OPHTH DROPS	-	NC	OPHTHALMIC AGENTS
JADENU SPRINKLE	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JAKAFI XR TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JANUMET TAB	-	NC	ANTIDIABETICS
JANUMET XR TAB	-	NC	ANTIDIABETICS
JANUVIA TAB	-	NC	ANTIDIABETICS
JARDIANCE TAB	-	NC	ANTIDIABETICS
JASCAYD TAB	-	NC	RESPIRATORY AGENTS - MISC.
JAVADIN SOLN	-	NC	ANTIHYPERTENSIVES
JAYPIRCA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JENLIVA CAP	-	NC	MULTIVITAMINS
JENTADUETO TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JIDEYTRO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
jinteli tab (FEMHRT equiv)	-	G	ESTROGENS
JIVI INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
JOURNAVX TAB	-	NC	ANALGESICS - NONNARCOTIC
JUBLIA SOLN	-	NC	DERMATOLOGICALS
JULUCA TAB	-	B	ANTIVIRALS
JUVMO TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
JUVMO TAB TITRATION PACK	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
JUXTAPID CAP	-	NC	ANTIHYPERLIPIDEMICS
JYLAMVO SOLN, XATMEP SOLN (Prior Authorization required for members age 9 years and older)	PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JYNARQUE PAK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
JYNNEOS INJ	VAC	$0	VACCINES
K CITRATE SOLN CITR ACD	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
K/NA CITRATE SOL CITR ACD	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
KALETRA SOLN	-	B	ANTIVIRALS
KALETRA TAB	-	B	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
KAPSPARGO CAP	-	NC	BETA BLOCKERS
KAPVAY TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
KARBINAL ER SUSP	-	NC	ANTIHISTAMINES
KATERZIA SUSP (Prior Authorization required for members age 9 years and older)	PA	B	CALCIUM CHANNEL BLOCKERS
KEFLEX CAP 750MG	-	NC	CEPHALOSPORINS
kelnor tab (DEMULEN equiv)	-	$0	CONTRACEPTIVES
KENALOG INJ	-	NC	CORTICOSTEROIDS
KENALOG INJ, TRIAMCINOLONE ACE INJ	-	NC	CORTICOSTEROIDS
KERAFOAM	-	NC	DERMATOLOGICALS
KERALAC CREAM	-	NC	DERMATOLOGICALS
KERAMATRIX	-	NC	DERMATOLOGICALS
KERASTAT CREAM	-	NC	DERMATOLOGICALS
KERASTAT GEL	-	NC	DERMATOLOGICALS
KERENDIA TAB (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
KERYDIN SOLN	-	NC	DERMATOLOGICALS
KESIMPTA INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
KETAMINE HCL TROCHES	-	NC	GENERAL ANESTHETICS
ketoconazole cream (NIZORAL CREAM equiv)	-	G	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL equiv)	-	G	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	G	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
KETOPROFEN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KETOPROFEN ER CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KETOROLAC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj (TORADOL equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
ketorolac ophth soln (ACULAR (LS) equiv)	-	G	OPHTHALMIC AGENTS
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	G	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KETOROLAC TROMETHAMINE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
KETOSTIX	OTC	G	DIAGNOSTIC PRODUCTS
KEVEYIS TAB	-	NC	DIURETICS
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
KHINDIVI SOLN (QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	B	CORTICOSTEROIDS
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	$0	TOXOIDS
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	$0	TOXOIDS
KIRSTY INJ	-	NC	ANTIDIABETICS
KISQALI PAK (QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KISQALI TAB (QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KITABIS PAK NEB SOLN	-	NC	AMINOGLYCOSIDES
KLARITY-B DROPS	-	NC	OPHTHALMIC AGENTS
KLARITY-L DROPS	-	NC	OPHTHALMIC AGENTS
KLISYRI OINT	-	NC	DERMATOLOGICALS
KLOXXADO NASAL SPRAY	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
KOGENATE FS INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
KOMBIGLYZE XR TAB	-	NC	ANTIDIABETICS
KOMZIFTI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KONVOMEP SUSP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINER CS
KORLYM TAB	-	NC	ANTIDIABETICS
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO SPRINKLE CAP (QL= 12 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KOSELUGO SPRINKLE CAP 5MG (QL= 20 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
K-PHOS NEUTRAL TAB 155-852-130MG	-	B	MINERALS & ELECTROLYTES
K-PHOS TAB	-	B	MINERALS & ELECTROLYTES
KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KRINTAFEL TAB	-	B	ANTIMALARIALS
K-TAB	-	G	MINERALS & ELECTROLYTES
KUVAN POWDER PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KUVAN TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KYBELLA INJ	-	NC	DERMATOLOGICALS
KYGEVVI POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
KYNAMRO INJ	-	NC	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
KYNMOBI FILM	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYNMOBI TITRATION KIT	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYZATREX CAP	-	NC	ANDROGENS-ANABOLIC
KYZATREX CAP, JATENZO CAP, TLANDO CAP	-	NC	ANDROGENS-ANABOLIC
L.E.T. GEL	-	NC	DERMATOLOGICALS
labetalol hcl tab 400mg	-	NC	BETA BLOCKERS
labetalol tab (NORMODYNE equiv)	-	G	BETA BLOCKERS
lacosamide oral solution (VIMPAT equiv)	-	G	ANTICONVULSANTS
lacosamide tab (VIMPAT equiv)	-	G	ANTICONVULSANTS
LACRISERT OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
lactulose oral crystal packet	-	NC	LAXATIVES
lactulose soln	-	G	LAXATIVES
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	$0	ANTIVIRALS
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	B	ANTIVIRALS
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	B	ANTICONVULSANTS
lamivudine soln (EPIVIR equiv)	-	G	ANTIVIRALS
lamivudine tab (EPIVIR equiv)	-	G	ANTIVIRALS
lamivudine tab 100mg (EPIVIR HBV equiv)	-	G	ANTIVIRALS
lamivudine/zidovudine tab (COMBIVIR equiv)	-	G	ANTIVIRALS
lamotrigine chew tab (LAMICTAL equiv)	-	G	ANTICONVULSANTS
lamotrigine ER tab (LAMICTAL XR equiv)	-	G	ANTICONVULSANTS
lamotrigine ODT (LAMICTAL equiv)	-	NC	ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL equiv)	-	NC	ANTICONVULSANTS
lamotrigine starter kit (LAMICTAL STARTER KIT equiv)	-	G	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	G	ANTICONVULSANTS
LAMPIT TAB (Restricted to Infectious Disease Specialist)	RS	B	ANTI-INFECTIVE AGENTS - MISC.
LANCET KIT	OTC	G	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	G	MEDICAL DEVICES AND SUPPLIES
LANGLARA INJ	-	NC	ANTIDIABETICS
LANOXIN INJ	-	NC	CARDIOTONICS
LANOXIN TAB 62.5MCG	-	NC	CARDIOTONICS
lansoprazole cap (PREVACID equiv) (Rx Only)	-	G	ULCER DRUGS
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
LANSOPRAZOLE SUSP	PA	B	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
LANSOPRAZOLE/AMOXICILLIN/CLARITHTHROMYCIN KIT	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
LANTUS INJ	-	B	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	B	ANTIDIABETICS
lapatinib ditosylate tab (TYKERB equiv)	LMSP-PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LASIX ONYU INJ 80MG/2.67ML (QL= 6 cartridges/fill)	QL	B	DIURETICS
LASIX ONYU REUSABLE UNIT (QL= 1 device/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	G	OPHTHALMIC AGENTS
LATISSE SOLN	-	NC	DERMATOLOGICALS
LATUDA TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	$0	CONTRACEPTIVES
LAZANDA NASAL SPRAY	-	NC	ANALGESICS - OPIOID
LAZCLUZE TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	G	MISCELLANEOUS THERAPEUTIC CLASSES
LENVIMA CAP (QL= 3 caps/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEQEMBI IQLIK INJ 250MG/1.25ML (QL= 8 inj/28 days; Only available through Caremed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LEQEMBI IQLK INJ (QL= 4 inj/28 days; Only available through CareMed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LEQSELVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523 or Optum 877-445-6874)	LD-PA-QL	B	DERMATOLOGICALS
LEROCHOL SOLN	-	NC	ANTIHYPERLIPIDEMICS
LESCOL XL TAB	-	NC	ANTIHYPERLIPIDEMICS
letrozole tab (FEMARA equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUCOVORIN CA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	G	ANTINEOPLASTICS
LEUKERAN TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LEUKINE INJ	-	NC	HEMATOPOIETIC AGENTS
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of an albuterol HFA product (6.7 or 8.5gm))	QL-ST	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levalbuterol neb soln (XOPENEX equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVBID ER TAB 0.375MG	-	B	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINER CS
LEVEMIR FLEXTOUCH INJ	-	B	ANTIDIABETICS
LEVEMIR INJ	-	B	ANTIDIABETICS
levetiracetam ER tab (KEPPRA XR equiv)	-	G	ANTICONVULSANTS
levetiracetam soln (KEPPRA equiv)	-	G	ANTICONVULSANTS
levetiracetam tab (KEPPRA equiv)	-	G	ANTICONVULSANTS
LEVETIRACETAM TAB FOR ORAL SUSP, SPRITAM TAB FOR ORAL SUSP	-	NC	ANTICONVULSANTS
LEVITRA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
LEVOBUNOLOL OPHTH SOLN	-	G	OPHTHALMIC AGENTS
levobunolol ophth soln (BETAGAN equiv)	-	G	OPHTHALMIC AGENTS
levocarnitine soln (CARNITOR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
levocarnitine tab (CARNITOR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
levocetirizine soln (XYZAL equiv)	-	EXC	ANTIHISTAMINES
levocetirizine tab (XYZAL equiv)	-	EXC	ANTIHISTAMINES
levofloxacin ophth soln (QUIXIN equiv)	-	G	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
LEVOFLOXACIN OPHTH SOLN 0.5%	-	G	OPHTHALMIC AGENTS
levofloxacin soln (LEVAQUIN equiv)	-	G	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	G	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	$0	CONTRACEPTIVES
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	NC	CONTRACEPTIVES
levorphanol tab (LEVORPHANOL equiv)	-	NC	ANALGESICS - OPIOID
LEVOTHYROXINE INJ	-	NC	THYROID AGENTS
LEVOTHYROXINE INJ 100MCG/ML	-	NC	THYROID AGENTS
levothyroxine tab (SYNTHROID equiv)	-	G	THYROID AGENTS
LEVSIN SL TAB 0.125MG	-	B	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
LEVSIN TAB 0.125MG	-	B	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
LEXTOL PAK	-	NC	DERMATOLOGICALS
l-glutamine powder packet (ENDARI equiv) (QL= 6 packets/day)	LMSP-PA-QL	G	HEMATOPOIETIC AGENTS
LIALDA TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIBERVANT FILM	-	NC	ANTICONVULSANTS
LICART PATCH	-	NC	DERMATOLOGICALS
LIDO/MENTHOL SPRAY	-	NC	DERMATOLOGICALS
LIDO/RAC/TET GEL	-	NC	DERMATOLOGICALS
LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
lidocaine gel (GLYDO equiv)	-	G	DERMATOLOGICALS
LIDOCAINE GEL	-	NC	DERMATOLOGICALS
LIDOCAINE JELLY 2%	-	B	DERMATOLOGICALS
lidocaine oint (QL= 36gm/fill)	QL	G	DERMATOLOGICALS
lidocaine oint/transparent dressing kit	-	NC	DERMATOLOGICALS
LIDOCAINE ORAL SOLN	-	NC	MOUTH/THROAT/DENTAL AGENTS
lidocaine patch 3.5% (GEN7T equiv)	OTC	NC	DERMATOLOGICALS
lidocaine patch 4% (LIDODERM equiv)	-	NC	DERMATOLOGICALS
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	PA-QL	G	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	G	DERMATOLOGICALS
LIDOCAINE SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
LIDOCAINE/HC CREAM	-	G	ANORECTAL AND RELATED PRODUCTS
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	G	DERMATOLOGICALS
LIDOCIN GEL	-	NC	DERMATOLOGICALS
LIDO-EP-TETR SOLN	-	NC	DERMATOLOGICALS
LIDOLOG KIT	-	NC	CORTICOSTEROIDS
LIDOSTREAM KIT	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LIDOTIN PAK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LIDOTREX GEL	-	NC	DERMATOLOGICALS
LIDOVEX CREAM	-	NC	DERMATOLOGICALS
LIFYORLI CAP DOSE PACK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LIKMEZ SUSP (Prior Authorization required for members age 9 years and older)	PA	B	ANTI-INFECTIVE AGENTS - MISC.
linezolid susp (Restricted to Infectious Disease Specialist)	RS	G	ANTI-INFECTIVE AGENTS - MISC.
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	G	ANTI-INFECTIVE AGENTS - MISC.
LINZESS CAP (QL= 1 cap/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	G	THYROID AGENTS
LIPFENDRA TAB	-	NC	ANTIHYPERLIPIDEMICS
LIPITOR TAB	-	NC	ANTIHYPERLIPIDEMICS
LIQREV SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
liraglutide (weight mngmt) soln pen-inj (SAXENDA equiv)	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
liraglutide soln pen-injector (VICTOZA equiv) (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	G	ANTIDIABETICS
lisdexamfetamine dimesylate cap (VYVANSE equiv) (QL= 1 cap/day)	QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
lisdexamfetamine dimesylate chew tab (VYVANSE equiv) (QL= 1 tab/day; Members age 9 or older require Prior Authorization)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	G	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	G	ANTIHYPERTENSIVES
LISRAYA TAB	-	NC	DERMATOLOGICALS
LITFULO CAP (QL= 1 cap/day; Only available through Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B	DERMATOLOGICALS
lithium carbonate cap (ESKALITH ER equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate ER tab (LITHOBID equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium carbonate tab	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lithium oral solution (LITHIUM equiv) (Prior Authorization required for members age 9 years and older)	PA	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LITHOSTAT TAB	-	B	GENITOURINARY AGENTS - MISCELLANEOUS
LIVALO TAB	-	NC	ANTIHYPERLIPIDEMICS
LIVDELZI CAP (QL= 1 cap/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI SOLN	-	NC	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI TAB (QL= 2 tabs/day; Only available through Eversana 866-849-4481)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
LIVMARLI TAB 30MG (QL= 1 tab/day; Only available through Eversana 866-849-4481)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTIVIRALS
L-METHYLFOLATE TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LO LOESTRIN TAB	-	NC	CONTRACEPTIVES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LOARGYS INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
LOCOID CREAM	-	NC	DERMATOLOGICALS
LOCOID LIPOCREAM	-	NC	DERMATOLOGICALS
LOCOID OINT	-	NC	DERMATOLOGICALS
LOCOID SOLN	-	NC	DERMATOLOGICALS
LODOCO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
loestrin 21 tab	-	NC	CONTRACEPTIVES
loestrin tab	-	NC	CONTRACEPTIVES
lofexidine hcl tab (LUCEMYRA equiv) (QL= 96 tabs/7 days)	PA-QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LOKELMA PAK (QL= 1 packet/day)	PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
LOKELMA PAK 10GM	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
LOKELMA PAK 5GM	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
lomustine cap (GLEOSTINE equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LONSURF TAB	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
loperamide cap (IMODIUM equiv)	-	NC	ANTIDIARRHEALS
loperamide hcl soln (LOPERAMIDE equiv)	OTC	NC	ANTIDIARRHEAL/PROBIOTIC AGENTS
lopinavir/ritonavir soln (KALETRA equiv)	-	G	ANTIVIRALS
lopinavir/ritonavir tab (KALETRA equiv)	-	G	ANTIVIRALS
LOPRESSOR SOLN (QL= 45ml/day; Prior Authorization required for members age 9 years and older)	PA-QL	B	BETA BLOCKERS
loratadine cap (CLARITIN equiv)	OTC	EXC	ANTIHISTAMINES
lorazepam conc (ATIVAN equiv)	-	G	ANTIANXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	G	ANTIANXIETY AGENTS
LORBRENA TAB 25MG (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LOREEV XR CAP	-	NC	ANTIANXIETY AGENTS
LORTAB ELIXIR	-	B	ANALGESICS - OPIOID
LORVATUS PHARMAPAK KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
losartan tab (COZAAR equiv)	-	G	ANTIHYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	G	ANTIHYPERTENSIVES
LOTEMAX OPHTH OINT	-	B	OPHTHALMIC AGENTS
LOTEMAX SM GEL 0.38%	-	NC	OPHTHALMIC AGENTS
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	G	OPHTHALMIC AGENTS
loteprednol etabonate-tobramycin ophth susp (ZYLET equiv)	-	NC	OPHTHALMIC AGENTS
loteprednol ophth susp (LOTEMAX, ALREX equiv)	-	G	OPHTHALMIC AGENTS
LOTRIMIN AF CREAM	-	NC	DERMATOLOGICALS
LOTRISONE CREAM	-	NC	DERMATOLOGICALS
lovastatin tab (MEVACOR equiv)	-	$0	ANTIHYPERLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	QL	G	GASTROINTESTINAL AGENTS - MISC.
LUCEMYRA TAB (QL= 96 tabs/7 days)	PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUCENTIS INJ	MSP-PA	B	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
LULICONAZOLE CREAM, LUZU CREAM	-	NC	DERMATOLOGICALS
LUMAKRAS TAB (QL= 8 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMAKRAS TAB 240MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMAKRAS TAB 320MG (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LUMIGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
LUMIZYME/MYOZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUMRYZ PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUMRYZ STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
LUPRON DEPOT PED INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT-PED INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
lurasidone hcl tab (LATUDA equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LUVIRA CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LUXIQ FOAM	-	NC	DERMATOLOGICALS
LYBALVI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LYNAVOY TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
LYNKUET CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
LYNPARZA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYRICA CAP	-	NC	ANTICONVULSANTS
LYRICA CAP 225MG	-	NC	ANTICONVULSANTS
LYRICA CAP 300MG	-	NC	ANTICONVULSANTS
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYUMJEV INJ	-	B	ANTIDIABETICS
LYUMJEV KWIKPEN INJ	-	B	ANTIDIABETICS
LYUMJEV TEMPO PEN	-	B	ANTIDIABETICS
LYVISPAH GRANULE PACKET (Prior Authorization required for members age 9 years and older)	PA	B	MUSCULOSKELETAL THERAPY AGENTS
macitentan tab (OPSUMIT equiv) (QL= 1 tab/day)	LMSP-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
MACRILEN PACK	-	NC	DIAGNOSTIC PRODUCTS
MAFENIDE ACETATE SOLN PACK	-	NC	DERMATOLOGICALS
MALARONE TAB	-	NC	ANTIMALARIALS
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	G	DERMATOLOGICALS
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	$0	MEDICAL DEVICES AND SUPPLIES
maraviroc tab (SELZENTRY equiv)	-	G	ANTIVIRALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MARPLAN TAB	-	NC	ANTIDEPRESSANTS
MATERVIA CAP	-	NC	MULTIVITAMINS
MATRONEX TAB 27-1 MG	-	NC	MULTIVITAMINS
MATULANE CAP (Only available through Walgreens 888-347-3416)	LD	B	ANTINEOPLASTICS
MAVENCLAD THERAPY PAK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAVYRET PAK (QL= 5 packs/day)	LMSP-PA-QL	B	ANTIVIRALS
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	B	ANTIVIRALS
MAXALT MLT TAB	-	NC	MIGRAINE PRODUCTS
MAXALT TAB	-	NC	MIGRAINE PRODUCTS
MAXIDEX OPHTH SOLN	-	B	OPHTHALMIC AGENTS
MAYZENT TAB	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MAYZENT TAB STARTER PACK	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MECLIZINE CHEW TAB	-	NC	ANTIEMETICS
meclizine tab (ANTIVERT equiv)	-	NC	ANTIEMETICS
MECLOFENAMATE CAP (Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen)	ST	G	ANALGESICS - ANTI-INFLAMMATORY
MEDI-PATCH W/LIDOCAINE PATCH	-	NC	DERMATOLOGICALS
MEDROL TAB	-	NC	CORTICOSTEROIDS
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	$0	CONTRACEPTIVES
medroxyprogesterone tab (PROVERA equiv)	-	G	PROGESTINS
mefenamic acid cap (PONSTEL equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
mefloquine tab (LARIAM equiv)	-	G	ANTIMALARIALS
megestrol ES susp (MEGACE ES equiv)	-	G	PROGESTINS
MEGESTROL SUSP	-	G	PROGESTINS
megestrol susp (MEGACE equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST SOLN	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKINIST TAB 2MG (QL= 1 tab/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MEKTOVI TAB (QL= 6 tabs/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam cap (VIVLODEX equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM COMFORT KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM SUSP, ZYBIC SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
meloxicam tab (MOBIC equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
MELQUIN 3 SOLN	-	NC	DERMATOLOGICALS
memantine ER cap (NAMENDA XR equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine hcl-donepezil hcl 24hr er cap (NAMZARIC equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine soln (NAMENDA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
memantine tab (NAMENDA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MEMANTINE TITRATION PAK	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENACTRA INJ	VAC	$0	VACCINES
MENEST TAB	-	B	ESTROGENS
MENOSTAR PATCH	-	NC	ESTROGENS
MENQUADFI INJ	VAC	$0	VACCINES
MENTAX CREAM	-	NC	DERMATOLOGICALS
MENTHOREAL10 THERAPY PACK	-	NC	DERMATOLOGICALS
MENVEO INJ	VAC	$0	VACCINES
meperidine tab (DEMEROL equiv)	-	NC	ANALGESICS - OPIOID
meprobamate tab (MILTOWN equiv)	-	NC	ANTIANXIETY AGENTS
mercaptopurine susp (PURIXAN equiv) (Prior Authorization required for members age 9 years and older)	PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
mercaptopurine tab (PURINETHOL equiv)	-	G	ANTINEOPLASTICS
MERILOG INJ	-	NC	ANTIDIABETICS
MERILOG SOLOSTAR INJ	-	NC	ANTIDIABETICS
MESALAMINE DR CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine DR cap (DELZICOL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine DR tab (LIALDA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema (ROWASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine enema kit (ROWASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (APRISO equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine ER cap (PENTASA CR equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesalamine supp (CANASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine tab (ASACOL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
mesna tab (MESNEX equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MESNEX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
METANX CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
METAXALONE TAB	-	NC	MUSCULOSKELETAL THERAPY AGENTS
metaxalone tab (SKELAXIN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METDRAY GEL	-	NC	DERMATOLOGICALS
metformin ER osmotic tab (FORTAMET equiv)	-	NC	ANTIDIABETICS
metformin ER osmotic tab (GLUMETZA equiv)	-	NC	ANTIDIABETICS
metformin ER tab (GLUCOPHAGE XR equiv)	-	G	ANTIDIABETICS
metformin hcl tab 625MG	-	NC	ANTIDIABETICS
metformin hcl tab 750MG	-	NC	ANTIDIABETICS
metformin soln (RIOMET equiv)	-	G	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	G	ANTIDIABETICS
METFORMIN TAB	-	NC	ANTIDIABETICS
methadone soln (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
METHADOSE CONC	ST	B	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
methadose tab (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
methamphetamine hcl tab (METHAMPHETAMINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methazolamide tab (NEPTAZANE equiv)	-	G	DIURETICS
METHENAM MAN TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
methenamine hippurate tab (HIPREX equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
METHENAMINE ORAL SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
methimazole tab (TAPAZOLE equiv)	-	G	THYROID AGENTS
METHITEST TAB	-	NC	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
methocarbamol tab 1000mg (ROBAXIN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
methotrexate inj	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	G	ANTINEOPLASTICS
METHOXSALEN CAP	-	B	DERMATOLOGICALS
methoxsalen cap (OXSORALEN ULTRA equiv)	-	G	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	G	ULCER DRUGS
methsuximide cap (CELONTIN equiv)	-	G	ANTICONVULSANTS
METHYLDOPA TAB	-	B	ANTIHYPERTENSIVES
methyldopa tab (ALDOMET equiv)	-	G	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	G	OXYTOCICS
METHYLIN SOLN	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate CD cap (METADATE CD equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate chew tab (METHYLIN equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate ER cap (RITALIN LA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate ER cap (APTENSIO XR equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate ER tab	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
METHYLPHENIDATE ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
METHYLPHENIDATE ER TAB 27MG	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
METHYLPHENIDATE ER TAB 36MG	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
METHYLPHENIDATE ER TAB 54MG	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate ER tab 72mg	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
METHYLPHENIDATE ER TAB, RELEXXII TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylphenidate tab (RITALIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
methylphenidate td patch (DAYTRANA equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprednisolone dose pack (MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprenisolone sod succinate inj (SOLU-MEDROL equiv)	-	G	CORTICOSTEROIDS
methyltestosterone cap	-	NC	ANDROGENS-ANABOLIC
metoclopramide soln (REGLAN equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
metoclopramide tab (REGLAN equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
metolazone tab (ZAROXOLYN equiv)	-	G	DIURETICS
metoprolol ER tab (TOPROL XL equiv)	-	G	BETA BLOCKERS
metoprolol tab (LOPRESSOR equiv)	-	G	BETA BLOCKERS
METOPROLOL TARTRATE TAB	-	NC	BETA BLOCKERS
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	G	ANTIHYPERTENSIVES
METOZOLV ODT	-	NC	GASTROINTESTINAL AGENTS - MISC.
metronidazole cap (FLAGYL equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	G	DERMATOLOGICALS
metronidazole gel 0.75% (METROGEL equiv)	-	G	DERMATOLOGICALS
metronidazole gel 1% (METROGEL equiv) (Step Therapy requires trial of metronidazole gel 0.75%)	ST	G	DERMATOLOGICALS
metronidazole lotion (METROLOTION equiv)	-	G	DERMATOLOGICALS
metronidazole tab (FLAGYL equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
METRONIDAZOLE TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
metronidazole vaginal gel (METROGEL equiv)	-	G	VAGINAL PRODUCTS
metyrosine cap (DEMSER equiv)	-	NC	ANTIHYPERTENSIVES
mexiletine hcl cap	-	G	ANTIARRHYTHMICS
MEXPAROX HC CREAM	-	NC	DERMATOLOGICALS
MFLUSIVA INJ (QL= 1 inj/28 days; Covered for members age 50 years and older)	QL-VAC	$0	VACCINES
MICARDIS HCT TAB	-	NC	ANTIHYPERTENSIVES
MICLARA LIQUID	OTC	NC	ANTIHISTAMINES
MICROVIX LP PAK	-	NC	DERMATOLOGICALS
MIDAZOLAM INJ (QL= 1 inj/fill)	QL	B	ANTICONVULSANTS
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
midodrine tab (PROAMATINE equiv)	-	G	VASOPRESSORS
MIDUELLA, PARAGARD IUD	-	$0	CONTRACEPTIVES
MIEBO OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
mifepristone tab (KORLYM equiv) (QL= 4 tabs/day)	LMSP-PA-QL	G	ANTIDIABETICS
mifepristone tab 200mg (MIFIPREX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
MIGERGOT SUPP	-	NC	MIGRAINE PRODUCTS
MIGLITOL TAB	-	B	ANTIDIABETICS
miglitol tab (MIGLITOL equiv)	-	G	ANTIDIABETICS
miglustat cap (ZAVESCA equiv) (QL= 3 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	G	HEMATOPOIETIC AGENTS
MILLIPRED DP PAK	-	NC	CORTICOSTEROIDS
MILLIPRED TAB	-	NC	CORTICOSTEROIDS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
milnacipran hcl tab (SAVELLA equiv) (QL= 2 tabs/day)	QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
milnacipran hcl tab pak (SAVELLA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MIMRYLO INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
minocycline cap (MINOCIN equiv)	-	G	TETRACYCLINES
MINOCYCLINE ER CAP	-	NC	TETRACYCLINES
minocycline ER tab (SOLODYN equiv)	-	NC	TETRACYCLINES
minocycline tab (DYNACIN equiv) (Step therapy requires trial of minocycline caps)	ST	G	TETRACYCLINES
MINOLIRA TAB	-	NC	TETRACYCLINES
minoxidil tab (LONITEN equiv)	-	G	ANTIHYPERTENSIVES
MINT REFILL KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
MINT STARTER KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
MIPLYFFA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
mirabegron granules for oral extended release susp (MYRBETRIQ equiv)	-	NC	URINARY ANTISPASMODICS
mirabegron tab er (MYRBETRIQ equiv)	-	NC	URINARY ANTISPASMODICS
MIRAPEX ER TAB	-	NC	ANTIPARKINSON AGENTS
MIRENA IUD	-	$0	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	G	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	G	ANTIDEPRESSANTS
MIRVASO GEL	-	EXC	DERMATOLOGICALS
misoprostol tab (CYTOTEC equiv)	-	G	ULCER DRUGS
M-M-R II INJ	VAC	$0	VACCINES
MNEXSPIKE INJ 10MCG/0.2ML (QL= 1 dose/24 days)	QL-VAC	$0	VACCINES
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
MODEYSO CAP (QL= 20 caps/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
moexipril tab (UNIVASC equiv)	-	G	ANTIHYPERTENSIVES
MOLINDONE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
mometasone cream (ELOCON equiv)	-	G	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv) (QL= 2 bottles/fill)	QL	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
mometasone oint (ELOCON equiv)	-	G	DERMATOLOGICALS
mometasone soln (ELOCON equiv)	-	G	DERMATOLOGICALS
MONOCLATE-P INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
MONODOX CAP 75MG	-	NC	TETRACYCLINES
montelukast chew tab (SINGULAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast granule pack (SINGULAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
montelukast tab (SINGULAIR equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
MONUROL GRANULE PACK	-	B	ANTI-INFECTIVE AGENTS - MISC.
MORPHABOND TAB	-	NC	ANALGESICS - OPIOID
MORPHINE SULFATE ER BEAD CAP	-	NC	ANALGESICS - OPIOID
morphine sulfate ER tab (MS CONTIN equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MORPHINE SULFATE ORAL SOLN 100MG/5ML	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE ORAL SOLN 10MG/5ML	-	G	ANALGESICS - OPIOID
morphine sulfate oral soln 10mg/5ml (MORPHINE SULFATE equiv)	-	G	ANALGESICS - OPIOID
morphine sulfate soln	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE SOLN 20MG/5ML	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE SUPP	-	G	ANALGESICS - OPIOID
morphine sulfate tab	-	G	ANALGESICS - OPIOID
MOTEGRITY TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
MOTOFEN TAB	-	NC	ANTIDIARRHEALS
MOTPOLY XR CAP	-	NC	ANTICONVULSANTS
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
MOVANTIK TAB (QL= 1 tab/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
MOVIPREP SOLN	-	NC	LAXATIVES
MOXATAG TAB	-	NC	PENICILLINS
MOXATAG TAB 775MG	-	NC	PENICILLINS
MOXEZA OPHTH SOLN 0.5%	-	NC	OPHTHALMIC AGENTS
MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	G	OPHTHALMIC AGENTS
MOXIFLOXACIN SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin tab (AVELOX equiv)	-	G	FLUOROQUINOLONES
MOZOBIL INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
MPM PAK	-	NC	OXYTOCICS
MRESVIA INJ (QL= 1 dose/lifetime)	QL-VAC	$0	VACCINES
MS CONTIN TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	B	ANALGESICS - OPIOID
MUCINEX LIQUID	-	NC	COUGH/COLD/ALLERGY
MULPLETA TAB	-	NC	HEMATOPOIETIC AGENTS
MULTAQ TAB	-	B	ANTIARRHYTHMICS
MULTIGEN FOLIC TAB	-	G	HEMATOPOIETIC AGENTS
MULTIGEN PLUS TAB	-	G	HEMATOPOIETIC AGENTS
MULTIGEN TAB	-	G	HEMATOPOIETIC AGENTS
MULTI-MAC TAB	-	NC	MULTIVITAMINS
MULTIPLE-VITAMIN/FL-FE DROPS	-	NC	MULTIVITAMINS
MULTIVITAMIN CHEW TAB	-	NC	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	NC	MULTIVITAMINS
mupirocin cream (BACTROBAN CREAM equiv)	-	NC	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	G	DERMATOLOGICALS
MYALEPT INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
MYCAPSSA CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
mycophenolate DR tab (MYFORTIC equiv)	-	G	ASSORTED CLASSES
mycophenolate mofetil cap (CELLCEPT equiv)	-	G	ASSORTED CLASSES
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	G	ASSORTED CLASSES
mycophenolate mofetil tab (CELLCEPT equiv)	-	G	ASSORTED CLASSES
MYDAYIS CAP 12.5MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
MYDAYIS CAP 25MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
MYDAYIS CAP 37.5MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
MYDAYIS CAP 50MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
MYDCOMBI OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	B	ESTROGENS
MYHIBBIN SUSP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
MYLERAN TAB	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MYNATAL-Z TAB	-	NC	MULTIVITAMINS
MYNEPHRON CAP	-	NC	MULTIVITAMINS
MYQORZO TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
MYRBETRIQ SUSP	-	NC	URINARY ANTISPASMODICS
MYRBETRIQ TAB	-	NC	URINARY ANTISPASMODICS
MYTESI TAB	-	NC	ANTIDIARRHEALS
nabumetone tab (RELAFEN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORGARD equiv)	-	G	BETA BLOCKERS
NAFLON CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAFTIFINE CREAM	-	NC	DERMATOLOGICALS
naftifine cream (NAFTIN equiv)	-	NC	DERMATOLOGICALS
naftifine hcl gel 2% (NAFTIN equiv)	-	NC	DERMATOLOGICALS
NAFTIN GEL 2%	-	NC	DERMATOLOGICALS
NAGLAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
naloxone hcl nasal spray (NARCAN equiv)	OTC	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone inj	-	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj	-	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
naltrexone tab (REVIA equiv)	-	G	ANTIDOTES
NAMENDA XR CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMENDA XR TITRATION PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAMZARIC STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NAPRELAN CR TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROSYN EC TAB 500MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
naproxen EC tab (NAPROSYN EC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen EC tab 500mg (NAPROSYN EC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SOD ER TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen sodium tab (ANAPROX equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
naproxen susp (NAPROSYN equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naproxen tab (NAPROSYN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
NARCAN NASAL SPRAY	OTC	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
NARDIL TAB 15MG	-	B	ANTIDEPRESSANTS
NASCOBAL SPRAY	-	NC	HEMATOPOIETIC AGENTS
NATACHEW	-	NC	MULTIVITAMINS
NATACYN OPHTH SUSP (QL= 15ml/fill)	QL	B	OPHTHALMIC AGENTS
NATAZIA TAB	-	NC	CONTRACEPTIVES
nateglinide tab (STARLIX equiv)	-	G	ANTIDIABETICS
NATESTO GEL	-	NC	ANDROGENS-ANABOLIC
NATESTO NASAL GEL	-	NC	ANDROGENS-ANABOLIC
NATROBA SUSP (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS
NATROBA SUSP 0.90% (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS
NAYZILAM SPRAY (QL= 4 doses/fill)	QL	B	ANTICONVULSANTS
nebivolol hcl tab (BYSTOLIC equiv)	-	G	BETA BLOCKERS
NEBUSAL NEB SOLN	-	B	COUGH/COLD/ALLERGY
NEEVO DHA	-	NC	MULTIVITAMINS
NEFAZODONE TAB	-	NC	ANTIDEPRESSANTS
NEFFY SPRAY (QL= 2 doses/fill)	QL	B	VASOPRESSORS
NEMLUVIO INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B	DERMATOLOGICALS
NENDRUX GEL	-	NC	DERMATOLOGICALS
NEO/BAC/POLY OPHTH OINT	-	G	OPHTHALMIC AGENTS
NEO/POLY/BAC/HC OPHTH OINT	-	G	OPHTHALMIC AGENTS
neomycin tab	-	G	AMINOGLYCOSIDES
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	G	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocoritisone otic soln (CORTISPORIN equiv)	-	G	OTIC AGENTS
neomycin/polymixin/hydrocoritisone otic susp (CORTISPORIN equiv)	-	G	OTIC AGENTS
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	G	OPHTHALMIC AGENTS
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	G	OPHTHALMIC AGENTS
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
NEONATAL 19 TAB	-	B	MULTIVITAMINS
NEONATAL FE TAB	-	B	MULTIVITAMINS
NEOSALUS FOAM	-	NC	DERMATOLOGICALS
NEOSALUS LOTION	-	NC	DERMATOLOGICALS
NEO-SYNALAR CREAM	-	NC	DERMATOLOGICALS
NEPHRON FA TAB	-	B	HEMATOPOIETIC AGENTS
NEREUS CAP	-	NC	ANTIEMETICS
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NESTABS DHA	-	NC	MULTIVITAMINS
NESTABS ONE	-	NC	MULTIVITAMINS
NEULASTA INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPRO PATCH	PA	B	ANTIPARKINSON AGENTS
NEURONTIN SOLN	-	NC	ANTICONVULSANTS
NEURONTIN TAB 600MG	-	NC	ANTICONVULSANTS
NEURONTIN TAB 800MG	-	NC	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NEVANAC OPHTH SUSP	-	B	OPHTHALMIC AGENTS
NEVIRAPINE ER TAB (Step Therapy requires trial of nevirapine)	ST	G	ANTIVIRALS
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	G	ANTIVIRALS
NEVIRAPINE SUSP	-	G	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	G	ANTIVIRALS
NEXICLON XR TAB	-	NC	ANTIHYPERTENSIVES
NEXLETOL TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	B	ANTIHYPERLIPIDEMICS
NEXLIZET TAB	-	NC	ANTIHYPERLIPIDEMICS
NEXPLANON IMPLANT	-	$0	CONTRACEPTIVES
NEXTSTELLIS TAB	-	NC	CONTRACEPTIVES
NGENLA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
niacin ER tab (NIASPAN equiv)	-	G	ANTIHYPERLIPIDEMICS
NIACOR TAB	-	NC	ANTIHYPERLIPIDEMICS
NIASPAN ER TAB	-	NC	ANTIHYPERLIPIDEMICS
nicardipine cap (CARDENE equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTINE KIT	OTC-QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nifedipine cap (PROCARDIA equiv)	-	G	CALCIUM CHANNEL BLOCKERS
nifedipine ER tab (ADALAT CC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
NILOTINB TAR CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NILOTINIB D-TAR CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nilotinib hcl cap (TASIGNA equiv)	LMSP-PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NILUTAMIDE TAB	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nilutamide tab (NILANDRON equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	G	CALCIUM CHANNEL BLOCKERS
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nintedanib esylate cap (OFEV equiv) (QL= 2 caps/day)	LMSP-PA-QL	G	RESPIRATORY AGENTS - MISC.
nisoldipine ER tab (SULAR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
NISOLDIPINE ER TAB 20MG, 30MG, 40MG	-	G	CALCIUM CHANNEL BLOCKERS
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	G	ANTI-INFECTIVE AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
nitisinone cap (ORFADIN equiv)	LMSP-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	NC	ANTIANGINAL AGENTS
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin monohydrate cap (MACROBID equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
nitrofurantoin susp (FURADANTIN equiv) (Covered for members age 9 years and younger)	-	G	ANTI-INFECTIVE AGENTS - MISC.
NITROFURANTOIN SUSP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
NITROGLYCERIN ER CAP	-	G	ANTIANGINAL AGENTS
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	G	ANTIANGINAL AGENTS
nitroglycerin oint (RECTIV equiv)	-	B	ANORECTAL AND RELATED PRODUCTS
nitroglycerin oint	-	G	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	G	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	G	ANTIANGINAL AGENTS
NITYR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NIVESTYM INJ	LMSP	B	HEMATOPOIETIC AGENTS
NIZATIDINE CAP	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
nizatidine cap (AXID equiv)	-	G	ULCER DRUGS
NOCDURNA SL TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NOCTIVA EMULSION SPRAY	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	NC	CONTRACEPTIVES
norethindrone acetate/ethinyl estradial FE chew tab (MINASTRIN equiv)	-	NC	CONTRACEPTIVES
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	$0	CONTRACEPTIVES
norethindrone tab (NORA-QD equiv)	-	$0	CONTRACEPTIVES
norethindrone tab (AYGESTIN equiv)	-	G	PROGESTINS
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	$0	CONTRACEPTIVES
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	NC	CONTRACEPTIVES
NORGESIC TAB FORTE	-	NC	MUSCULOSKELETAL THERAPY AGENTS
NORITATE CREAM	-	NC	DERMATOLOGICALS
NORLIQVA ORAL SOLN (Prior Authorization required for members age 9 years and older)	PA	B	CALCIUM CHANNEL BLOCKERS
NORPACE CR CAP	-	B	ANTIARRHYTHMICS
NORTHERA CAP	-	NC	VASOPRESSORS
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	$0	CONTRACEPTIVES
nortrel tab (OVCON 35 equiv)	-	$0	CONTRACEPTIVES
nortriptyline cap (PAMELOR equiv)	-	G	ANTIDEPRESSANTS
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	G	ANTIDEPRESSANTS
NORVIR POWDER PACK	-	B	ANTIVIRALS
NOVACORT GEL	-	NC	DERMATOLOGICALS
NOVAVAX INJ (QL= 1 dose/24 days)	QL-VAC	$0	VACCINES
NOVOEIGHT INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
NOVOFINE PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOVOLIN 70/30 FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 FLEXPEN RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 INJ	OTC	NC	ANTIDIABETICS
NOVOLIN 70/30 RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N INJ	OTC	NC	ANTIDIABETICS
NOVOLIN N RELION 100UNIT/ML	OTC	NC	ANTIDIABETICS
NOVOLIN R FLEXPEN INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R INJ	OTC	NC	ANTIDIABETICS
NOVOLIN R RELION INJ	OTC	NC	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	NC	ANTIDIABETICS
NOVOLOG FLEXPEN RELION INJ	-	NC	ANTIDIABETICS
NOVOLOG INJ	-	NC	ANTIDIABETICS
NOVOLOG MIX FLEXPEN INJ	-	NC	ANTIDIABETICS
NOVOLOG MIX INJ	-	NC	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	NC	ANTIDIABETICS
NOVOPEN ECHO	-	B	MEDICAL DEVICES AND SUPPLIES
NOVOSEVEN RT INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
NOXAFIL PAK	-	B	ANTIFUNGALS
NOXAFIL TAB	-	NC	ANTIFUNGALS
NPLATE INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
NUCARACLINPA KIT	-	NC	DERMATOLOGICALS
NUCARARXPAK KIT	-	NC	DERMATOLOGICALS
NUCYNTA ER TAB (QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	B	ANALGESICS - OPIOID
NUCYNTA TAB	-	B	ANALGESICS - OPIOID
NUEDEXTA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nulido pad (NULIDO equiv)	-	NC	DERMATOLOGICALS
NUPLAZID CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NUPLAZID TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NUQUIN HP CREAM	-	NC	DERMATOLOGICALS
NURTEC ODT	-	NC	MIGRAINE PRODUCTS
NUTRICHEW CHEW 29-1 MG	-	NC	MULTIVITAMINS
NUVAKAAN II KIT	-	NC	DERMATOLOGICALS
NUVARING	-	NC	CONTRACEPTIVES
NUVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
NUWIQ INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
NUZOLVENCE GRANULE PACK	-	NC	ANTI-INFECTIVE AGENTS - MISC.
NUZYRA TAB	-	NC	TETRACYCLINES
NYMALIZE SOLN	-	NC	CALCIUM CHANNEL BLOCKERS
NYPOZI INJ	-	NC	HEMATOPOIETIC AGENTS
nystatin cream (MYCOSTATIN CREAM equiv)	-	G	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
nystatin oint	-	G	DERMATOLOGICALS
nystatin susp	-	G	MOUTH/THROAT/DENTAL AGENTS
NYSTATIN SUSP	-	NC	MOUTH/THROAT/DENTAL AGENTS
nystatin tab	-	G	ANTIFUNGALS
nystatin topical powder	-	G	DERMATOLOGICALS
nystatin/triamcinolone cream	-	NC	DERMATOLOGICALS
nystatin/triamcinolone oint	-	NC	DERMATOLOGICALS
NYVEPRIA INJ	LMSP	B	HEMATOPOIETIC AGENTS
OB COMPLETE ONE	-	NC	MULTIVITAMINS
OB COMPLETE PETITE	-	NC	MULTIVITAMINS
OB COMPLETE PREMIER	-	NC	MULTIVITAMINS
OBIZUR INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	LMSP	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
OCTREOTIDE INJ 100MCG	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ODACTRA SL TAB	-	NC	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
ODEFSEY TAB	-	B	ANTIVIRALS
ODOMZO CAP (QL= 1 cap/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP	-	NC	RESPIRATORY AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	G	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	G	OTIC AGENTS
OFLOXACIN TAB	-	G	FLUOROQUINOLONES
OGSIVEO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OGSIVEO TAB 50MG (QL= 6 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OHTUVAYRE SUSP (QL= 60 ampules/30 days; Only available through CVS Specialty 800-238-7828 or AcariaHealth 800-511-5144)	LD-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OJEMDA SUSP (QL= 96ml/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OJEMDA TAB (QL= 24 tabs/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OJJAARA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
olanzapine ODT (ZYPREXA equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine tab (ZYPREXA equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
OLLIZAC POWDER	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
olmesartan tab (BENICAR equiv)	-	G	ANTIHYPERTENSIVES
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	NC	ANTIHYPERTENSIVES
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	G	ANTIHYPERTENSIVES
olopatadine hcl ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	B	OPHTHALMIC AGENTS
olopatadine nasal spray (PATANASE equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
olopatadine ophth soln (PATANOL equiv)	-	NC	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
OLPRUVA PACK	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OLUX E FOAM	-	NC	DERMATOLOGICALS
OLUX FOAM	-	NC	DERMATOLOGICALS
OMEGA-3 RX PAK COMPLETE	-	NC	ANTIHYPERLIPIDEMICS
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	G	ANTIHYPERLIPIDEMICS
omeprazole DR cap (PRILOSEC equiv)	-	G	ULCER DRUGS
omeprazole tab	OTC	EXC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC	ULCER DRUGS
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC	ULCER DRUGS
OMLONTI OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
OMLYCLO SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OMLYCLO SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OMLYCLO SYRINGE 300MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
OMNARIS NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
OMNIPAQUE INJ	-	NC	DIAGNOSTIC PRODUCTS
OMNIPAQUE SOLN	-	NC	DIAGNOSTIC PRODUCTS
OMNIPOD 5 DEX G7G6 INTRO KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 DEX G7G6 PODS (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 LIBRE2 PLUS G6 PODS (QL= 10 pods/30 days)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PDM KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD GO KIT (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNITROPE INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
OMVOH INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
ONAPGO INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
ondansetron ODT (ZOFRAN equiv)	-	G	ANTIEMETICS
ondansetron soln (ZOFRAN equiv)	-	G	ANTIEMETICS
ondansetron tab (ZOFRAN equiv)	-	G	ANTIEMETICS
ONDANSETRON TAB	-	NC	ANTIEMETICS
ONDANSETRON TAB ODT	-	NC	ANTIEMETICS
ONEXTON GEL 1.2-3.75%	-	NC	DERMATOLOGICALS
ONFI SUSP	-	NC	ANTICONVULSANTS
ONFI TAB	-	NC	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ONGENTYS CAP (QL= 1 tab/day, 30 tabs per fill)	PA-QL	B	ANTIPARKINSON AND RELATED THERAPY AGENTS
ONGLYZA TAB	-	NC	ANTIDIABETICS
ONTRALFY ORAL SOLN	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ONUREG TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ONYCHO-MED KIT	-	NC	DERMATOLOGICALS
ONYDA XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
ONZETRA XSAIL	-	NC	MIGRAINE PRODUCTS
OPANA TAB	-	NC	ANALGESICS - OPIOID
OPILL TAB	OTC	$0	CONTRACEPTIVES
OPIPZA FILM	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
OPIUM TINCTURE	-	NC	ANTIDIARRHEAL/PROBIOTIC AGENTS
OPSUMIT TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
OPSYNVI TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
OPVEE NASAL SPRAY	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
OPZELURA CREAM (QL= 4 tubes/30 days for the first two months; then QL= 12 tubes/year thereafter)	PA-QL	B	DERMATOLOGICALS
ORACEA CAP	-	NC	DERMATOLOGICALS
ORACIT SOLN	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
ORALAIR SL TAB	-	NC	BIOLOGICALS MISC
ORAPRED ODT TAB, PREDNISOLONE ODT TAB	-	NC	CORTICOSTEROIDS
ORAVIG TAB	-	NC	MOUTH/THROAT/DENTAL AGENTS
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ORENITRAM TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORENITRAM TAB MONTH PAK	-	NC	CARDIOVASCULAR AGENTS - MISC.
ORFADIN CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORFADIN SUSP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORGOVYX TAB (QL= 30 tabs/28 days; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	B	ESTROGENS
ORILISSA TAB 150MG (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORILISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
ORLADEYO CAP (QL= 1 cap/day; Only available through CareMed 877-227-3405 or Onco360 877-662-6633)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
ORLADEYO PACK (QL= 1 packet/day; Only available through CareMed 877-227-3405 or Onco360 877-662-6633)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ORLYNVAH TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
ORSERDU TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORSERDU TAB 345MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORTHOVISC/MONOVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ORTIKOS ER CAP	-	NC	CORTICOSTEROIDS
ORUDIS CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill, 1 fill/calendar year)	QL	G	ANTIVIRALS
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill, 1 fill/calendar year)	QL	G	ANTIVIRALS
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill, 1 fill per calendar year)	QL	G	ANTIVIRALS
OSMOLEX ER TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
OSMOPREP TAB	-	NC	LAXATIVES
OSPHENA TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OTEZLA/OTEZLA XR STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
otomax-HC otic soln (CORTANE-B equiv)	-	NC	OTIC AGENTS
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC	OTIC AGENTS
OTULFI INJ	-	NC	DERMATOLOGICALS
OTULFI, USTEKINUMAB-AAUZ SYRINGE	-	NC	DERMATOLOGICALS
OVACE PLUS CREAM	-	NC	DERMATOLOGICALS
OVACE PLUS LIQ WASH 10%	-	B	DERMATOLOGICALS
OVACE PLUS LOTION	-	NC	DERMATOLOGICALS
OVACE PLUS SHAMPOO	-	NC	DERMATOLOGICALS
OVACE PLUS FOAM	-	NC	DERMATOLOGICALS
OVEEZA CAP	-	NC	HEMATOPOIETIC AGENTS
OVIDREL INJ	INF	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
oxaprozin tab (DAYPRO equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	G	ANTIANXIETY AGENTS
OXBRYTA TAB	-	NC	HEMATOPOIETIC AGENTS
OXBRYTA TAB FOR ORAL SUSP	-	NC	HEMATOPOIETIC AGENTS
oxcarbazepine er tab (OXTELLAR equiv)	-	NC	ANTICONVULSANTS
oxcarbazepine susp (TRILEPTAL equiv)	-	G	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	G	ANTICONVULSANTS
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	B	OPHTHALMIC AGENTS
OXIANUJO CREAM	-	NC	DERMATOLOGICALS
oxiconazole nitrate cream (OXISTAT equiv)	-	NC	DERMATOLOGICALS
OXISTAT CREAM	-	NC	DERMATOLOGICALS
OXISTAT LOTION	-	NC	DERMATOLOGICALS
OXTELLAR XR TAB	-	NC	ANTICONVULSANTS
oxybutynin ER tab (DITROPAN XL equiv)	-	G	URINARY ANTISPASMODICS
oxybutynin syrup	-	G	URINARY ANTISPASMODICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
oxybutynin tab (DITROPAN equiv)	-	G	URINARY ANTISPASMODICS
oxybutynin tab 2.5mg	-	NC	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	G	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
OXYCODONE TAB	-	NC	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN	-	G	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML	-	NC	ANALGESICS - OPIOID
oxycodone/acetaminophen tab (PERCOCET equiv)	-	G	ANALGESICS - OPIOID
OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG	-	NC	ANALGESICS - OPIOID
OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
oxymetazoline hcl cream (RHOFADE equiv)	-	EXC	DERMATOLOGICALS
OXYMORPHONE ER TAB	-	NC	ANALGESICS - OPIOID
oxymorphone tab (OPANA equiv)	-	NC	ANALGESICS - OPIOID
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
OZEMPIC TAB, RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	B	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	B	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of aripiprazole or quetiapine ER)	ST	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PALSONIFY TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Orsini 800-410-8575)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PALYNZIQ INJ (QL= 1 inj/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PANCREAZE CAP, PERTZYE CAP	-	NC	DIGESTIVE AIDS
PANDEL CREAM	-	NC	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv)	-	G	ULCER DRUGS
pantoprazole sodium packet (PROTONIX equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
paramox hc gel (NOVACORT GEL equiv)	-	NC	DERMATOLOGICALS
PAREGORIC TINCTURE	-	NC	ANTIDIARRHEALS
paricalcitol cap (ZEMPLAR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
paroxetine cap (BRISDELLE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	G	ANTIDEPRESSANTS
PAROXETINE SUSP	-	G	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	G	ANTIDEPRESSANTS
PAXLOVID PAK (QL= 11 tabs/90 days)	QL	B	ANTIVIRALS
PAXLOVID TAB 150-100MG (QL= 20 tabs/90 days)	QL	B	ANTIVIRALS
PAXLOVID TAB 300-100MG (QL= 30 tabs/90 days)	QL	B	ANTIVIRALS
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PAZOPANIB TAB 400MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEAK FLOW METER	OTC	G	MEDICAL DEVICES AND SUPPLIES
PEDIARIX INJ	VAC	$0	TOXOIDS
pediatric multiple vitamins/fluoride soln	-	NC	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	NC	MULTIVITAMINS
PEDIZOLPAK THERAPY PACK	-	NC	DERMATOLOGICALS
PEDVAXHIB INJ	VAC	$0	VACCINES
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	$0	LAXATIVES
peg 3350/electrolytes soln (COLYTE equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	$0	LAXATIVES
peg 3350/electrolytes soln (NULYTELY equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	$0	LAXATIVES
PEGASYS INJ	LMSP	B	ANTIVIRALS
PEG-PREP KIT	PA	B	LAXATIVES
PELLIX SOLN	-	NC	DERMATOLOGICALS
PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEN NEEDLE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
PENBRAYA INJ	VAC	$0	VACCINES
penciclovir cream (DENAVIR equiv)	-	NC	DERMATOLOGICALS
penicillamine cap (CUPRIMINE equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
penicillamine tab (DEPEN TITRATAB equiv)	-	G	MISCELLANEOUS THERAPEUTIC CLASSES
penicillin vk tab (VEETIDS equiv)	-	G	PENICILLINS
PENICILLN VK SOLN	-	G	PENICILLINS
PENICILLN VK SOLN 125MG/5ML	-	NC	PENICILLINS
PENICILLN VK SOLN 250MG/5ML	-	NC	PENICILLINS
PENLAC SOLN	-	NC	DERMATOLOGICALS
PENMENVY INJ	VAC	$0	VACCINES
PENNSAID SOLN	-	NC	DERMATOLOGICALS
PENTACEL INJ	VAC	$0	TOXOIDS
pentamidine neb soln (NEBUPENT equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
PENTASA CR CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
PENTAZOCINE/NALOXONE TAB	-	G	ANALGESICS - OPIOID
pentazocine/naloxone tab (TALWIN NX equiv)	-	G	ANALGESICS - OPIOID
PENTOSAN CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
pentoxifylline ER tab (TRENTAL equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
PEPCID SUSP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
perampanel susp (FYCOMPA equiv)	-	G	ANTICONVULSANTS
perampanel tab (FYCOMPA equiv)	-	G	ANTICONVULSANTS
PERINDOPRIL TAB	-	G	ANTIHYPERTENSIVES
perindopril tab (ACEON equiv)	-	G	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	G	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PERPHENAZINE/ AMITRIPTYLINE TAB	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PEXEVA TAB	-	NC	ANTIDEPRESSANTS
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523)	LD	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PHENAZOPYRIDINE TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
phenazopyridine tab (PYRIDIUM equiv)	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PHENDIMETRAZINE ER TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
phendimetrazine tab (BONTRIL PDM equiv)	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
PHENELZINE SULFATE TAB	-	G	ANTIDEPRESSANTS
phenelzine tab (NARDIL equiv)	-	G	ANTIDEPRESSANTS
phenobarbital elixir	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL ELXIR	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenobarbital tab	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 100MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 15MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 16.2MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 30MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 32.4MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 60MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 64.8MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
PHENOBARBITAL TAB 97.2MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenoxybenzamine cap (DIBENZYLINE equiv)	-	G	ANTIHYPERTENSIVES
phenylephrine ophth soln (MYDFRIN equiv)	-	G	OPHTHALMIC AGENTS
phenytoin cap (DILANTIN equiv)	-	G	ANTICONVULSANTS
phenytoin chew tab (DILANTIN equiv)	-	G	ANTICONVULSANTS
phenytoin susp (DILANTIN equiv)	-	G	ANTICONVULSANTS
PHEXXI GEL (QL= 1 box/fill)	QL	$0	VAGINAL AND RELATED PRODUCTS
PHOSPHA 250 NEUTRAL TAB	-	G	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PHOSPHO-TRIN K500 TAB	-	G	MINERALS & ELECTROLYTES
PHOTREXA OP KIT	-	NC	OPHTHALMIC AGENTS
PHOTREXA VISCOUS OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PHYRAGO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
phytonadione tab (MEPHYTON equiv)	-	G	VITAMINS
PIFELTRO TAB	-	B	ANTIVIRALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	G	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
pimecrolimus cream (ELIDEL equiv) (Covered for members age 2 years and older)	-	G	DERMATOLOGICALS
pimozide tab (ORAP equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pindolol tab (VISKEN equiv)	-	G	BETA BLOCKERS
pioglitazone tab (ACTOS equiv)	-	G	ANTIDIABETICS
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC	ANTIDIABETICS
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC	ANTIDIABETICS
PIQRAY TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	LMSP-PA-QL	G	RESPIRATORY AGENTS - MISC.
PIRFENIDONE TAB	-	NC	RESPIRATORY AGENTS - MISC.
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	LMSP-PA-QL	G	RESPIRATORY AGENTS - MISC.
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	LMSP-PA-QL	G	RESPIRATORY AGENTS - MISC.
piroxicam cap (FELDENE equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
pitavastatin calcium tab (LIVALO equiv)	-	NC	ANTIHYPERLIPIDEMICS
PIVOT INSULIN PUMP STARTER KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
PIVOT SUPPLY KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
PIVYA TAB	-	NC	PENICILLINS
PLAN B TAB	OTC	$0	CONTRACEPTIVES
PLAVIX TAB 300MG	-	NC	HEMATOLOGICAL AGENTS - MISC.
PLEGRIDY INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLEGRIDY PEN INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PLENITY CAP	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
PLENVU SOLN	-	NC	LAXATIVES
plerixafor subcutaneous inj (MOZOBIL INJ equiv)	MSP-PA	B	HEMATOPOIETIC AGENTS
PLEXION CREAM 9.8-4.8%	-	NC	DERMATOLOGICALS
PLIAGLIS CREAM	-	NC	DERMATOLOGICALS
PLIAGLIS KIT	-	NC	DERMATOLOGICALS
PNEUMOVAX INJ	VAC	$0	VACCINES
PNV PRENATOL TAB 27-1 MG	-	NC	MULTIVITAMINS
PODIAPN CAP	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
PODOCON SOLN	-	B	DERMATOLOGICALS
podofilox gel (CONDYLOX equiv)	-	G	DERMATOLOGICALS
PODOFILOX SOLN	-	G	DERMATOLOGICALS
podofilox soln (CONDYLOX equiv)	-	G	DERMATOLOGICALS
POKONZA ORAL SOLN	-	NC	MINERALS & ELECTROLYTES
POKONZA POWDER	-	NC	MINERALS & ELECTROLYTES
POLYETHYLENE GLYCOL 8000 GRANULES	-	B	PHARMACEUTICAL ADJUVANTS
POLY-IRON CAP 150 FORTE	-	G	HEMATOPOIETIC AGENTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	G	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
POLY-TUSSIN DM SYRUP	-	NC	COUGH/COLD/ALLERGY
POLY-VI-FLOR SUSP	-	NC	MULTIVITAMINS
pomalidomide cap (POMALYST equiv) (QL= 21 caps/28 days)	MSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
POMALYST CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PONVORY TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PONVORY TAB STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
posaconazole DR tab (NOXAFIL equiv) (QL= 93 tabs/30 days)	PA-QL	G	ANTIFUNGALS
posaconazole susp (NOXAFIL equiv) (QL= 525ml/26 days)	PA-QL	G	ANTIFUNGALS
potassium bicarbonate effer tab (K-LYTE equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride ER cap (MICRO-K equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride ER tab (K-TAB equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride micro tab (K-DUR equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride powder packet (KLOR-CON equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride soln	-	G	MINERALS & ELECTROLYTES
POTASSIUM CHLORIDE TAB ER	-	G	MINERALS & ELECTROLYTES
potassium citrate CR tab (UROCIT-K TAB equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
POTASSIUM IODIDE ORAL SOLN	-	NC	COUGH/COLD/ALLERGY
PRADAXA PELLET PACK	-	NC	ANTICOAGULANTS
pramipexole ER tab (MIRAPEX ER equiv)	-	G	ANTIPARKINSON AGENTS
pramipexole tab (MIRAPEX equiv)	-	G	ANTIPARKINSON AGENTS
PRAMOSONE CREAM 1-1%	-	NC	DERMATOLOGICALS
PRAMOSONE CREAM 1-2.5%	-	NC	DERMATOLOGICALS
PRAMOSONE LOTION	-	NC	DERMATOLOGICALS
PRAMOSONE OINT	-	NC	DERMATOLOGICALS
PRANDIMET TAB	-	NC	ANTIDIABETICS
prasugrel tab (EFFIENT equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv)	-	$0	ANTIHYPERLIPIDEMICS
praziquantel tab (BILTRICIDE equiv)	-	G	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	G	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP	OTC	NC	DIAGNOSTIC PRODUCTS
PRECISION XTRA METER	OTC	$0	MEDICAL DEVICES AND SUPPLIES
PRECISION XTRA TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
PRED FORTE OPHTH SUSP	-	B	OPHTHALMIC AGENTS
PRED MILD OPHTH SOLN	-	B	OPHTHALMIC AGENTS
prednisolone acetate ophth susp (PRED FORTE equiv)	-	G	OPHTHALMIC AGENTS
prednisolone ODT (ORAPRED equiv)	-	NC	CORTICOSTEROIDS
PREDNISOLONE OPHTH SUSP	-	G	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
PREDNISOLONE SOLN	-	B	CORTICOSTEROIDS
prednisolone soln	-	G	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	G	CORTICOSTEROIDS
prednisolone tab (MILLIPRED equiv)	-	NC	CORTICOSTEROIDS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISOLONE/NEPAFENAC OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
PREDNISONE DR TAB	-	NC	CORTICOSTEROIDS
PREDNISONE DR TAB, RAYOS DR TAB	-	NC	CORTICOSTEROIDS
prednisone pack	-	NC	CORTICOSTEROIDS
PREDNISONE SOLN	-	B	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	G	CORTICOSTEROIDS
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC	CORTICOSTEROIDS
pregabalin cap (LYRICA equiv) (QL= 3 caps/day)	QL	G	ANTICONVULSANTS
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	G	ANTICONVULSANTS
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	G	ANTICONVULSANTS
pregabalin ER tab (LYRICA CR equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	G	ANTICONVULSANTS
PREGEN DHA CAP	-	NC	MULTIVITAMINS
PREGENNA TAB	-	NC	MULTIVITAMINS
PREHEVBRIO SUSP	VAC	$0	VACCINES
PREMARIN TAB	-	B	ESTROGENS
PREMARIN VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
PREMPHASE TAB, PREMPRO TAB	-	B	ESTROGENS
PRENA1 CHEW	-	NC	MULTIVITAMINS
PRENA1 PEARL, VITAPEARL	-	NC	MULTIVITAMINS
PRENA1 TRUE, VITATRUE	-	NC	MULTIVITAMINS
PRENACHEW CHEW	-	NC	MULTIVITAMINS
PRENARA CAP	-	NC	MULTIVITAMINS
PRENATA	-	G	MULTIVITAMINS
PRENATABS RX TAB	-	G	MULTIVITAMINS
PRENATAL 19 CHEW TAB	-	G	MULTIVITAMINS
PRENATAL 19 TAB	-	G	MULTIVITAMINS
PRENATAL FORMULA, PRENATAL MULTI + DHA	-	G	MULTIVITAMINS
PRENATAL MULTIVITAMIN + D	-	G	MULTIVITAMINS
PRENATAL PLUS IRON	-	G	MULTIVITAMINS
PRENATAL VITAMINS (NON-PREFERRED)	-	B	MULTIVITAMINS
PRENATE AM	-	NC	MULTIVITAMINS
PRENATE CHEWABLE	-	NC	MULTIVITAMINS
PRENATE DHA	-	NC	MULTIVITAMINS
PRENATE ELITE	-	NC	MULTIVITAMINS
PRENATE ESSENTIAL	-	NC	MULTIVITAMINS
PRENATE MAX TAB	-	NC	MULTIVITAMINS
PRENATE MINI	-	NC	MULTIVITAMINS
PRENATE MINI, TRISTART DHA	-	NC	MULTIVITAMINS
PRENATE TAB	-	NC	MULTIVITAMINS
PRENATOL-M TAB 27-1.2MG	-	NC	MULTIVITAMINS
PRENATRIX TAB	-	NC	MULTIVITAMINS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PRENATRYL TAB	-	NC	MULTIVITAMINS
PRESTALIA TAB	-	NC	ANTIHYPERTENSIVES
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTIMYCOBACTERIAL AGENTS
PREVACID CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
PREVIDENT 5000 PASTE 1.1%	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT GEL	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT SOLN 0.2%	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVNAR 20 INJ	VAC	$0	VACCINES
PREVYMIS PAK (QL= 4 packets/day; Limit 800 packets/365 days)	LMSP-PA-QL	B	ANTIVIRALS
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	LMSP-PA-QL	B	ANTIVIRALS
PREZCOBIX TAB	-	B	ANTIVIRALS
PREZISTA SUSP	-	B	ANTIVIRALS
PREZISTA TAB	-	B	ANTIVIRALS
PRIFTIN TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
PRILOSEC CAP	-	NC	ULCER DRUGS
PRIMACARE	-	NC	MULTIVITAMINS
primaquine tab (PRIMAQUINE equiv)	-	G	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	G	ANTICONVULSANTS
PRIMIDONE TAB	-	NC	ANTICONVULSANTS
PRIMLEV TAB 10-300MG	-	NC	ANALGESICS - OPIOID
PRIMLEV TAB 5-300MG	-	NC	ANALGESICS - OPIOID
PRIORIX INJ	VAC	$0	VACCINES
probenecid tab (BENEMID equiv)	-	G	GOUT AGENTS
prochlorperazine supp (COMPAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PROCRIT INJ	-	NC	HEMATOPOIETIC AGENTS
PROCTOCORT SUPP	-	NC	ANORECTAL AND RELATED PRODUCTS
PROCTOFOAM HC FOAM	-	B	ANORECTAL AGENTS
proctosol HC cream (ANUSOL HC equiv)	-	G	ANORECTAL AGENTS
PROCYSBI CAP	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PROCYSBI GRANULES PACKET	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PRODRIN TAB	-	NC	MIGRAINE PRODUCTS
PROFILNINE INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
PROFINAC PAK	-	NC	DERMATOLOGICALS
progesterone cap (PROMETRIUM equiv)	-	G	PROGESTINS
progesterone oil inj	-	G	PROGESTINS
PROGESTERONE SUPP	PA	B	VAGINAL PRODUCTS
progesterone vaginal insert (ENDOMETRIN equiv)	-	NC	VAGINAL AND RELATED PRODUCTS
PROGRAF PACKET	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
PROLATE TAB 7.5-300MG	-	NC	ANALGESICS - OPIOID
PROLENSA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
PROLIA INJ (QL= 1 fill/6 months)	LMSP-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PROMACTA POWDER	-	NC	HEMATOPOIETIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
PROMACTA TAB 12.5MG, 25MG	-	NC	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	G	COUGH/COLD/ALLERGY
promethazine supp (PHENERGAN equiv)	-	G	ANTIHISTAMINES
promethazine syrup	-	G	ANTIHISTAMINES
promethazine tab (PHENERGAN equiv)	-	G	ANTIHISTAMINES
PROMETHAZINE VC SYRUP	-	G	COUGH/COLD/ALLERGY
promethazine VC syrup (PHENERGAN VC equiv)	-	G	COUGH/COLD/ALLERGY
PROMETHAZINE VC/CODEINE SYRUP	-	G	COUGH/COLD/ALLERGY
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	G	COUGH/COLD/ALLERGY
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	G	COUGH/COLD/ALLERGY
PROMETHEGAN SUPP	-	G	ANTIHISTAMINES
PROMISEB CREAM	-	NC	DERMATOLOGICALS
propafenone ER cap (RYTHMOL SR equiv)	-	G	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	G	ANTIARRHYTHMICS
proparacaine ophth soln (ALCAINE equiv)	-	G	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	G	BETA BLOCKERS
propranolol hcl oral soln 20mg/5ml	-	G	BETA BLOCKERS
PROPRANOLOL SOLN	-	G	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	G	BETA BLOCKERS
propylthiouracil tab	-	G	THYROID AGENTS
PROQUAD INJ	VAC	$0	VACCINES
PROQUIN XR TAB	-	NC	FLUOROQUINOLONES
PROSED DS TAB	-	NC	URINARY ANTI-INFECTIVES
PROTHELIAL PASTE	-	NC	MOUTH/THROAT/DENTAL AGENTS
protriptyline tab (VIVACTIL equiv)	-	G	ANTIDEPRESSANTS
PROVIDA OB	-	NC	MULTIVITAMINS
PROVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
PROZAC WEEKLY CAP	-	NC	ANTIDEPRESSANTS
PROZENA PAD	-	NC	DERMATOLOGICALS
prucalopride succinate tab (MOTEGRITY equiv) (QL= 1 tab/day)	QL	G	GASTROINTESTINAL AGENTS - MISC.
PULMICORT FLEXHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMOZYME INH SOLN	LMSP	B	RESPIRATORY AGENTS - MISC.
PUREFOLIX TAB	-	NC	HEMATOPOIETIC AGENTS
PYLERA CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
pyrazinamide tab	-	G	ANTIMYCOBACTERIAL AGENTS
PYRIDIUM TAB 100MG	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PYRIDIUM TAB 200MG	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
pyridostigmine CR tab (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyridostigmine tab (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS
PYRIDOSTIGMINE TAB 30MG	-	NC	ANTIMYASTHENIC/CHOLINERGIC AGENTS
PYRIDOXINE INJ	-	G	VITAMINS
pyridstigmine soln (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	G	ANTIMALARIALS
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC	ANTIMALARIALS
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
PYZCHIVA INJ	-	NC	DERMATOLOGICALS
QBRELIS SOLN (Prior Authorization required for members age 9 years and older)	PA	B	ANTIHYPERTENSIVES
QBREXZA PAD	-	NC	DERMATOLOGICALS
QDOLO SOLN, TRAMADOL SOLN	-	NC	ANALGESICS - OPIOID
QELBREE ER CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
QFITLIA INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
QLOSI OPHTH SOLN, VUITY OPHTH SOLN	-	EXC	OPHTHALMIC AGENTS
QMIIZ ODT TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
QNASL NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
QTERN TAB	-	NC	ANTIDIABETICS
QUALAQUIN CAP	-	NC	ANTIMALARIALS
QUAZEPAM TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
QUDEXY XR CAP	-	NC	ANTICONVULSANTS
quetiapine tab (SEROQUEL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
QUETIAPINE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
QUILLICHEW ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
QUILLIVANT XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
quinapril tab (ACCUPRIL equiv)	-	G	ANTIHYPERTENSIVES
QUINAPRIL/HCTZ TAB	-	NC	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	NC	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	G	ANTIARRHYTHMICS
quinidine sulfate tab	-	G	ANTIARRHYTHMICS
QUINIDINE SULFATE TAB	-	NC	ANTIARRHYTHMICS
quinine sulfate cap (QUALAQUIN equiv)	-	NC	ANTIMALARIALS
QUINIXIL PAK	-	NC	DERMATOLOGICALS
QUIOFIC SOLN	-	NC	HEMATOPOIETIC AGENTS
QULIPTA TAB	-	NC	MIGRAINE PRODUCTS
QUVIVIQ TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS
QVAR AERO	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
QVAR REDIHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
RABAVERT INJ	VAC	EXC	VACCINES
rabeprazole EC tab (ACIPHEX equiv)	PA	G	ULCER DRUGS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
RAGWITEK SL TAB	-	NC	BIOLOGICALS MISC
RALDESY SOLN	-	NC	ANTIDEPRESSANTS
raloxifene tab (EVISTA equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	PA-QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ramipril cap (ALTACE equiv)	-	G	ANTIHYPERTENSIVES
RANITIDINE TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEI CS
ranolazine tab (RANEXA equiv)	-	G	ANTIANGINAL AGENTS
rasagiline tab (AZILECT equiv)	-	G	ANTIPARKINSON AGENTS
RASONQUE TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RAVICTI LIQUID	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYALDEE CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
REBIF INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBINYN INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
RECOMBINATE INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
RECORLEV TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RECTIV OINT	-	B	ANORECTAL AND RELATED PRODUCTS
REDEMPLO PFS INJ (QL= 1 inj/84 days; Only available through Vanscoy Rare Pharmacy 855-826-7269)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
REDITREX INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
RELAFEN DS TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
RELENZA DISKHALER (QL= 1 inhaler/calendar year)	QL	B	ANTIVIRALS
RELEUKO INJ	-	NC	HEMATOPOIETIC AGENTS
RELEUKO PREFILLED SYRINGE INJ	-	NC	HEMATOPOIETIC AGENTS
RELEVIA TAB 27-1MG	-	NC	MULTIVITAMINS
RELEXXI ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
RELISTOR INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR INJ KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELPAX TAB	-	NC	MIGRAINE PRODUCTS
RELTONE CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
REMICADE INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
REMODULIN SOLN 8MG/20ML (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
RENACIDIN SOLN	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
RENAGEL TAB 800MG	-	NC	GASTROINTESTINAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
renaphro cap (NEPHROCAP equiv)	-	NC	MULTIVITAMINS
RENFLEXIS INJ	MSP-PA	B	GASTROINTESTINAL AGENTS - MISC.
RENOVA CREAM	-	EXC	DERMATOLOGICALS
RENVELA TAB	-	B	GASTROINTESTINAL AGENTS - MISC.
repaglinide tab (PRANDIN equiv)	-	G	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	B	ANTIHYPERLIPIDEMICS
REQUIP XL TAB	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
RESERVAPAK SYRUP	-	NC	ALTERNATIVE MEDICINES
RESTASIS OPHTH EMULSION	-	NC	OPHTHALMIC AGENTS
RETACRIT INJ	LMSP	B	HEMATOPOIETIC AGENTS
RETEVMO CAP (QL= 2 caps/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETEVMO CAP 40MG (QL= 3 caps/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETEVMO TAB (QL= 2 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETEVMO TAB 40MG (QL= 3 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETIN-A CREAM	-	NC	DERMATOLOGICALS
RETIN-A GEL	-	NC	DERMATOLOGICALS
RETIN-A MICRO GEL/GEL PUMP	-	NC	DERMATOLOGICALS
RETIN-A MICRO GEL/GEL PUMP, TRETINOIN MICROSPHERE GEL/GEL PUI	-	NC	DERMATOLOGICALS
REVATIO SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
REVLIMID CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
REVUFORJ TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REVUFORJ TAB 110MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REVUFORJ TAB 25MG (QL= 8 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REXAPHENAC CREAM	-	NC	DERMATOLOGICALS
REXASIL KIT	-	NC	DERMATOLOGICALS
REXULTI TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
REYATAZ POWDER PACK	-	B	ANTIVIRALS
REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
REZDIFFRA TAB (QL= 1 tab/day; Only available through Optum 877-445-6874)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
REZENOPY SPRAY 10MG/0.11ML	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
REZVOGLAR INJ	-	NC	ANTIDIABETICS
REZYST CHEW TAB	-	NC	ANTIDIARRHEALS
RHAPSIDO TAB	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
RHOFADE CREAM	-	EXC	DERMATOLOGICALS
RHOPRESSA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
RIASTAP INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
RIBAVIRIN CAP	LMSP	B	ANTIVIRALS
ribavirin cap (REBETOL equiv)	LMSP	G	ANTIVIRALS
RIBAVIRIN INH	-	NC	ANTIVIRALS
ribavirin inh soln (VIRAZOLE equiv)	-	NC	ANTIVIRALS
RIBAVIRIN TAB	LMSP	B	ANTIVIRALS
rifabutin cap (MYCOBUTIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
rifampin cap (RIFADIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
rifapentine tab (PRIFTIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
rilpivirine hcl tab (EDURANT equiv)	-	G	ANTIVIRALS
riluzole tab (RILUTEK equiv)	-	G	NEUROMUSCULAR AGENTS
RIMANTADINE TAB	-	NC	ANTIVIRALS
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
RINVOQ ORAL SOLN (QL= 12ml/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
riociguat tab (ADEMPAS equiv) (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
risedronate DR tab (ATELVIA equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
risedronate tab (ACTONEL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
RISPERIDONE ODT	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone ODT (RISPERDAL M equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone soln (RISPERDAL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
risperidone tab (RISPERDAL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ritonavir tab (NORVIR equiv)	-	G	ANTIVIRALS
RITUXAN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
rivaroxaban for susp (XARELTO equiv)	-	G	ANTICOAGULANTS
rivaroxaban tab 2.5mg (XARELTO equiv)	-	G	ANTICOAGULANTS
rivastigmine cap (EXELON equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
RIVFLOZA INJ (QL= 1 inj/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	GENITOURINARY AGENTS - MISCELLANEOUS
RIVFLOZA INJ 160MG (QL= 1 inj/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	GENITOURINARY AGENTS - MISCELLANEOUS
RIVFLOZA VIAL (QL= 2 vials/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	GENITOURINARY AGENTS - MISCELLANEOUS
RIVIVE, REXTOVY SPRAY	OTC	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
RIXUBIS INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
RIZAFILM MIS	-	NC	MIGRAINE PRODUCTS
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G	MIGRAINE PRODUCTS
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G	MIGRAINE PRODUCTS
ROAOXIA GEL	-	NC	DERMATOLOGICALS
ROCKLATAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
roflumilast tab	PA	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ROMVIMZA CAP (QL= 8 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ropinirole ER tab (REQUIP XL equiv)	-	G	ANTIPARKINSON AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ropinirole tab (REQUIP equiv)	-	G	ANTIPARKINSON AGENTS
ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC	LOCAL ANESTHETICS-PARENTERAL
ROSADAN KIT	-	NC	DERMATOLOGICALS
rosuvastatin tab (CRESTOR equiv)	-	$0	ANTIHYPERLIPIDEMICS
ROSZET TAB	-	NC	ANTIHYPERLIPIDEMICS
ROSZET TAB, EZETIMIBE/ROSUVASTATIN TAB	-	NC	ANTIHYPERLIPIDEMICS
ROTARIX SUSP	VAC	$0	VACCINES
ROTATEQ INJ	VAC	$0	VACCINES
ROWASA KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
ROXYBOND TAB	-	NC	ANALGESICS - OPIOID
ROZEREM TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ROZLYTREK CAP (QL= 3 caps/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ROZLYTREK PAK (QL= 6 packs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
rufinamide susp (BANZEL equiv) (Prior Authorization required for members age 9 years and older)	PA	G	ANTICONVULSANTS
rufinamide tab (BANZEL equiv)	-	G	ANTICONVULSANTS
RUKOBIA ER TAB (Restricted to Infectious Disease Specialist)	RS	B	ANTIVIRALS
RYALTRIS SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
RYBIX ODT	-	NC	ANALGESICS - OPIOID
RYDAPT CAP (QL= 56 caps/28 days)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SABRIL TAB	-	NC	ANTICONVULSANTS
sacubitril-valsartan tab (ENTRESTO equiv) (QL= 2 tabs/day)	QL	G	CARDIOVASCULAR AGENTS - MISC.
SAFYRAL TAB	-	NC	CONTRACEPTIVES
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SALEX LOTION KIT	-	NC	DERMATOLOGICALS
SALEX SHAMPOO	-	NC	DERMATOLOGICALS
SALICATE LIQUID	-	NC	DERMATOLOGICALS
SALICYLIC AC SOLN ER, XALIX SOLN	-	NC	DERMATOLOGICALS
SALIMEZ FORTE CREAM	-	NC	DERMATOLOGICALS
SALSALATE TAB	-	NC	ANALGESICS - NONNARCOTIC
salsalate tab (DISALCID equiv)	-	NC	ANALGESICS - NONNARCOTIC
SANCUSO PATCH (QL= 4 patches/fill)	QL	B	ANTIEMETICS
SANDIMMUNE SOLN 100MG/ML	-	B	ASSORTED CLASSES
SANTYL OINT (QL= 90gm/30 days)	QL	B	DERMATOLOGICALS
SAPHNELO INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
SAPHNELO PEN INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
sapropterin dihydrochloride powder packet (KUVAN equiv)	LMSP-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
sapropterin dihydrochloride soluble tab (KUVAN equiv)	LMSP-PA	G	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SARAFEM TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVAYSA TAB	-	NC	ANTICOAGULANTS
SAVELLA PAK	-	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SAVELLA TAB (QL= 2 tabs/day)	QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
saxagliptin hcl tab (ONGLYZA equiv)	-	NC	ANTIDIABETICS
saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv)	-	NC	ANTIDIABETICS
SAXENDA INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
SCARCIN GEL	-	NC	DERMATOLOGICALS
SCARCIN LIQUID ROLL-ON	-	NC	DERMATOLOGICALS
SCEMBLIX TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SCEMBLIX TAB 100 MG (QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
scopolamine patch (TRANSDERM-SCOP equiv)	-	G	ANTIEMETICS
SDAMLO SOLN	-	NC	CALCIUM CHANNEL BLOCKERS
SECUADO PATCH	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SEGLENTIS TAB	-	NC	ANALGESICS - OPIOID
SEGLUROMET TAB	-	NC	ANTIDIABETICS
SELARSDI INJ	-	NC	DERMATOLOGICALS
SELECT OB + DHA	-	NC	MULTIVITAMINS
selegiline cap (ELDEPRYL equiv)	-	G	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	G	ANTIPARKINSON AGENTS
SELENIUM SUL SHA	-	G	DERMATOLOGICALS
SELENIUM SUL SHA 2%	-	NC	DERMATOLOGICALS
SELENIUM SULFIDE LOTION	-	G	DERMATOLOGICALS
selenium sulfide lotion 2.5% (SELSUN equiv)	-	G	DERMATOLOGICALS
selenium sulfide shampoo (SELSEB equiv)	-	G	DERMATOLOGICALS
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC	DERMATOLOGICALS
SELZENTRY SOLN	-	B	ANTIVIRALS
SELZENTRY TAB	-	B	ANTIVIRALS
SEMGLEE INJ (SINGLE PEN)	-	NC	ANTIDIABETICS
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	B	ANTIDIABETICS
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	B	ANTIDIABETICS
SEMGLEE SOLN	-	NC	ANTIDIABETICS
SEMPREX-D CAP	-	EXC	COUGH/COLD/ALLERGY
SENSIPAR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEPHIENCE POWDER (Only available through Optum Frontier Therapies 855-768-9727 or Orsini 800-410-8575)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SEREVENT DISKUS INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SERNIVO SPRAY	-	NC	DERMATOLOGICALS
SEROQUEL XR TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SERTRALINE CAP	-	NC	ANTIDEPRESSANTS
sertraline conc (ZOLOFT equiv)	-	G	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sertraline hcl cap	-	NC	ANTIDEPRESSANTS
sertraline tab (ZOLOFT equiv)	-	G	ANTIDEPRESSANTS
sevelamer hydrochloride tab (RENAGEL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
sevelamer powder pak (RENVELA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
sevelamer tab (RENVELA TAB equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
SEVENFACT INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
SEYSARA TAB	-	NC	TETRACYCLINES
SHINGRIX INJ (Covered for members age 19 years and older)	VAC	$0	VACCINES
SIGNIFOR INJ (QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SIKLOS TAB	-	NC	HEMATOPOIETIC AGENTS
SILALITE PAK MIS	-	NC	DERMATOLOGICALS
SILATRIX GEL	-	NC	MOUTH/THROAT/DENTAL AGENTS
sildenafil susp (REVATIO equiv) (Prior Authorization required for members age 9 years and older)	PA	G	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab (VIAGRA equiv) (QL=6 tabs/30 days)	QL	G	CARDIOVASCULAR AGENTS - MISC.
sildenafil tab 20mg (REVATIO equiv)	PA	G	CARDIOVASCULAR AGENTS - MISC.
SILIPAC KIT	-	NC	DERMATOLOGICALS
SILIQ INJ	-	NC	DERMATOLOGICALS
silodosin cap (RAPAFLO equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	G	DERMATOLOGICALS
SILVERA PAD	-	NC	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	B	OPHTHALMIC AGENTS
SIMCOR TAB	-	NC	ANTIHYPERLIPIDEMICS
SIMLANDI INJ, ADALIMUMAB-RYVK INJ (QUALLENT)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI AUTO-INJECTOR 50MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI INJ 50MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	$0	ANTIHYPERLIPIDEMICS
simvastatin tab 80mg (ZOCOR equiv)	-	NC	ANTIHYPERLIPIDEMICS
sirolimus soln (RAPAMUNE equiv)	-	G	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	G	ASSORTED CLASSES
SIRTURO TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
sitagliptin phosphate tab (JANUVIA equiv) (QL= 1 tab/day)	QL-¢	G	ANTIDIABETICS
sitagliptin phosphate-metformin hcl er tab (JANUMET equiv) (QL= 2 tabs/day)	QL	G	ANTIDIABETICS
sitagliptin phosphate-metformin hcl tab (JANUMET equiv) (QL= 2 tabs/day)	QL	G	ANTIDIABETICS
SITAGLIPTIN/METFORMIN TAB	-	NC	ANTIDIABETICS
SITAVIG TAB	-	NC	ANTIVIRALS
SITZMARKS CAP	-	NC	DIAGNOSTIC PRODUCTS
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTI-INFECTIVE AGENTS - MISC.
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTI-INFECTIVE AGENTS - MISC.
SKLICE LOTION	-	NC	DERMATOLOGICALS
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	NEUROMUSCULAR AGENTS
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SKYRIZI INJ 55MG/0.37ML (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
SKYTROFA INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SLYND TAB	-	NC	CONTRACEPTIVES
smz/tmp (DS) tab (BACTRIM DS equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
SOAANZ TAB	-	NC	DIURETICS
SOD SUL/SULF LIQ 9-4.5%	-	G	DERMATOLOGICALS
SOD SUL/SULF SUSP 10-5%	-	NC	DERMATOLOGICALS
SOD SUL/SULF SUSP 8-4%	-	NC	DERMATOLOGICALS
sodium citrate/citric acid soln (BICITRA equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
sodium fluoride chew tab (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE GEL	-	G	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE PASTE	-	G	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride soln (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0	MINERALS & ELECTROLYTES
SODIUM FLUORIDE SOLN	-	G	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE TAB ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0	MINERALS & ELECTROLYTES
SODIUM HYALU INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SODIUM IODIDE I-131 SOLN	-	NC	THYROID AGENTS
sodium oxybate oral soln (XYREM equiv) (QL= 540ml/30 days)	LMSP-PA-QL	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
sodium phenylbutyrate powder (BUPHENYL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium phenylbutyrate tab (BUPHENYL equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
sodium polystyrene powder (KAYEXALATE equiv)	-	G	ASSORTED CLASSES
sodium polystyrene susp (SPS equiv)	-	G	ASSORTED CLASSES
SODIUM SULFA LIQ WASH	-	G	DERMATOLOGICALS
sodium sulfacetamide lotion (KLARON equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide shampoo (OVACE equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide wash (OVACE WASH equiv)	-	G	DERMATOLOGICALS
SODIUM SULFACETAMIDE WASH, OVACE PLUS GEL WASH	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	G	DERMATOLOGICALS
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	G	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR CREAM 10-2%	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR LOTION	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR SUSP	-	NC	DERMATOLOGICALS
SODIUM SULFACETAMIDE/SULFUR WASH	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC	DERMATOLOGICALS
sodium/magnesium/potassium soln (SUPREP equiv) ($0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year)	QL	$0	LAXATIVES
SOFDRA GEL	-	NC	DERMATOLOGICALS
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
SOGROYA INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOHONOS CAP 1.5MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 10MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 1MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 2.5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	MUSCULOSKELETAL THERAPY AGENTS
SOHONOS CAP 5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B	MUSCULOSKELETAL THERAPY AGENTS
SOLAICE PATCH	-	NC	DERMATOLOGICALS
SOLARAVIX PAK	-	NC	DERMATOLOGICALS
solifenacin tab (VESICARE equiv)	-	G	URINARY ANTISPASMODICS
SOLIQUA INJ (QL= 15ml/25 days)	QL	B	ANTIDIABETICS
SOLOSEC GRANULES PACKET	-	NC	AMEBICIDES
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	B	CORTICOSTEROIDS
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	B	CORTICOSTEROIDS
SOLU-MEDROL INJ	-	NC	CORTICOSTEROIDS
SOLU-MEDROL INJ 2GM	-	B	CORTICOSTEROIDS
SOLU-MEDROL PF INJ	-	NC	CORTICOSTEROIDS
SOMA TAB 250MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOMAVERT INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOOLANTRA CREAM	-	NC	DERMATOLOGICALS
sorafenib tosylate tab (NEXAVAR equiv)	LMSP-PA	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
sotalol AF tab (BETAPACE AF equiv)	-	G	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	G	BETA BLOCKERS
SOTYKTU TAB	-	NC	DERMATOLOGICALS
SOTYLIZE SOLN	-	NC	BETA BLOCKERS
SOTYLIZE SOLN 5MG/ML (Prior Authorization required for members age 9 years and older)	PA	B	BETA BLOCKERS
SOVALDI PELLET PAK	-	NC	ANTIVIRALS
SOVALDI TAB	-	NC	ANTIVIRALS
SOVUNA TAB 200MG	-	NC	ANTIMALARIALS
SOVUNA TAB 300MG	-	NC	ANTIMALARIALS
SPEVIGO INJ (QL= 2ml/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	DERMATOLOGICALS
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	$0	VACCINES
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	$0	VACCINES
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SPIRIVA HANDIHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), o SYMBICORT (BUDESONIDE/FORMOTEROL))	QL-ST	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 years and older)	PA	G	DIURETICS
spironolactone tab (ALDACTONE equiv)	-	G	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	G	DIURETICS
SPORANOX CAP	-	NC	ANTIFUNGALS
SPORANOX SOLN	PA	B	ANTIFUNGALS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	$0	CONTRACEPTIVES
SPRIX NASAL SPRAY	PA	B	ANALGESICS - ANTI-INFLAMMATORY
SPRYCEL TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SPS	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
STARJEMZA INJ	-	NC	DERMATOLOGICALS
STARJEMZA PFS INJ	-	NC	DERMATOLOGICALS
STAVZOR CAP	-	NC	ANTICONVULSANTS
STEGLATRO TAB	-	NC	ANTIDIABETICS
STEGLUJAN TAB	-	NC	ANTIDIABETICS
STELARA INJ	-	NC	DERMATOLOGICALS
STENDRA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
STEQEYMA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
STEQEYMA INJ 90MG (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
STEQEYMA VIAL	-	NC	DERMATOLOGICALS
STIMUFEND INJ	-	NC	HEMATOPOIETIC AGENTS
STIOLTO INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
STRIANT FILM	-	NC	ANDROGENS-ANABOLIC
STRIBILD TAB	-	B	ANTIVIRALS
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
STROMECTOL TAB	-	NC	ANTHELMINTICS
SUBLOCADE SOLN, BRIXADI SOLN	LMSP	B	ANALGESICS - OPIOID
SUBOXONE SL FILM	-	NC	ANALGESICS - OPIOID
SUBSYS SPRAY	-	NC	ANALGESICS - OPIOID
SUBVENITE SUSP (Prior Authorization required for members age 9 years and older)	PA	B	ANTICONVULSANTS
SUCRAID SOLN	-	NC	DIGESTIVE AIDS
sucralfate susp (CARAFATE equiv)	PA	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
sucralfate tab (CARAFATE equiv)	-	G	ULCER DRUGS
SUFLAVE SOLN (QL= 2 fills/365 days)	QL	B	LAXATIVES
SULAR ER TAB 17MG	-	B	CALCIUM CHANNEL BLOCKERS
SULAR ER TAB 34MG	-	B	CALCIUM CHANNEL BLOCKERS
SULAR ER TAB 8.5MG	-	B	CALCIUM CHANNEL BLOCKERS
SULFACETAMIDE SOD OPHTH SOLN	-	G	OPHTHALMIC AGENTS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	G	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	G	OPHTHALMIC AGENTS
sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv)	-	NC	DERMATOLOGICALS
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	NC	DERMATOLOGICALS
SULFACETAMIDE SODIUM/SULFUR CREAM 9.8-4.8%	-	NC	DERMATOLOGICALS
sulfadiazine tab	-	G	SULFONAMIDES
SULFAMYLON CREAM	-	B	DERMATOLOGICALS
sulfasalazine EC tab (AZULFIDINE equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
sulfasalazine tab (AZULFIDINE equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
sulindac tab (CLINORIL equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
SUMADAN WASH 9-4.5%	-	NC	DERMATOLOGICALS
SUMADEN XLT KIT	-	NC	DERMATOLOGICALS
SUMANSETRON PAK	-	NC	MIGRAINE PRODUCTS
sumatriptan inj (IMITREX equiv) (QL= 6 inj/fill, 3 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 3 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan vial inj (IMITREX equiv) (QL= 10 vials/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC	MIGRAINE PRODUCTS
SUMAVEL DOSEPRO INJ	-	NC	MIGRAINE PRODUCTS
SUMAXIN WASH	-	NC	DERMATOLOGICALS
sunitinib malate cap (SUTENT equiv) (QL= 1 cap/day)	LMSP-PA-QL	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SUNLENCA INJ	-	NC	ANTIVIRALS
SUNLENCA TAB	-	NC	ANTIVIRALS
SUNLENCA TAB 300MG	-	NC	ANTIVIRALS
SUNOSI TAB (QL= 1 tab/day)	PA-QL	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ NOREXIANTS
SUPPRELIN LA INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SUPRAX CAP	-	B	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	B	CEPHALOSPORINS
SUPREP BOWEL PREP PACK	-	NC	LAXATIVES
SUSTIVA TAB	-	B	ANTIVIRALS
SUSTOL INJ	-	NC	ANTIEMETICS
SUTAB TAB	-	NC	LAXATIVES
SUTENT CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYLATRON INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMBICORT INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SYMBRAVO TAB	-	NC	MIGRAINE PRODUCTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	B	ANTIVIRALS
SYMLINPEN INJ	PA	B	ANTIDIABETICS
SYMPAZAN ORAL FILM	-	NC	ANTICONVULSANTS
SYMPROIC TAB (QL= 1 tab/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
SYMTUZA TAB	-	B	ANTIVIRALS
SYNAREL NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SYNJARDY TAB	-	NC	ANTIDIABETICS
SYNJARDY XR TAB	-	NC	ANTIDIABETICS
SYNTHROID TAB	-	NC	THYROID AGENTS
TABLOID TAB	-	B	ANTINEOPLASTICS
TABRECTA TAB (QL= 4 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TACLONEX SUSP	-	NC	DERMATOLOGICALS
tacrolimus cap (PROGRAF equiv)	-	G	ASSORTED CLASSES
tacrolimus cap er (ASTAGRAF XL equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
tacrolimus oint (PROTOPIC OINT equiv)	-	G	DERMATOLOGICALS
tadalafil tab (CIALIS equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab (PAH) (ADCIRCA equiv)	PA	G	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day)	QL	G	CARDIOVASCULAR AGENTS - MISC.
TADLIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	B	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAFINLAR TAB	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv)	-	NC	OPHTHALMIC AGENTS
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TALICIA CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
TALTZ INJ 20MG/0.25ML (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
TALTZ INJ 40 MG/0.5ML (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
TALZENNA CAP 0.1MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.35MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tamoxifen tab (NOLVADEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamsulosin cap (FLOMAX equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
TANZEUM INJ	-	NC	ANTIDIABETICS
TAPENTADOL ER TAB 100MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 150MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 200MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 250MG	-	NC	ANALGESICS - OPIOID
TAPENTADOL ER TAB 50MG	-	NC	ANALGESICS - OPIOID
tapentadol hcl tab (NUCYNTA equiv)	-	G	ANALGESICS - OPIOID
TAPENTADOL SOLN	-	NC	ANALGESICS - OPIOID
TARCEVA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGRETIN GEL	-	NC	DERMATOLOGICALS
TARPEYO CAP	-	NC	CORTICOSTEROIDS
TASCENSO ODT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TASIGNA CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tasimelteon cap (HETLIOZ equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
TASOPROL CREAM KIT	-	NC	DERMATOLOGICALS
tavaborole soln (KERYDIN equiv)	-	NC	DERMATOLOGICALS
TAVALISSE TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TAYTULLA CAP	-	NC	CONTRACEPTIVES
tazarotene cream 0.05% (TAZORAC equiv)	PA	G	DERMATOLOGICALS
tazarotene cream 0.1% (TAZORAC equiv)	PA	G	DERMATOLOGICALS
tazarotene gel (TAZORAC equiv)	-	NC	DERMATOLOGICALS
TAZORAC CREAM	-	NC	DERMATOLOGICALS
TECFIDERA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
telmisartan tab (MICARDIS equiv)	-	G	ANTIHYPERTENSIVES
TELMISARTAN/AMLODIPINE TAB	-	NC	ANTIHYPERTENSIVES
telmisartan/amlodipine tab (TWYNSTA equiv)	-	NC	ANTIHYPERTENSIVES
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC	ANTIHYPERTENSIVES
temazepam cap 15mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 22.5mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 30mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
temazepam cap 7.5mg (RESTORIL equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
TEMOVATE CREAM	-	NC	DERMATOLOGICALS
TEMOVATE OINT	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
temozolomide cap (TEMODAR equiv)	LMSP	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TEMPO SMART BUTTON (QL= 1 button/8 months)	QL	B	MEDICAL DEVICES AND SUPPLIES
temsirolimus inj (TORISEL equiv)	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	G	ANTIVIRALS
TEPMETKO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TERAVAX CAP	-	NC	MULTIVITAMINS
terazosin cap (HYTRIN equiv)	-	G	ANTIHYPERTENSIVES
terbinafine tab (LAMISIL equiv)	-	G	ANTIFUNGALS
terbutaline sulfate tab (BRETHINE equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
terconazole cream (TERAZOL equiv)	-	G	VAGINAL PRODUCTS
TERCONAZOLE CREAM 0.8%	-	G	VAGINAL PRODUCTS
terconazole supp (TERAZOL equiv)	-	G	VAGINAL PRODUCTS
teriflunomide tab (AUBAGIO equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
teriparatide (recombinant) soln pen-inj (FORTEO equiv)	LMSP	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
TEST STRIP (all other test strips)	OTC	NC	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	G	ANDROGENS-ANABOLIC
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	B	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 1% 25MG	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1% 25mg (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1% 50mg (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1% pump (VOGELXO GEL, ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv)	-	NC	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 10MG/ACT	-	NC	ANDROGENS-ANABOLIC
testosterone gel 2% (FORTESTA equiv)	-	NC	ANDROGENS-ANABOLIC
TESTOSTERONE GEL 20.25MG/1.25GM	-	NC	ANDROGENS-ANABOLIC
TESTOSTERONE GEL PUMP 1%	-	NC	ANDROGENS-ANABOLIC
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	G	ANDROGENS-ANABOLIC
TESTOSTERONE GEL, VOGELXO GEL	-	NC	ANDROGENS-ANABOLIC
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	G	ANDROGENS-ANABOLIC
TETANUS/DIPHTHERIA TOXOID INJ	VAC	$0	TOXOIDS
tetrabenazine tab (XENAZINE equiv)	LMSP	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracaine hcl ophth soln	-	G	OPHTHALMIC AGENTS
TETRACAINE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
tetracycline cap	-	G	TETRACYCLINES
TETRACYCLINE TAB	-	NC	TETRACYCLINES
TEXACORT SOLN	-	NC	DERMATOLOGICALS
TEZRULY SOLN	-	NC	ANTIHYPERTENSIVES
TEZSPIRE INJ (QL= 1 pen/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THALITONE TAB	-	NC	DIURETICS
THALOMID CAP	MSP	B	ASSORTED CLASSES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
theophylline er tab (THEOPHYLLINE ER equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THEOPHYLLINE TAB ER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THIOLA EC TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
thioridazine hcl tab (THIORIDAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
THRIVITE RX	-	NC	MULTIVITAMINS
THYQUIDITY SOLN	-	NC	THYROID AGENTS
TIAGABINE TAB	-	G	ANTICONVULSANTS
tiagabine tab (GABITRIL equiv)	-	G	ANTICONVULSANTS
TIBSOVO TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ticagrelor tab (BRILINTA equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
TICANASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
TICOVAC INJ	VAC	EXC	VACCINES
TIGAN INJ	-	NC	ANTIEMETICS
TIGLUTIK SUSP	-	NC	NEUROMUSCULAR AGENTS
timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate ophth soln (TIMOPTIC equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	G	OPHTHALMIC AGENTS
timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv)	-	G	OPHTHALMIC AGENTS
TIMOLOL MALEATE TAB	-	G	BETA BLOCKERS
timolol maleate tab (BLOCADREN equiv)	-	G	BETA BLOCKERS
timolol ophth soln (BETIMOL equiv)	-	G	OPHTHALMIC AGENTS
tinidazole tab (TINDAMAX equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
tiopronin tab (THIOLA equiv)	LMSP-PA	G	GENITOURINARY AGENTS - MISCELLANEOUS
tiopronin tab delayed release (THIOLA EC equiv)	LMSP-PA	G	GENITOURINARY AGENTS - MISCELLANEOUS
tiotropium bromide cap inhaler (SPIRIVA equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TIROSINT CAP	-	NC	THYROID AGENTS
TIROSINT-SOL	-	NC	THYROID AGENTS
TIVICAY PD TAB	-	B	ANTIVIRALS
TIVICAY TAB	-	B	ANTIVIRALS
TIVORBEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
tizanidine cap (ZANAFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
TIZANIDINE COMFORT KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER (Only available through Walgreens 888-347-3416)	LD-PA	B	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	B	OPHTHALMIC AGENTS
TOBRADEX ST OPHTH SUSP	-	B	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	G	AMINOGLYCOSIDES
tobramycin neb soln (BETHKIS equiv)	-	NC	AMINOGLYCOSIDES
tobramycin ophth soln (TOBREX equiv)	-	G	OPHTHALMIC AGENTS
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	G	OPHTHALMIC AGENTS
TOBREX OPHTH OINT	-	B	OPHTHALMIC AGENTS
TODAY SPONGE	OTC	$0	VAGINAL PRODUCTS
tofacitinib citrate ER tab (XELJANZ equiv) (QL= 1 tab/day)	LMSP-QL	G	ANALGESICS - ANTI-INFLAMMATORY
tofacitinib citrate oral soln (XELJANZ equiv) (QL= 10ml/day)	LMSP-QL	G	ANALGESICS - ANTI-INFLAMMATORY
tofacitinib citrate tab (XELJANZ equiv) (QL= 2 tabs/day)	LMSP-QL	G	ANALGESICS - ANTI-INFLAMMATORY
tolcapone tab (TASMAR equiv)	-	G	ANTIPARKINSON AGENTS
TOLECTIN DS CAP, TOLMETIN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLECTIN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN TAB, TOLECTIN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLSURA CAP	-	NC	ANTIFUNGALS
tolterodine SR cap (DETROL LA equiv)	-	G	URINARY ANTISPASMODICS
tolterodine tab (DETROL equiv)	-	G	URINARY ANTISPASMODICS
tolvaptan tab (JYNARQUE equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
tolvaptan tab (SAMSCA equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
tolvaptan tab therapy pack (JYNARQUE equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
TONMYA SL TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TOPICORT CREAM	-	NC	DERMATOLOGICALS
TOPICORT CREAM 0.05%	-	NC	DERMATOLOGICALS
TOPICORT GEL	-	NC	DERMATOLOGICALS
TOPICORT OINT	-	NC	DERMATOLOGICALS
TOPICORT OINT 0.05%	-	NC	DERMATOLOGICALS
topiramate ER cap (QUDEXY equiv)	-	NC	ANTICONVULSANTS
topiramate er cap (TROKENDI XR equiv)	-	NC	ANTICONVULSANTS
topiramate oral soln (EPRONTIA equiv)	-	NC	ANTICONVULSANTS
topiramate sprinkle cap (TOPAMAX equiv)	-	G	ANTICONVULSANTS
topiramate tab (TOPAMAX equiv)	-	G	ANTICONVULSANTS
toremifene tab (FARESTON equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TORISEL INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
torsemide tab (DEMADEX equiv)	-	G	DIURETICS
TOSYMRA SOLN	-	NC	MIGRAINE PRODUCTS
TOUJEO MAX SOLOSTAR INJ	-	B	ANTIDIABETICS
TOUJEO SOLOSTAR INJ	-	B	ANTIDIABETICS
TOVET KIT	-	NC	DERMATOLOGICALS
TOVIAZ TAB	-	NC	URINARY ANTISPASMODICS
TRACLEER TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
TRAMADOL COMPOUND KIT	-	NC	DERMATOLOGICALS
TRAMADOL ER CAP	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
tramadol ER tab (ULTRAM ER equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
TRAMADOL HCL ER TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G	ANALGESICS - OPIOID
TRAMADOL HCL TAB	-	NC	ANALGESICS - OPIOID
tramadol hcl tab 100mg	-	NC	ANALGESICS - OPIOID
tramadol hcl tab 25mg	-	NC	ANALGESICS - OPIOID
tramadol tab (ULTRAM equiv)	-	G	ANALGESICS - OPIOID
tramadol/acetaminophen tab (ULTRACET equiv)	-	G	ANALGESICS - OPIOID
trandolapril tab (MAVIK equiv)	-	G	ANTIHYPERTENSIVES
TRANDOLAPRIL/VERAPAMIL ER TAB	-	NC	ANTIHYPERTENSIVES
tranexamic acid tab (LYSTEDA equiv)	-	G	HEMOSTATICS
tranylcypromine tab (PARNATE equiv)	-	G	ANTIDEPRESSANTS
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days; Step Therapy requires trial of latanoprost)	QL-ST	G	OPHTHALMIC AGENTS
trazodone tab (DESYREL equiv)	-	G	ANTIDEPRESSANTS
TRAZODONE TAB	-	NC	ANTIDEPRESSANTS
trazodone tab 300mg (DESYREL equiv)	-	NC	ANTIDEPRESSANTS
TREANDA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRECATOR TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
TRELEGY ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TREMFYA INDUCTION INJ 200MG/ML (QL= 2 inj/28 days; 6 inj/year)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
TREMFYA INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B	DERMATOLOGICALS
TREMFYA INJ 200MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
treprostinil inj 10mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
treprostinil inj 1mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
treprostinil inj 2.5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
treprostinil inj 5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
TRESIBA FLEXTOUCH INJ	-	B	ANTIDIABETICS
TRESIBA INJ	-	B	ANTIDIABETICS
tretinoin cap (VESANOID equiv)	LMSP	G	ANTINEOPLASTICS
tretinoin cream (QL= 20gm/fill; Acne Only - Prior Authorization required for members age 35 years and older)	PA-QL	G	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (QL= 15gm/fill; Acne Only - Prior Authorization required for members age 35 years and older)	PA-QL	G	DERMATOLOGICALS
tretinoin gel 0.05% (ATRALIN equiv)	-	NC	DERMATOLOGICALS
tretinoin microsphere gel	-	NC	DERMATOLOGICALS
TRETTEN INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
TREXALL TAB	-	NC	ANTINEOPLASTICS
TREXIMET TAB	-	NC	MIGRAINE PRODUCTS
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC	ANALGESICS - OPIOID
triamcinolone acetonide inj (KENALOG equiv)	-	G	CORTICOSTEROIDS
triamcinolone acetonide oint (TRIANEX equiv)	-	NC	DERMATOLOGICALS
triamcinolone cream	-	G	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
triamcinolone lotion	-	G	DERMATOLOGICALS
triamcinolone oint	-	G	DERMATOLOGICALS
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
TRIAMCINOLONE SPRAY	-	NC	DERMATOLOGICALS
triamcinolone spray (KENALOG equiv)	-	NC	DERMATOLOGICALS
triamterene cap (DYRENIUM equiv)	-	NC	DIURETICS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	G	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	G	DIURETICS
TRIAMVEX KIT	-	NC	DERMATOLOGICALS
TRIANEX OINT	-	NC	DERMATOLOGICALS
triazolam tab (HALCION equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
TRIBENZOR TAB	-	NC	ANTIHYPERTENSIVES
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC	DIAGNOSTIC PRODUCTS
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
TRICHOSOL SOLN	-	NC	PHARMACEUTICAL ADJUVANTS
trientine cap (SYPRINE equiv)	LMSP-PA	G	MISCELLANEOUS THERAPEUTIC CLASSES
TRIENTINE CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
trifluoperazine tab (STELAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
TRIFLURIDINE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
TRIGLIDE TAB	-	NC	ANTIHYPERLIPIDEMICS
trihexyphenidyl elixir (ARTANE equiv)	-	G	ANTIPARKINSON AND RELATED THERAPY AGENTS
trihexyphenidyl tab (ARTANE equiv)	-	G	ANTIPARKINSON AGENTS
TRIJARDY XR TAB	-	NC	ANTIDIABETICS
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	RESPIRATORY AGENTS - MISC.
tri-legest tab (ESTROSTEP FE equiv)	-	$0	CONTRACEPTIVES
TRILIPIX CAP	-	NC	ANTIHYPERLIPIDEMICS
TRILOCICLO KIT	-	NC	DERMATOLOGICALS
TRI-LUMA CREAM	-	EXC	DERMATOLOGICALS
trimethobenzamide cap (TIGAN equiv)	-	G	ANTIEMETICS
trimethobenzamide hcl inj (TIGAN equiv)	-	NC	ANTIEMETICS
TRIMETHOPRIM TAB	-	G	ANTI-INFECTIVE AGENTS - MISC.
trimethoprim tab (PROLOPRIM equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	G	ANTIDEPRESSANTS
TRINTELLIX TAB (QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine)	QL-ST-¢	B	ANTIDEPRESSANTS
TRIONEX PAK	-	NC	DERMATOLOGICALS
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	$0	CONTRACEPTIVES
TRIUMEQ PD TAB	-	B	ANTIVIRALS
TRIUMEQ TAB	-	B	ANTIVIRALS
TRIVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
TRI-VITAMIN FLUORIDE DROPS	-	NC	MULTIVITAMINS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TROKENDI XR CAP	-	NC	ANTICONVULSANTS
tropicamide ophth soln (MYDRIACYL equiv)	-	G	OPHTHALMIC AGENTS
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
trospium chloride SR cap (SANCTURA XR equiv)	-	G	URINARY ANTISPASMODICS
trospium tab (SANCTURA equiv)	-	G	URINARY ANTISPASMODICS
TRUDHESA NASAL SPRAY	-	NC	MIGRAINE PRODUCTS
TRULANCE TAB (QL= 1 tab/day)	PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B	ANTIDIABETICS
TRUMENBA INJ	VAC	$0	VACCINES
TRUQAP TAB (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRUQAP THERAPY PACK (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRUTAKNA INJ	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
TRYNGOLZA INJ (QL= 1 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
TRYPTYR SOLN	-	NC	OPHTHALMIC AGENTS
TRYVIO TAB	-	NC	ANTIHYPERTENSIVES
TUDORZA PRESSAIR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TUKYSA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TUSSICAPS	-	NC	COUGH/COLD/ALLERGY
tussigon tab (HYCODAN equiv)	-	G	COUGH/COLD/ALLERGY
TUXARIN ER TAB	-	NC	COUGH/COLD/ALLERGY
TUZISTRA XR SUSP	-	NC	COUGH/COLD/ALLERGY
TWIIST REFILL KIT (QL= 1 kit/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
TWIIST STARTER KIT (QL= 1 kit/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
TWINRIX INJ	VAC	$0	VACCINES
TWIRLA PATCH	-	NC	CONTRACEPTIVES
TWYNEO CREAM	-	NC	DERMATOLOGICALS
TYBLUME TAB	-	$0	CONTRACEPTIVES
TYBOST TAB	-	B	ANTIVIRALS
TYENNE INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
TYKERB TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYMLOS INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYPHIM VI INJ	VAC	EXC	VACCINES
TYR EASY TAB PLUS, HCU EASY TAB PLUS	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
TYRVAYA NASAL SPRAY (QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist; Step Therapy Requires trial of cyclosporine opth emulsion)	QL-RS-ST	B	OPHTHALMIC AGENTS
TYSABRI INJ	MSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER 48-80MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
UCERIS RECTAL FOAM	-	B	ANORECTAL AND RELATED PRODUCTS
UDENYCA INJ	-	NC	HEMATOPOIETIC AGENTS
ULORIC TAB	-	NC	GOUT AGENTS
ULTRAVATE LOTION	-	NC	DERMATOLOGICALS
ULTRAVATE PAC KIT	-	NC	DERMATOLOGICALS
UMECLIDINIUM ELLIPTA INHALER 62.5MCG/INH	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
UMECLIDINIUM/VILANTEROL INHALER 62.5-25MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
UMECTA EMULSION	-	NC	DERMATOLOGICALS
UMECTA PD EMULSION	-	NC	DERMATOLOGICALS
UMECTA SUSP	-	NC	DERMATOLOGICALS
UPNEEQ SOLN	-	EXC	OPHTHALMIC AGENTS
UPTRAVI INJ	-	NC	CARDIOVASCULAR AGENTS - MISC.
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
UPTRAVI THERAPY PACK (QL= 1 pack/year; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
URAMAXIN CREAM	-	NC	DERMATOLOGICALS
URAMAXIN GEL	-	NC	DERMATOLOGICALS
urea cream	-	NC	DERMATOLOGICALS
urea emulsion	-	NC	DERMATOLOGICALS
urea gel (URAMAXIN equiv)	-	NC	DERMATOLOGICALS
UREA LOT	-	NC	DERMATOLOGICALS
UREA NAIL KIT	-	NC	DERMATOLOGICALS
UREA SUSP	-	NC	DERMATOLOGICALS
urea susp 40% (UMECTA equiv)	-	NC	DERMATOLOGICALS
UREA/SALICYLIC CREAM	-	NC	DERMATOLOGICALS
ursodiol cap (ACTIGALL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
URSODIOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
URSOLIGN CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
USTEKINUMAB INJ 45/0.5ML	-	NC	DERMATOLOGICALS
USTEKINUMAB INJ 90MG/ML	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
USTEKINUMAB-AEKN 45MG/0.5ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B	DERMATOLOGICALS
USTEKINUMAB-AEKN 90MG/ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B	DERMATOLOGICALS
UTA CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VAFSEO TAB	-	NC	HEMATOPOIETIC AGENTS
valacyclovir tab (VALTREX equiv)	-	G	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	G	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	G	ANTIVIRALS
valproate inj (DEPACON equiv)	-	NC	ANTICONVULSANTS
valproic acid cap (DEPAKENE equiv)	-	G	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	G	ANTICONVULSANTS
valsartan oral soln (VALSARTAN equiv)	-	NC	ANTIHYPERTENSIVES
valsartan tab (DIOVAN equiv)	-	G	ANTIHYPERTENSIVES
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	G	ANTIHYPERTENSIVES
VALTOCO NASAL SPRAY (QL= 5 doses/fill)	QL	B	ANTICONVULSANTS
VALTYA 1/50 TAB	-	$0	CONTRACEPTIVES
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	G	ANTI-INFECTIVE AGENTS - MISC.
vancomycin hcl soln (VANCOMYCIN equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN ORAL SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANFLYTA TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VANOS CREAM	-	NC	DERMATOLOGICALS
VANRAFIA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or CareMed 877-227-3405)	LD-PA-QL	B	GENITOURINARY AGENTS - MISCELLANEOUS
vardenafil ODT (STAXYN equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
vardenafil tab (LEVITRA equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
varenicline tartrate tab starter pack (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VARIVAX INJ	VAC	$0	VACCINES
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	B	ANTIEMETICS
VASCEPA CAP	-	NC	ANTIHYPERLIPIDEMICS
vasolex oint (XENADERM equiv)	-	NC	DERMATOLOGICALS
VAXCHORA SUSP	VAC	EXC	VACCINES
VAXELIS INJ	VAC	$0	TOXOIDS
VAXNEUVANCE INJ	VAC	$0	VACCINES
V-C FORTE CAP	-	NC	MULTIVITAMINS
v-c forte cap (V-C FORTE equiv)	-	NC	MULTIVITAMINS
VECAMYL TAB	-	NC	ANTIHYPERTENSIVES
VECTICAL OINT	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VEKLURY INJ	-	B	ANTIVIRALS
VELIVET PAK	-	$0	CONTRACEPTIVES
velivet tab (CYCLESSA equiv)	-	$0	CONTRACEPTIVES
VELPHORO CHEW TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELSIPITY TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELTASSA POWDER (QL= 1 packet/day)	PA-QL	B	ASSORTED CLASSES
VELTASSA POWDER 1GM (QL= 4 packets/day)	PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
VEMLIDY TAB	PA	B	ANTIVIRALS
VENCLEXTA STARTER PACK (Only available through Optum 877-445-6874)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB (Only available through Optum 877-445-6874)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
venlafaxine ER cap (EFFEXOR XR equiv)	-	G	ANTIDEPRESSANTS
VENLAFAXINE ER TAB	-	NC	ANTIDEPRESSANTS
venlafaxine tab (EFFEXOR equiv)	-	G	ANTIDEPRESSANTS
VENLAFAXINE TAB	-	NC	ANTIDEPRESSANTS
VENNGEL ONE KIT	-	NC	DERMATOLOGICALS
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VEOZAH TAB (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
VEPESID CAP	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VEPPANU TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VERAPAMIL CR CAP, VERELAN CAP	-	NC	CALCIUM CHANNEL BLOCKERS
VERAPAMIL ER CAP	-	NC	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN equiv)	-	NC	CALCIUM CHANNEL BLOCKERS
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	G	CALCIUM CHANNEL BLOCKERS
verapamil tab (CALAN equiv)	-	G	CALCIUM CHANNEL BLOCKERS
VERDESO FOAM	-	NC	DERMATOLOGICALS
VERDROCET TAB 2.5MG-325MG	-	NC	ANALGESICS - OPIOID
VEREGEN OINT	-	B	DERMATOLOGICALS
VERELAN CAP	-	NC	CALCIUM CHANNEL BLOCKERS
VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist)	QL-RS	B	CARDIOVASCULAR AGENTS - MISC.
VERSACLOZ SUSP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VERSAPENN AL GEL ANHYDROU	-	NC	PHARMACEUTICAL ADJUVANTS
VERZENIO TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VESICARE LS SUSP	-	NC	URINARY ANTISPASMODICS
VESICARE TAB	-	NC	URINARY ANTISPASMODICS
VEVYE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
VFEND SUSP	-	NC	ANTIFUNGALS
V-GO INJ KIT	-	NC	MEDICAL DEVICES AND SUPPLIES
VIBERZI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VICTOZA INJ	-	NC	ANTIDIABETICS
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	$0	CONTRACEPTIVES
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G	ANTICONVULSANTS
vigadrone powder pack (Only available through PantheRx 855-726-8479)	LD-PA	G	ANTICONVULSANTS
VIGAFYDE SOLN	-	NC	ANTICONVULSANTS
VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
VIIBRYD STARTER KIT	-	NC	ANTIDEPRESSANTS
VIJOICE GRANULES PACKET (QL= 1 packet/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
VIJOICE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
VIJOICE TAB 250MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
vilazodone hcl tab (VIIBRYD equiv)	-	G	ANTIDEPRESSANTS
VIMKUNYA INJ	VAC	EXC	VACCINES
VIMOVO TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIMPAT SOLN	-	NC	ANTICONVULSANTS
VIMPAT TAB	-	NC	ANTICONVULSANTS
VINATE II	-	G	MULTIVITAMINS
viorele tab, kariva tab (MIRCETTE equiv)	-	$0	CONTRACEPTIVES
VIRACEPT TAB	-	B	ANTIVIRALS
VIRAMUNE XR TAB	-	NC	ANTIVIRALS
VIREAD TAB	-	B	ANTIVIRALS
VISCO-3 INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
VISTOGARD PAK	-	NC	ANTIDOTES
VITAFOL GUMMIES	-	NC	MULTIVITAMINS
VITAFOL OB	-	NC	MULTIVITAMINS
VITAFOL STRIPS	-	B	MULTIVITAMINS
VITAFOL ULTRA	-	NC	MULTIVITAMINS
VITAFOL-OB + DHA	-	NC	MULTIVITAMINS
VITAFOL-ONE, VITAFOL FE+	-	NC	MULTIVITAMINS
vitamin D cap (RX strength only)	-	G	VITAMINS
vitamin D cap 1000unit	OTC	NC	VITAMINS
vitamin D cap 400unit	OTC	NC	VITAMINS
VITAMIN D TAB 2000IU	OTC	NC	VITAMINS
VITAMIN D TAB 400UNIT	OTC	NC	VITAMINS
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VIVELLE-DOT, MINIVELLE PATCH	-	NC	ESTROGENS
VIVITROL INJ	LMSP	B	ANTIDOTES
VIVJOA CAP	-	NC	ANTIFUNGALS
VIVLODEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIVOTIF CAP	VAC	EXC	VACCINES
VIZZ OPHTH SOLN	-	EXC	OPHTHALMIC AGENTS
VOGELXO GEL PUMP 1%	-	NC	ANDROGENS-ANABOLIC
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VONVENDI INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
VOPAC 5 CREAM	-	B	DERMATOLOGICALS
VOPAC CREAM	-	NC	DERMATOLOGICALS
VOPAC GB CREAM	-	NC	DERMATOLOGICALS
VOQUEZNA DUAL PAK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERCS
VOQUEZNA TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERCS
VOQUEZNA TRIP PAK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERCS
VORANIGO TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VORANIGO TAB 10MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
voriconazole susp (VFEND equiv)	-	G	ANTIFUNGALS
voriconazole tab (VFEND equiv)	-	G	ANTIFUNGALS
VOSEVI TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
VOTRIENT TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
VOYDEYA TAB (QL= 6 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
VOYDEYA TAB THERAPY PACK (QL= 6 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
VOYXACT INJ	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
VP-PNV-DHA CAP	-	G	MULTIVITAMINS
VPRIV INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
VRAYLAR CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VRAYLAR PACK	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VSL #3 CAP	-	NC	ANTIDIARRHEALS
VTAMA CREAM	-	NC	DERMATOLOGICALS
VTOL SOLN	-	NC	ANALGESICS - NONNARCOTIC
VUITY OPHTH SOLN 1.25%	-	EXC	OPHTHALMIC AGENTS
VUMERITY CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYALEV INJ	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
VYBRIQUE ORAL FILM	-	NC	CARDIOVASCULAR AGENTS - MISC.
VYJUVEK GEL (QL= 4 vials/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	DERMATOLOGICALS
VYKAT XR TAB (QL= 4 tabs/day; Only available through PantherRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
VYKAT XR TAB 150MG (QL= 3 tabs/day; Only available through PantherRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
VYKAT XR TAB 75MG (QL= 7 tabs/day; Only available through PantherRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
VYLEESI INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYNDAMAX CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VYSCOXA SUSP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VYTONE CREAM 1.9-1%	-	NC	DERMATOLOGICALS
VYVANSE CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
VYVANSE CHEW TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
VYVGART HYTRULO INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
VYZULTA SOLN	-	NC	OPHTHALMIC AGENTS
WAINUA INJ (QL= 1 inj/28 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
WAKIX TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
warfarin tab (COUMADIN equiv)	-	G	ANTICOAGULANTS
WAYRILZ TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
WEGOVY HD INJ 7.2MG/0.75ML	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
WEGOVY INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
WEGOVY INJ 1.7MG/0.75ML	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
WEGOVY INJ 2.4MG/0.75ML	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
WEGOVY TAB	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
WELCHOL PACK	-	NC	ANTIHYPERLIPIDEMICS
WELCHOL TAB	-	NC	ANTIHYPERLIPIDEMICS
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
WELLBUTRIN SR TAB	-	NC	ANTIDEPRESSANTS
WELLBUTRIN XL TAB	-	NC	ANTIDEPRESSANTS
WESTCORT OINT	-	NC	DERMATOLOGICALS
WEZLANA INJ	-	NC	DERMATOLOGICALS
WEZLANA SYRINGE	-	NC	DERMATOLOGICALS
WIDAPLIK TAB	-	NC	ANTIHYPERTENSIVES
WILATE INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
WINLEVI CREAM	-	NC	DERMATOLOGICALS
WINREVAIR INJ (Only available through Accredo 800-803-2523)	LD-PA	B	CARDIOVASCULAR AGENTS - MISC.
WOUND-DRESSING GELS	-	NC	DERMATOLOGICALS
WPR PLUS	-	NC	DERMATOLOGICALS
WYNZORA CREAM	-	NC	DERMATOLOGICALS
XACIATO GEL (QL= 1 applicator/fill)	QL	B	VAGINAL AND RELATED PRODUCTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XADAGO TAB (QL= 1 tab/day)	PA-QL	B	ANTIPARKINSON AGENTS
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XALKORI SPRINKLE CAP (QL= 4 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XARELTO STARTER PACK	-	B	ANTICOAGULANTS
XARELTO SUSP	-	B	ANTICOAGULANTS
XARELTO TAB	-	B	ANTICOAGULANTS
XCOPRI PAK 100-150MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI TAB 25MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TAB 50MG, 100MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day)	QL	B	ANTICONVULSANTS
XDEMVY DROP (QL= 1 bottle/42 days; Only available through CVS Specialty 800-238-7828 or Walgreens 888-347-3416)	LD-PA-QL	B	OPHTHALMIC AGENTS
XELJANZ ORAL SOLN	-	NC	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
XELPROS OPHTH EMULSION	-	NC	OPHTHALMIC AGENTS
XELSTRYM PAD	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	PASSIVE IMMUNIZING AND TREATMENT AGENTS
XENADERM OINT	-	NC	DERMATOLOGICALS
XENAZINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XENICAL CAP	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTI-INFECTIVE AGENTS - MISC.
XEOMIN INJ	MSP-PA	B	NEUROMUSCULAR AGENTS
XEPI CREAM	-	NC	DERMATOLOGICALS
XERESE CREAM	-	NC	DERMATOLOGICALS
XERMELO TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
XGEVA INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
XHANCE NASAL EXHALER	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
XIAFLEX INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B	ASSORTED CLASSES
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	PA-QL	B	ANTI-INFECTIVE AGENTS - MISC.
XIFAXAN TAB 550MG (QL= 2 tabs/day)	PA-QL	B	ANTI-INFECTIVE AGENTS - MISC.
XIGDUO XR TAB	-	NC	ANTIDIABETICS
XIGDUO XR TAB 2.5-1000 (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
XIIDRA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
XOCOVA TAB	-	NC	ANTIVIRALS
XODOL TAB 10MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 5MG-300MG	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XODOL TAB 7.5MG-300MG	-	NC	ANALGESICS - OPIOID
XOFLUZA TAB	-	NC	ANTIVIRALS
XOLAIR INJ	LMSP-PA	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR INJ 300MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLAIR SYRINGE 300MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLEGEL	-	NC	DERMATOLOGICALS
XOLREMDI CAP (QL= 4 caps/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
XOPENEX HFA INHALER 45MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XPHOZAH TAB (QL= 2 tabs/day)	MSP-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
XPOVIO PAK (QL= 32 tabs/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XROMI SOLN (Prior Authorization required for members age 9 years and older)	PA	B	HEMATOPOIETIC AGENTS
XRYLIX PAK	-	NC	DERMATOLOGICALS
XTAMPZA ER CAP (QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	B	ANALGESICS - OPIOID
XTANDI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTANDI TAB 40MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTANDI TAB 80MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTORO OTIC SUSP	-	NC	OTIC AGENTS
XULTOPHY INJ (QL= 15ml/30 days)	QL	B	ANTIDIABETICS
XURIDEN POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
XYNTHA INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
XYOSTED INJ	-	NC	ANDROGENS-ANABOLIC
XYREM SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYWAV SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYZAL SOLN	-	EXC	ANTIHISTAMINES
XYZAL TAB	-	EXC	ANTIHISTAMINES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
XYZBAC TAB	-	EXC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
YAZ TAB, YASMIN 28 TAB	-	NC	CONTRACEPTIVES
YBUPHEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YESINTEK INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
YESINTEK SYRINGE (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
YESINTEK SYRINGE 90MG (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
YEZTUGO INJ (QL= 2 inj/180 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	$0	ANTIVIRALS
YEZTUGO TAB (QL= 4 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	$0	ANTIVIRALS
YF-VAX INJ	VAC	EXC	VACCINES
YONSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
YORVIPATH INJ (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
YORVIPATH INJ 294MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
YORVIPATH INJ 420MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
YOSPRALA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
YUFLYMA INJ KIT (adalimumab-aaty)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUFLYMA KIT (adalimumab-aaty)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUPELRI SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
YUSIMRY INJ (adalimumab-aqvh)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YUTREPIA CAP (QL= 112 caps/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
YUVEZZI SOLN	-	EXC	OPHTHALMIC AGENTS
YUVIWEL INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
zafemy patch (XULANE equiv)	-	$0	CONTRACEPTIVES
zafirlukast tab (ACCOLATE equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZANAFLEX CAP	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ZARXIO INJ	LMSP	B	HEMATOPOIETIC AGENTS
ZAVESCA CAP	-	NC	HEMATOPOIETIC AGENTS
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	B	MIGRAINE PRODUCTS
ZECUITY PAD	-	NC	MIGRAINE PRODUCTS
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
ZEGERID POWDER PACK	-	NC	ULCER DRUGS
ZEGFROVY TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	NC	ANTIPARKINSON AGENTS
ZELBORAF TAB (QL= 8 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZELSUVMI GEL (QL= 1 carton/fill, 2 fills/365 days)	PA-QL	B	DERMATOLOGICALS
ZENBEXUS CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZENPEP CAP	-	B	DIGESTIVE AIDS
zenzedi tab 10mg (DEXEDRINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ZEPATIER TAB	-	NC	ANTIVIRALS
ZEPBOUND INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ZEPBOUND KWIKPEN INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ZEPBOUND VIAL INJ	-	EXC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/A NOREXIANTS
ZEPOSIA CAP (QL= 1 cap/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZEPOSIA STARTER PACK (QL= 1 cap/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZERVIATE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ZETIA TAB	-	NC	ANTIHYPERLIPIDEMICS
zidovudine cap (RETROVIR equiv)	-	G	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	G	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	G	ANTIVIRALS
ZIEXTENZO INJ	-	NC	HEMATOPOIETIC AGENTS
ZILACAINE PAK	-	NC	DERMATOLOGICALS
ZILBRYSQ INJ (QL= 1 inj/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
ZILBRYSQ INJ 23MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
ZILBRYSQ INJ 32.4MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
zileuton ER tab (ZYFLO CR equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZILXI FOAM	-	NC	DERMATOLOGICALS
ZIMHI SOLN	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
ZINBRYTA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
zinc gluconate tab	OTC	G	MINERALS & ELECTROLYTES
ZIOPTAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ziprasidone cap (GEODON equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ZIPSOR CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZIRGAN OPHTH GEL	-	B	OPHTHALMIC AGENTS
ZITHROMAX POWDER PACK	-	B	MACROLIDES
ZITUVIMET XR TAB	-	NC	ANTIDIABETICS
ZITUVIO TAB	-	NC	ANTIDIABETICS
ZOCOR TAB 80MG	-	NC	ANTIHYPERLIPIDEMICS
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZOLADEX INJ	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZOLINZA CAP	LMSP-PA-SF	B	ANTINEOPLASTICS
zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	G	MIGRAINE PRODUCTS
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days; Step Therapy Requires trial of the following sumatriptan, naratriptan, rizatriptan and zolmitriptan)	QL-ST	G	MIGRAINE PRODUCTS
ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B	MIGRAINE PRODUCTS
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
ZOLPAK KIT	-	NC	DERMATOLOGICALS
ZOLPIDEM CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
zolpidem ER tab (AMBIEN CR equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	G	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZOLPIDEM TARTRATE SL TAB 1.75MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZOLPIDEM TARTRATE SL TAB 3.5MG	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZOLPIMIST SPRAY	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZOLYMBUS OPHTH GEL	-	NC	OPHTHALMIC AGENTS
ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B	MIGRAINE PRODUCTS
ZOMIG TAB	-	NC	MIGRAINE PRODUCTS
ZONATUSS CAP 150MG	-	NC	COUGH/COLD/ALLERGY
ZONISADE SUSP (Prior Authorization required for members age 9 years and older)	PA	B	ANTICONVULSANTS
zonisamide cap (ZONEGRAN equiv)	-	G	ANTICONVULSANTS
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	B	HEMATOLOGICAL AGENTS - MISC.
ZORVOLEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	B	DERMATOLOGICALS
ZORYVE CREAM 0.05%	-	NC	DERMATOLOGICALS
ZORYVE CREAM 0.15%	-	NC	DERMATOLOGICALS
ZORYVE FOAM (QL= 60 grams/30 days)	PA-QL	B	DERMATOLOGICALS
ZOVIRAX CREAM	-	NC	DERMATOLOGICALS
ZOVIRAX OINT	-	NC	DERMATOLOGICALS
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B	ANTICONVULSANTS
ZUBSOLV SL TAB	-	NC	ANALGESICS - OPIOID
ZUNVEYL TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZUPLENZ SL FILM	-	NC	ANTIEMETICS
ZURAMPIC TAB	-	NC	GOUT AGENTS

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Drug Name	Special Code	Tier	Category
ZURNAI INJ	-	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
ZURZUVAE CAP 20MG, 25MG (QL= 28 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B	ANTIDEPRESSANTS
ZURZUVAE CAP 30MG (QL= 14 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B	ANTIDEPRESSANTS
ZYCLARA CREAM	-	NC	DERMATOLOGICALS
ZYCUBO INJ	-	NC	MINERALS & ELECTROLYTES
ZYDELIG TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYFLO TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYKADIA TAB (QL= 3 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
ZYLOTROL-L KIT	-	NC	DERMATOLOGICALS
ZYMFENTRA INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
ZYPITAMAG TAB	-	NC	ANTIHYPERLIPIDEMICS
ZYRTEC CHILD CHEW ALLERGY	OTC	NC	ANTIHISTAMINES

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	G
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	G
dextroamphetamine ER cap (DEXEDRINE equiv)	-	G
dextroamphetamine soln (PROCENTRA equiv)	-	G
dextroamphetamine tab (DEXEDRINE equiv)	-	G
lisdexamfetamine dimesylate cap (VYVANSE equiv) (QL= 1 cap/day)	QL	G
lisdexamfetamine dimesylate chew tab (VYVANSE equiv) (QL= 1 tab/day; Members age 9 or older require Prior Authorization)	PA-QL	G
ADDERALL XR CAP	-	NC
ADZENYS ER SUSP	-	NC
ADZENYS XR ODT	-	NC
amphetamine er odt (ADZENYS XR equiv)	-	NC
AMPHETAMINE ER SUSP, DYANAVEL XR SUSP	-	NC
amphetamine tab (EVEKEO equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv)	-	NC
amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv)	-	NC
ARYNTA SOLN	-	NC
dextroamphetamine sulfate tab 15mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 20mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 30mg (ZENZEDI equiv)	-	NC
dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv)	-	NC
DYANAVEL XR CHEW	-	NC
EVEKEO ODT	-	NC
methamphetamine hcl tab (METHAMPHETAMINE equiv)	-	NC
MYDAYIS CAP 12.5MG	-	NC
MYDAYIS CAP 25MG	-	NC
MYDAYIS CAP 37.5MG	-	NC
MYDAYIS CAP 50MG	-	NC
VYVANSE CAP	-	NC
VYVANSE CHEW TAB	-	NC
XELSTRYM PAD	-	NC
zenzedi tab 10mg (DEXEDRINE equiv)	-	NC
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC
ANALEPTICS		
caffeine citrate soln (CAFCIT equiv) (Covered for members age 11 months and younger)	-	G
CAFCIT INJ	-	NC
ANOREXIANTS NON-AMPHETAMINE		
benzphetamine tab	-	EXC
DIETHYLPROPION ER TAB	-	EXC
diethylpropion tab	-	EXC
PHENDIMETRAZINE ER TAB	-	EXC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
phendimetrazine tab (BONTRIL PDM equiv)	-	EXC
PLENITY CAP	-	EXC
ANTI-OBESITY AGENTS		
FOUNDAYO TAB	-	EXC
liraglutide (weight mngmt) soln pen-inj (SAXENDA equiv)	-	EXC
SAXENDA INJ	-	EXC
WEGOVY HD INJ 7.2MG/0.75ML	-	EXC
WEGOVY INJ	-	EXC
WEGOVY INJ 1.7MG/0.75ML	-	EXC
WEGOVY INJ 2.4MG/0.75ML	-	EXC
WEGOVY TAB	-	EXC
XENICAL CAP	-	EXC
ZEPBOUND INJ	-	EXC
ZEPBOUND KWIKPEN INJ	-	EXC
ZEPBOUND VIAL INJ	-	EXC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA equiv)	-	G
clonidine ER tab (KAPVAY equiv)	-	G
guanfacine ER tab (INTUNIV equiv)	-	G
ATONCY SOLN, ATOMOXETINE HCL SOLN	-	NC
KAPVAY TAB	-	NC
ONYDA XR SUSP	-	NC
QELBREE ER CAP	-	NC
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB (QL= 1 tab/day)	PA-QL	B
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
STIMULANTS - MISC.		
armodafanil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	G
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	G
dexmethylphenidate tab (FOCALIN equiv)	-	G
methylphenidate CD cap (METADATE CD equiv)	-	G
methylphenidate ER cap (RITALIN LA equiv)	-	G
methylphenidate ER tab	-	G
METHYLPHENIDATE ER TAB 27MG	-	G
METHYLPHENIDATE ER TAB 36MG	-	G
METHYLPHENIDATE ER TAB 54MG	-	G
methylphenidate soln (METHYLIN equiv)	-	G
methylphenidate tab (RITALIN equiv)	-	G
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	G
APTENSIO XR CAP	-	NC
AZSTARYS CAP	-	NC
COTEMPLA XR TAB, METHYLPHENIDATE ER TAB	-	NC
FOCALIN XR CAP	-	NC
METHYLIN SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
methylphenidate chew tab (METHYLIN equiv)	-	NC
methylphenidate ER cap (APTENSIO XR equiv)	-	NC
METHYLPHENIDATE ER TAB	-	NC
methylphenidate ER tab 72mg	-	NC
METHYLPHENIDATE ER TAB, RELEXXII TAB	-	NC
methylphenidate td patch (DAYTRANA equiv)	-	NC
NUVIGIL TAB	-	NC
PROVIGIL TAB	-	NC
QUILLICHEW ER TAB	-	NC
QUILLIVANT XR SUSP	-	NC
RELEXXI ER TAB	-	NC
ALLERGENIC EXTRACTS/BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416)	LD-PA	B
PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416)	LD-PA	B
ODACTRA SL TAB	-	NC
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC
ALTERNATIVE MEDICINES		
ALTERNATIVE MEDICINE - R'S		
RESERVAPAK SYRUP	-	NC
AMEBICIDES		
AMEBICIDES		
SOLOSEC GRANULES PACKET	-	NC
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	B
TOBI PODHALER (Only available through Walgreens 888-347-3416)	LD-PA	B
neomycin tab	-	G
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	G
HUMATIN CAP	-	NC
KITABIS PAK NEB SOLN	-	NC
tobramycin neb soln (BETHKIS equiv)	-	NC
ANALGESICS - ANTI-INFLAMMATORY		
ANTIRHEUMATIC - ENZYME INHIBITORS		
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	B
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	B
RINVOQ ORAL SOLN (QL= 12ml/day)	LMSP-PA-QL	B
tofacitinib citrate ER tab (XELJANZ equiv) (QL= 1 tab/day)	LMSP-QL	G
tofacitinib citrate oral soln (XELJANZ equiv) (QL= 10ml/day)	LMSP-QL	G
tofacitinib citrate tab (XELJANZ equiv) (QL= 2 tabs/day)	LMSP-QL	G
XELJANZ ORAL SOLN	-	NC
XELJANZ TAB	-	NC
XELJANZ XR TAB	-	NC
ANTIRHEUMATIC ANTIMETABOLITES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
REDITREX INJ	-	NC
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT (YUFLYMA equiv) (QL= 1 kit/fill; 1 fill/plan year)	LMSP-PA-QL	B
ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B
SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B
SIMPONI INJ 100MG (QL=1 inj/28 days)	LMSP-PA-QL	B
ABRILADA INJ	-	NC
ADALIMUMAB-ADAZ INJ	-	NC
ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv)	-	NC
ADALIMUMAB-ADAZ INJ 10/0.1ML	-	NC
ADALIMUMAB-ADAZ PFS INJ (HYRIMOZ equiv)	-	NC
ADALIMUMAB-RYVK INJ (SIMLANDI equiv)	-	NC
AMJEVITA AUTO-INJECTOR (adalimumab-atto)	-	NC
AMJEVITA INJ (adalimumab-atto)	-	NC
CYLTEZO AUTO-INJECTOR KIT (adalimumab-adbm)	-	NC
CYLTEZO INJ (adalimumab-adbm)	-	NC
HADLIMA INJ (adalimumab-bwwd)	-	NC
HADLIMA PUSH INJ (adalimumab-bwwd)	-	NC
HULIO INJ (adalimumab-fkjp)	-	NC
HULIO KIT (adalimumab-fkjp)	-	NC
HUMIRA INJ 10MG	-	NC
HUMIRA INJ 20MG	-	NC
HUMIRA INJ 40MG	-	NC
HUMIRA INJ 80MG	-	NC
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	-	NC
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	-	NC
HUMIRA INJ PEDIATRIC UC STARTER PACK	-	NC
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	-	NC
HUMIRA PEN INJ 40MG	-	NC
HYRIMOZ INJ (adalimumab-adaz)	-	NC
HYRIMOZ PFS INJ (adalimumab-adaz)	-	NC
IDACIO INJ (adalimumab-aacf)	-	NC
SIMLANDI INJ, ADALIMUMAB-RYVK INJ (QUALLENT)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
SIMPONI AUTO-INJECTOR 50MG	-	NC
SIMPONI INJ 50MG	-	NC
YUFLYMA INJ KIT (adalimumab-aaty)	-	NC
YUFLYMA KIT (adalimumab-aaty)	-	NC
YUSIMRY INJ (adalimumab-aqvh)	-	NC
GOLD COMPOUNDS		
AURANOFIN CAP, RIDAURA CAP	-	NC
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ	-	NC
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA IV INJ	MSP-PA	B
AVTOZMA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
TYENNE INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
ACTEMRA ACTPEN INJ	-	NC
ACTEMRA SC INJ	-	NC
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
SPRIX NASAL SPRAY	PA	B
celecoxib cap (CELEBREX equiv)	-	G
diclofenac potassium tab (CATAFLAM equiv)	-	G
diclofenac sodium EC tab (VOLTAREN equiv)	-	G
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	G
etodolac cap (LODINE equiv)	-	G
etodolac ER tab (LODINE XL equiv)	-	G
etodolac tab	-	G
ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv)	-	G
ibuprofen tab	-	G
ibuprofen tab ((RX only))	-	G
indomethacin cap (INDOCIN equiv)	-	G
indomethacin CR cap (INDOCIN SR equiv)	-	G
ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G
ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G
ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days)	QL	G
ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	G
MECLOFENAMATE CAP (Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen)	ST	G
meloxicam tab (MOBIC equiv)	-	G
nabumetone tab (RELAFEN equiv)	-	G
naproxen sodium tab (ANAPROX equiv)	-	G
naproxen tab (NAPROSYN equiv)	-	G
oxaprozin tab (DAYPRO equiv)	-	G
piroxicam cap (FELDENE equiv)	-	G
sulindac tab (CLINORIL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
ANAPROX TAB	-	NC
ARTHROTEC TAB	-	NC
CELEBREX CAP	-	NC
COMBOGESIC TAB	-	NC
COXANTO CAP	-	NC
DICLOFENAC CAP	-	NC
diclofenac potassium cap (ZIPSOR equiv)	-	NC
diclofenac potassium tab 25mg (DICLOFENAC equiv)	-	NC
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC
fenoprofen calcium cap (NALFON equiv)	-	NC
FENOPROFEN CAP, NAFLON CAP	-	NC
FENOPROFEN TAB	-	NC
FENOPRON CAP	-	NC
FLURBIPROFEN TAB	-	NC
flurbiprofen tab (ANSAID equiv)	-	NC
IBU 600-EZS KIT	-	NC
IBUPROFEN TAB	-	NC
ibuprofen-famotidine tab (DUEXIS equiv)	-	NC
INDOCIN SUPP	-	NC
INDOCIN SUSP	-	NC
INDOMETHACIN CAP, TIVORBEX CAP	-	NC
indomethacin suppository (INDOCIN equiv)	-	NC
indomethacin susp (INDOCIN equiv)	-	NC
INFLATHERM PAK	-	NC
KETOPROFEN CAP	-	NC
KETOPROFEN ER CAP	-	NC
KETOROLAC INJ	-	NC
ketorolac inj (TORADOL equiv)	-	NC
mefenamic acid cap (PONSTEL equiv)	-	NC
meloxicam cap (VIVLODEX equiv)	-	NC
MELOXICAM COMFORT KIT	-	NC
MELOXICAM SUSP, ZYBIC SUSP	-	NC
NAFLON CAP	-	NC
NAPRELAN CR TAB	-	NC
NAPROSYN EC TAB	-	NC
NAPROSYN EC TAB 500MG	-	NC
naproxen EC tab (NAPROSYN EC equiv)	-	NC
naproxen EC tab 500mg (NAPROSYN EC equiv)	-	NC
NAPROXEN SOD ER TAB	-	NC
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC
NAPROXEN SUSP	-	NC
naproxen susp (NAPROSYN equiv)	-	NC
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC
ORUDIS CAP	-	NC
QMIIZ ODT TAB	-	NC
RELAFEN DS TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
TIVORBEX CAP	-	NC
TOLECTIN DS CAP, TOLMETIN CAP	-	NC
TOLECTIN TAB	-	NC
TOLMETIN TAB, TOLECTIN TAB	-	NC
VIMOVO TAB	-	NC
VIVLODEX CAP	-	NC
VYSCOXA SUSP	-	NC
YBUPHEN TAB	-	NC
ZIPSOR CAP	-	NC
ZORVOLEX CAP	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B
OTEZLA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
OTEZLA XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
OTEZLA/OTEZLA XR STARTER PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab (ARAVA equiv)	-	G
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLICK INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B
ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days)	LMSP-PA-QL	B
ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days)	LMSP-PA-QL	B
ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days)	LMSP-PA-QL	B
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25MG (QL= 8 inj/28 days)	LMSP-PA-QL	B
ENBREL INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B
ENBREL MINI INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B
ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days)	LMSP-PA-QL	B
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
butalbital/acetaminophen tab 50-325mg (PHRENILIN equiv) (QL= 60 tabs/30 days)	PA-QL	G
butalbital/acetaminophen/caffeine tab (FIORICET equiv) (QL= 60 tabs/30 days)	PA-QL	G
butalbital/aspirin/caffeine cap (FIORINAL equiv) (QL= 60 tabs/30 days)	PA-QL	G
ALLZITAL TAB	-	NC
bupap tab	-	NC
butalbital/acetaminophen cap	-	NC
butalbital/acetaminophen/caffeine cap (FIORICET equiv)	-	NC
butalbital/acetaminophen/caffeine soln	-	NC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC
DOLGIC PLUS TAB	-	NC
VTOL SOLN	-	NC
ANALGESICS - SODIUM CHANNEL PAIN SIGNAL INHIBITORS		
JOURNAVX TAB	-	NC
SALICYLATES		
aspirin chew tab 81mg (Covered for female members only age 59 years and younger)	OTC	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - NONNARCOTIC Cont.		
aspirin ec tab 81mg (Covered for female members only age 59 years and younger)	OTC	$0
diflunisal tab (DOLOBID equiv)	-	G
ASPIRIN EC TAB 325MG	OTC	NC
aspirin tab 325mg	OTC	NC
DOLOBID TAB	-	NC
SALSALATE TAB	-	NC
salsalate tab (DISALCID equiv)	-	NC
ANALGESICS - OPIOID		
OPIOID AGONISTS		
HYDROCODONE BITARTRATE ER CAP (QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	B
METHADOSE CONC	ST	B
MS CONTIN TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	B
NUCYNTA ER TAB (QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	B
NUCYNTA TAB	-	B
XTAMPZA ER CAP (QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	B
CODEINE SULFATE TAB	-	G
DISKETS TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
fentanyl patch (DURAGESIC equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
HYDROCODONE BITARTRATE ER TAB (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioi ER Dependency))	QL-ST	G
hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	G
hydromorphone tab (DILAUDID equiv)	-	G
methadone soln (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
methadone tab (DOLOPHINE equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
methadose tab (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
morphine sulfate ER tab (MS CONTIN equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
MORPHINE SULFATE ORAL SOLN 100MG/5ML	-	G
MORPHINE SULFATE ORAL SOLN 10MG/5ML	-	G
morphine sulfate oral soln 10mg/5ml (MORPHINE SULFATE equiv)	-	G
morphine sulfate soln	-	G
MORPHINE SULFATE SOLN 20MG/5ML	-	G
MORPHINE SULFATE SUPP	-	G
MORPHINE SULFATE TAB	-	G
oxycodone cap (OXYIR equiv)	-	G
oxycodone conc (ROXICODONE equiv)	-	G
oxycodone soln (ROXICODONE equiv)	-	G
oxycodone tab (ROXICODONE equiv)	-	G
tapentadol hcl tab (NUCYNTA equiv)	-	G
tramadol ER tab (ULTRAM ER equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
TRAMADOL HCL ER TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	ST	G
tramadol tab (ULTRAM equiv)	-	G
ABSTRAL SL TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
ACTIQ LOZENGE	-	NC
DSUVIA SL TAB	-	NC
FENTANYL BUCCAL TAB	-	NC
FENTANYL CITRATE LOLLIPOP	-	NC
fentanyl citrate lollipop (ACTIQ equiv)	-	NC
fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC
FENTORA TAB	-	NC
hydromorphone ER tab (EXALGO TAB equiv)	-	NC
HYDROMORPHONE SUPP	-	NC
LAZANDA NASAL SPRAY	-	NC
levorphanol tab (LEVORPHANOL equiv)	-	NC
meperidine tab (DEMEROL equiv)	-	NC
MORPHABOND TAB	-	NC
MORPHINE SULFATE ER BEAD CAP	-	NC
OPANA TAB	-	NC
OXYCODONE TAB	-	NC
OXYCONTIN CR TAB	-	NC
OXYMORPHONE ER TAB	-	NC
oxymorphone tab (OPANA equiv)	-	NC
QDOLO SOLN, TRAMADOL SOLN	-	NC
ROXYBOND TAB	-	NC
RYBIX ODT	-	NC
SUBSYS SPRAY	-	NC
TAPENTADOL ER TAB 100MG	-	NC
TAPENTADOL ER TAB 150MG	-	NC
TAPENTADOL ER TAB 200MG	-	NC
TAPENTADOL ER TAB 250MG	-	NC
TAPENTADOL ER TAB 50MG	-	NC
TAPENTADOL SOLN	-	NC
TRAMADOL ER CAP	-	NC
TRAMADOL HCL TAB	-	NC
tramadol hcl tab 100mg	-	NC
tramadol hcl tab 25mg	-	NC
OPIOID COMBINATIONS		
APAP/CODEINE SOLN	-	B
HYDROCODONE/IBUPROFEN TAB 10-200MG	-	B
LORTAB ELIXIR	-	B
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	G
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	G
hydrocodone/acetaminophen tab (LORTAB equiv)	-	G
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	G
OXYCODONE/ACETAMINOPHEN SOLN	-	G
oxycodone/acetaminophen tab (PERCOCET equiv)	-	G
tramadol/acetaminophen tab (ULTRACET equiv)	-	G
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC
APADAZ TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	NC
hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv)	-	NC
hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv)	-	NC
OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML	-	NC
OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG	-	NC
PRIMLEV TAB 10-300MG	-	NC
PRIMLEV TAB 5-300MG	-	NC
PROLATE TAB 7.5-300MG	-	NC
SEGLENTIS TAB	-	NC
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC
VERDROCET TAB 2.5MG-325MG	-	NC
XODOL TAB 10MG-300MG	-	NC
XODOL TAB 5MG-300MG	-	NC
XODOL TAB 7.5MG-300MG	-	NC
OPIOID PARTIAL AGONISTS		
SUBLOCADE SOLN, BRIXADI SOLN	LMSP	B
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency))	QL-ST	G
buprenorphine SL tab (SUBUTEX equiv)	-	G
buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv)	-	G
buprenorphine/naloxone SL tab (SUBOXONE equiv)	-	G
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	G
PENTAZOCINE/NALOXONE TAB	-	G
pentazocine/naloxone tab (TALWIN NX equiv)	-	G
BELBUCA FILM	-	NC
BUNAVAIL FILM	-	NC
buprenorphine hcl buccal film (BELBUCA equiv)	-	NC
SUBOXONE SL FILM	-	NC
ZUBSOLV SL TAB	-	NC
ANDROGENS-ANABOLIC		
ANDROGENS		
TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill)	QL	B
danazol cap (DANOCRINE equiv)	-	G
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	G
testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days)	PA-QL	G
testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days)	PA-QL	G
ANDROGEL 1% 25MG	-	NC
ANDROGEL 1% 50MG, TESTIM GEL 1%	-	NC
ANDROGEL 1.62% 1.25GM	-	NC
ANDROGEL 1.62% 2.5GM	-	NC
KYZATREX CAP	-	NC
KYZATREX CAP, JATENZO CAP, TLANDO CAP	-	NC
METHITEST TAB	-	NC
methyltestosterone cap	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANDROGENS-ANABOLIC Cont.		
NATESTO GEL	-	NC
NATESTO NASAL GEL	-	NC
STRIANT FILM	-	NC
TESTOSTERONE GEL 1% 25MG	-	NC
testosterone gel 1% 25mg (ANDROGEL equiv)	-	NC
testosterone gel 1% 50mg (ANDROGEL equiv)	-	NC
testosterone gel 1% pump (VOGELXO GEL, ANDROGEL equiv)	-	NC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv)	-	NC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv)	-	NC
TESTOSTERONE GEL 10MG/ACT	-	NC
testosterone gel 2% (FORTESTA equiv)	-	NC
TESTOSTERONE GEL 20.25MG/1.25GM	-	NC
TESTOSTERONE GEL PUMP 1%	-	NC
TESTOSTERONE GEL, VOGELXO GEL	-	NC
VOGELXO GEL PUMP 1%	-	NC
XYOSTED INJ	-	NC
ANORECTAL AGENTS		
INTRARECTAL STEROIDS		
CORTIFOAM	-	B
hydrocortisone enema (CORTENEMA equiv)	-	G
RECTAL COMBINATIONS		
ANALPRAM-E KIT	-	B
PROCTOFOAM HC FOAM	-	B
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC
RECTAL STEROIDS		
hydrocortisone supp (ANUSOL HC equiv)	-	G
proctosol HC cream (ANUSOL HC equiv)	-	G
anusol-HC supp	-	NC
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS		
budesonide rectal foam (UCERIS RECTAL FOAM equiv)	-	B
UCERIS RECTAL FOAM	-	B
RECTAL COMBINATIONS		
ANALPRAM HC CREAM 2.5-1%	-	B
ANALPRAM-HC CREAM	-	B
ANALPRAM HC CREAM 2.5-1%	-	G
HYDROCORTISONE ACETATE/PRAMOXINE CREAM	-	G
LIDOCAINE/HC CREAM	-	G
HYDROCORTISONE/PRAMOXINE SUPP	-	NC
RECTAL LOCAL ANESTHETICS		
LIDOCAINE SUPP	-	NC
RECTAL STEROIDS		
ANUCORT-HC SUPP 25MG	-	G
ANUCORT-HC SUPP 30MG	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANORECTAL AND RELATED PRODUCTS Cont.		
HYDROCORTISONE CREAM	-	G
PROCTOCORT SUPP	-	NC
VASODILATING AGENTS		
nitroglycerin oint (RECTIV equiv)	-	B
RECTIV OINT	-	B
ANTHELMINTICS		
ANTHELMINTICS		
BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist)	RS	B
BILTRICIDE TAB	-	B
ivermectin tab (STROMECTOL equiv)	-	G
praziquantel tab (BILTRICIDE equiv)	-	G
EGATEN TAB	-	NC
EMVERM TAB	-	NC
IVERMECTIN TAB	-	NC
STROMECTOL TAB	-	NC
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
ranolazine tab (RANEXA equiv)	-	G
ASPRUZYO SPRINKLE GRANULES	-	NC
NITRATES		
isosorbide dinitrate tab (ISORDIL equiv)	-	G
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	G
isosorbide mononitrate ER tab (IMDUR equiv)	-	G
isosorbide mononitrate tab (MONOKET equiv)	-	G
NITROGLYCERIN ER CAP	-	G
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	G
nitroglycerin oint	-	G
nitroglycerin patch (NITRO-DUR equiv)	-	G
nitroglycerin SL tab (NITROSTAT equiv)	-	G
GONITRO POWDER	-	NC
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	NC
ANTIANXIETY AGENTS		
ANTIANXIETY AGENTS - MISC.		
buspirone tab (BUSPAR equiv)	-	G
hydroxyzine pamoate cap (VISTARIL equiv)	-	G
hydroxyzine syrup (ATARAX equiv)	-	G
hydroxyzine tab (ATARAX equiv)	-	G
BUCAPSOL CAP	-	NC
BUSPIRONE TAB	-	NC
buspirone tab 30mg (BUSPAR equiv)	-	NC
meprobamate tab (MILTOWN equiv)	-	NC
BENZODIAZEPINES		
alprazolam ER tab (XANAX XR equiv)	-	G
alprazolam ODT (NIRAVAM equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIANXIETY AGENTS Cont.		
alprazolam tab (XANAX equiv)	-	G
chlordiazepoxide cap (LIBRIUM equiv)	-	G
clorazepate tab (TRANXENE-T equiv)	-	G
diazepam conc (VALIUM equiv)	-	G
diazepam oral soln 5mg/5ml (DIAZEPAM equiv)	-	G
diazepam tab (VALIUM equiv)	-	G
lorazepam conc (ATIVAN equiv)	-	G
lorazepam tab (ATIVAN equiv)	-	G
oxazepam cap (SERAX equiv)	-	G
LOREEV XR CAP	-	NC
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
NORPACE CR CAP	-	B
disopyramide cap (NORPACE equiv)	-	G
quinidine gluconate CR tab	-	G
quinidine sulfate tab	-	G
QUINIDINE SULFATE TAB	-	NC
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap	-	G
ANTIARRHYTHMICS TYPE I-C		
flecainide tab (TAMBOCOR equiv)	-	G
propafenone ER cap (RYTHMOL SR equiv)	-	G
propafenone tab (RYTHMOL equiv)	-	G
ANTIARRHYTHMICS TYPE III		
MULTAQ TAB	-	B
amiodarone tab (CORDARONE equiv)	-	G
dofetilide cap (TIKOSYN equiv)	-	G
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
FASENRA PEN INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
OMLYCLO SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	B
OMLYCLO SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
OMLYCLO SYRINGE 300MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B
TEZSPIRE INJ (QL= 1 pen/28 days)	LMSP-PA-QL	B
XOLAIR INJ	LMSP-PA	B
XOLAIR INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
XOLAIR INJ 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
XOLAIR INJ 300MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B
XOLAIR SYRINGE (QL= 2 inj/28 days)	LMSP-PA-QL	B
XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
XOLAIR SYRINGE 300MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B
ANTI-INFLAMMATORY AGENTS		
cromolyn neb soln (INTAL equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
BRONCHODILATORS - ANTICHOLINERGICS		
INCRUSE ELLIPTA INHALER	-	B
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL))	QL-ST	B
ATROVENT HFA AERO	-	G
ipratropium neb soln (ATROVENT equiv)	-	G
ipratropium bromide hfa inhaler aerosol (ATROVENT equiv)	-	NC
SPIRIVA HANDIHALER	-	NC
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC
tiotropium bromide cap inhaler (SPIRIVA equiv)	-	NC
TUDORZA PRESSAIR INHALER	-	NC
UMECLIDINIUM ELLIPTA INHALER 62.5MCG/INH	-	NC
YUPELRI SOLN	-	NC
LEUKOTRIENE MODULATORS		
montelukast chew tab (SINGULAIR equiv)	-	G
montelukast granule pack (SINGULAIR equiv)	-	G
montelukast tab (SINGULAIR equiv)	-	G
zafirlukast tab (ACCOLATE equiv)	-	G
zileuton ER tab (ZYFLO CR equiv)	-	NC
ZYFLO TAB	-	NC
PHOSPHODIESTERASE 3 & 4 (PDE3 & PDE4) INHIBITORS		
OHTUVAYRE SUSP (QL= 60 ampules/30 days; Only available through CVS Specialty 800-238-7828 or AcariaHealth 800-511-5144)	LD-PA-QL	B
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
roflumilast tab	PA	G
DALIRESP TAB	-	NC
STEROID INHALANTS		
ALVESCO INHALER	-	G
ARNUITY ELLIPTA INHALER	-	G
ASMANEX HFA INHALER	-	G
ASMANEX INHALER	-	G
budesonide inh susp (PULMICORT equiv)	-	G
QVAR REDIHALER	-	G
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC
FLOVENT DISKUS INHALER	-	NC
FLOVENT HFA INHALER	-	NC
FLUTICASONE DISKUS INHALER	-	NC
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100MCG/ACT	-	NC
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200MCG/ACT	-	NC
FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50MCG/ACT	-	NC
FLUTICASONE HFA INHALER	-	NC
fluticasone propionate hfa inhal aero (FLUTICASONE equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
PULMICORT FLEXHALER	-	NC
QVAR AERO	-	NC
SYMPATHOMIMETICS		
ADVAIR HFA INHALER	-	B
ANORO ELLIPTA INHALER	-	B
BREO ELLIPTA INHALER	-	B
BREO ELLIPTA INHALER 50-25 MCG/ACT	-	B
BREZTRI AEROSPHERE INHALER	-	B
COMBIVENT RESPIMAT INHALER	-	B
DULERA INHALER	-	B
LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of an albuterol HFA product (6.7 or 8.5gm))	QL-ST	B
STIOLTO INHALER	-	B
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	B
TRELEGY ELLIPTA INHALER	-	B
albuterol HFA (6.7gm, 8.5gm) inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days)	QL	G
albuterol neb soln	-	G
ALBUTEROL NEBULIZER SOLN	-	G
albuterol sulfate syrup	-	G
albuterol sulfate tab	-	G
albuterol/ipratropium neb soln (DUONEB equiv)	-	G
arformoterol tartrate neb soln (BROVANA equiv) (Step Therapy requires trial of PERFOROMIST)	ST	G
budesonide/formoterol inhaler (SYMBICORT equiv)	-	G
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	G
FLUTICASONE-SALMETEROL INHALER 113-14 MCG/ACT	-	G
FLUTICASONE-SALMETEROL INHALER 232-14 MCG/ACT	-	G
FLUTICASONE-SALMETEROL INHALER 55-14 MCG/ACT	-	G
formoterol fumarate neb soln (PERFOROMIST equiv)	-	G
levalbuterol neb soln (XOPENEX equiv)	-	G
terbutaline sulfate tab (BRETHINE equiv)	-	G
ADVAIR DISKUS INHALER	-	NC
AIRDUO POWDER INHALER W/SENSOR	-	NC
AIRDUO RESPICLICK	-	NC
AIRSUPRA INH	-	NC
albuterol HFA (18gm) inhaler (VENTOLIN equiv)	-	NC
BEVESPI AEROSPHERE INHALER	-	NC
DUAKLIR INHALER	-	NC
FLUTICASONE-SALMETEROL INHALER 115-21 MCG/ACT	-	NC
FLUTICASONE-SALMETEROL INHALER 230-21 MCG/ACT	-	NC
FLUTICASONE-SALMETEROL INHALER 45-21 MCG/ACT	-	NC
FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT	-	NC
FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT	-	NC
SEREVENT DISKUS INHALER	-	NC
SYMBICORT INHALER	-	NC
UMECLIDINIUM/VILANTEROL INHALER 62.5-25MCG/ACT	-	NC
XOPENEX HFA INHALER 45MCG/ACT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
XANTHINES		
ELIXOPHYLLIN ELIXIR	-	B
THEOPHYLLINE TAB ER	-	B
theophylline er tab (THEOPHYLLINE ER equiv)	-	G
theophylline ER tab (UNIPHYL equiv)	-	G
theophylline soln	-	G
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	G
DIRECT FACTOR XA INHIBITORS		
ELIQUIS SPRINKLE CAP	-	B
ELIQUIS TAB FOR ORAL SUSP	-	B
ELIQUIS TAB, ELIQUIS STARTER PACK	-	B
XARELTO STARTER PACK	-	B
XARELTO SUSP	-	B
XARELTO TAB	-	B
rivaroxaban for susp (XARELTO equiv)	-	G
rivaroxaban tab 2.5mg (XARELTO equiv)	-	G
SAVAYSA TAB	-	NC
HEPARINS AND HEPARINOID-LIKE AGENTS		
FRAGMIN INJ	-	B
enoxaparin inj (LOVENOX equiv)	-	G
fondaparinux inj (ARIXTRA equiv)	-	G
ARIXTRA INJ	-	NC
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap (PRADAXA equiv)	-	G
PRADAXA PELLET PACK	-	NC
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA SUSP	-	B
FYCOMPA TAB	-	B
perampanel susp (FYCOMPA equiv)	-	G
perampanel tab (FYCOMPA equiv)	-	G
ANTICONVULSANTS - BENZODIAZEPINES		
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 4 doses/fill)	QL	B
MIDAZOLAM INJ (QL= 1 inj/fill)	QL	B
NAYZILAM SPRAY (QL= 4 doses/fill)	QL	B
VALTOCO NASAL SPRAY (QL= 5 doses/fill)	QL	B
clobazam susp (ONFI equiv) (Prior Authorization required for members age 9 years and older)	PA	G
clobazam tab (ONFI equiv)	PA	G
clonazepam ODT (KLONOPIN equiv)	-	G
clonazepam tab (KLONOPIN equiv)	-	G
diazepam rectal gel (QL= 4 doses/fill)	QL	G
CLONAZEPAM TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
DIASTAT ACDL GEL	-	NC
LIBERVANT FILM	-	NC
ONFI SUSP	-	NC
ONFI TAB	-	NC
SYMPAZAN ORAL FILM	-	NC
ANTICONVULSANTS - MISC.		
DIACOMIT CAP (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B
DIACOMIT POWDER PACK (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B
EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553)	LD-PA	B
FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	B
SUBVENITE SUSP (Prior Authorization required for members age 9 years and older)	PA	B
ZONISADE SUSP (Prior Authorization required for members age 9 years and older)	PA	B
ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
carbamazepine chew tab (TEGRETOL equiv)	-	G
carbamazepine ER cap (CARBATROL equiv)	-	G
carbamazepine ER tab (TEGRETOL XR equiv)	-	G
carbamazepine susp (TEGRETOL equiv)	-	G
carbamazepine tab (TEGRETOL equiv)	-	G
gabapentin cap 100mg (NEURONTIN equiv) (QL= 9 caps/day)	QL	G
gabapentin cap 300mg (NEURONTIN equiv) (QL= 6 caps/day)	QL	G
gabapentin cap 400mg (NEURONTIN equiv) (QL= 4 caps/day)	QL	G
gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day)	QL	G
gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day)	QL	G
gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day)	QL	G
lacosamide oral solution (VIMPAT equiv)	-	G
lacosamide tab (VIMPAT equiv)	-	G
lamotrigine chew tab (LAMICTAL equiv)	-	G
lamotrigine ER tab (LAMICTAL XR equiv)	-	G
lamotrigine starter kit (LAMICTAL STARTER KIT equiv)	-	G
lamotrigine tab (LAMICTAL equiv)	-	G
levetiracetam ER tab (KEPPRA XR equiv)	-	G
levetiracetam soln (KEPPRA equiv)	-	G
levetiracetam tab (KEPPRA equiv)	-	G
oxcarbazepine susp (TRILEPTAL equiv)	-	G
oxcarbazepine tab (TRILEPTAL equiv)	-	G
pregabalin cap (LYRICA equiv) (QL= 3 caps/day)	QL	G
pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day)	QL	G
pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day)	QL	G
pregabalin soln (LYRICA equiv) (QL= 30ml/day)	QL	G
primidone tab (MYSOLINE equiv)	-	G
rufinamide susp (BANZEL equiv) (Prior Authorization required for members age 9 years and older)	PA	G
rufinamide tab (BANZEL equiv)	-	G
topiramate sprinkle cap (TOPAMAX equiv)	-	G
topiramate tab (TOPAMAX equiv)	-	G
zonisamide cap (ZONEGRAN equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
APTIOM TAB	-	NC
BANZEL SUSP	-	NC
BANZEL TAB	-	NC
brivaracetam inj (BRIVIACT equiv)	-	NC
brivaracetam oral soln 10mg/ml (BRIVIACT equiv)	-	NC
brivaracetam tab (BRIVIACT equiv)	-	NC
BRIVIACT INJ	-	NC
BRIVIACT SOLN 10MG/ML	-	NC
BRIVIACT TAB	-	NC
CARBAMAZEPINE CHEW TAB	-	NC
ELEPSIA XR TAB	-	NC
EPRONTIA SOLN	-	NC
eslicarbazepine acetate tab (APTIOM equiv)	-	NC
gabapentin cap 200mg (RELGAABI equiv)	-	NC
GABARONE TAB	-	NC
lamotrigine ODT (LAMICTAL equiv)	-	NC
lamotrigine ODT kit (LAMICTAL equiv)	-	NC
LEVETIRACETAM TAB FOR ORAL SUSP, SPRITAM TAB FOR ORAL SUSP	-	NC
LYRICA CAP	-	NC
LYRICA CAP 225MG	-	NC
LYRICA CAP 300MG	-	NC
MOTPOLY XR CAP	-	NC
NEURONTIN SOLN	-	NC
NEURONTIN TAB 600MG	-	NC
NEURONTIN TAB 800MG	-	NC
oxcarbazepine er tab (OXTELLAR equiv)	-	NC
OXTELLAR XR TAB	-	NC
PRIMIDONE TAB	-	NC
QUDEXY XR CAP	-	NC
topiramate ER cap (QUDEXY equiv)	-	NC
topiramate er cap (TROKENDI XR equiv)	-	NC
topiramate oral soln (EPRONTIA equiv)	-	NC
TROKENDI XR CAP	-	NC
VIMPAT SOLN	-	NC
VIMPAT TAB	-	NC
CARBAMATES		
XCOPRI PAK 100-150MG (QL= 2 tabs/day)	QL	B
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	B
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day)	QL	B
XCOPRI TAB 25MG (QL= 1 tab/day)	QL	B
XCOPRI TAB 50MG, 100MG (QL= 1 tab/day)	QL	B
XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day)	QL	B
XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day)	QL	B
XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day)	QL	B
felbamate susp (FELBATOL equiv)	-	G
felbamate tab (FELBATOL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
FELBATOL TAB	-	NC
GABA MODULATORS		
TIAGABINE TAB	-	G
tiagabine tab (GABITRIL equiv)	-	G
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G
vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G
vigadrone powder pack (Only available through PantheRx 855-726-8479)	LD-PA	G
SABRIL TAB	-	NC
VIGAFYDE SOLN	-	NC
HYDANTOINS		
DILANTIN CAP 30MG	-	B
phenytoin cap (DILANTIN equiv)	-	G
phenytoin chew tab (DILANTIN equiv)	-	G
phenytoin susp (DILANTIN equiv)	-	G
SUCCINIMIDES		
ethosuximide cap (ZARONTIN equiv)	-	G
ethosuximide soln (ZARONTIN equiv)	-	G
methsuximide cap (CELONTIN equiv)	-	G
VALPROIC ACID		
divalproex ER tab (DEPAKOTE ER equiv)	-	G
divalproex sodium DR tab (DEPAKOTE equiv)	-	G
divalproex sprinkle cap (DEPAKOTE equiv)	-	G
valproic acid cap (DEPAKENE equiv)	-	G
valproic acid syrup (DEPAKENE equiv)	-	G
DEPACON INJ	-	NC
STAVZOR CAP	-	NC
valproate inj (DEPACON equiv)	-	NC
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	G
mirtazapine tab (REMERON equiv)	-	G
ANTIDEPRESSANT COMBINATIONS		
AUVELITY TAB	-	NC
AUVELITY TAB TITRATION PACK	-	NC
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	G
bupropion tab (WELLBUTRIN equiv)	-	G
bupropion XL tab (WELLBUTRIN XL equiv)	-	G
APLENZIN TAB	-	NC
BUPROPION XL TAB, FORFIVO XL TAB	-	NC
WELLBUTRIN SR TAB	-	NC
WELLBUTRIN XL TAB	-	NC
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID		
ZURZUVAE CAP 20MG, 25MG (QL= 28 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
ZURZUVAE CAP 30MG (QL= 14 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
EMSAM PATCH	-	B
NARDIL TAB 15MG	-	B
PHENELZINE SULFATE TAB	-	G
phenelzine tab (NARDIL equiv)	-	G
tranylcypromine tab (PARNATE equiv)	-	G
MARPLAN TAB	-	NC
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram soln (CELEXA equiv)	-	G
citalopram tab (CELEXA equiv)	-	G
escitalopram soln (LEXAPRO equiv)	-	G
escitalopram tab (LEXAPRO equiv)	-	G
fluoxetine cap (PROZAC equiv)	-	G
fluoxetine soln (PROZAC equiv)	-	G
fluoxetine tab (PROZAC equiv)	-	G
fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine)	ST	G
fluvoxamine tab (LUVOX equiv)	-	G
paroxetine ER tab (PAXIL CR equiv)	-	G
PAROXETINE SUSP	-	G
paroxetine tab (PAXIL equiv)	-	G
sertraline conc (ZOLOFT equiv)	-	G
sertraline tab (ZOLOFT equiv)	-	G
CITALOPRAM CAP	-	NC
citalopram hydrobromide cap	-	NC
ESCITALOPRAM CAP	-	NC
fluoxetine tab 60mg	-	NC
fluoxetine weekly cap (PROZAC equiv)	-	NC
PEXEVA TAB	-	NC
PROZAC WEEKLY CAP	-	NC
SERTRALINE CAP	-	NC
sertraline hcl cap	-	NC
SEROTONIN MODULATORS		
TRINTELLIX TAB (QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine)	QL-ST-¢	B
trazodone tab (DESYREL equiv)	-	G
vilazodone hcl tab (VIIBRYD equiv)	-	G
EXXUA TAB/EXXUA TITRATION PACK	-	NC
NEFAZODONE TAB	-	NC
RALDESY SOLN	-	NC
TRAZODONE TAB	-	NC
trazodone tab 300mg (DESYREL equiv)	-	NC
VIIBRYD STARTER KIT	-	NC
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDEPRESSANTS Cont.		
desvenlafaxine ER tab (PRISTIQ equiv)	-	G
duloxetine EC cap (CYMBALTA equiv)	-	G
venlafaxine ER cap (EFFEXOR XR equiv)	-	G
venlafaxine tab (EFFEXOR equiv)	-	G
DESVENLAFAXINE ER TAB	-	NC
DRIZALMA DR CAP	-	NC
duloxetine cap 40mg (IRENKA equiv)	-	NC
DULOXETINE DR CAP	-	NC
EFFEXOR XR CAP	-	NC
FETZIMA CAP	-	NC
FETZIMA TITRATION PACK	-	NC
venlafaxine ER tab	-	NC
VENLAFAXINE TAB	-	NC
TRICYCLIC AGENTS		
amitriptyline tab (ELAVIL equiv)	-	G
amoxapine tab (AMOXAPINE equiv)	-	G
clomipramine cap (ANAFRANIL equiv)	-	G
desipramine tab (NORPRAMIN equiv)	-	G
doxepin cap (SINEQUAN equiv)	-	G
doxepin conc (SINEQUAN equiv)	-	G
DOXEPIN HCL CAP	-	G
DOXEPIN HCL CONC	-	G
imipramine pamoate cap (TOFRANIL PM equiv)	-	G
imipramine tab (TOFRANIL equiv)	-	G
nortriptyline cap (PAMELOR equiv)	-	G
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	G
protriptyline tab (VIVACTIL equiv)	-	G
trimipramine cap (SURMONTIL equiv)	-	G
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
MIGLITOL TAB	-	B
acarbose tab (PRECOSE equiv)	-	G
miglitol tab (MIGLITOL equiv)	-	G
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN INJ	PA	B
ANTIDIABETIC COMBINATIONS		
JENTADUETO TAB (QL= 2 tabs/day)	QL	B
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	B
SOLIQUA INJ (QL= 15ml/25 days)	QL	B
XIGDUO XR TAB 2.5-1000 (QL= 2 tabs/day)	QL	B
XULTOPHY INJ (QL= 15ml/30 days)	QL	B
dapagliflozin-metformin er tab (XIGDUO XR equiv) (QL= 1 tab/day)	QL	G
dapagliflozin-metformin er tab 5-1000MG (XIGDUO XR equiv) (QL= 2 tabs/day)	QL	G
glipizide/metformin tab (METAGLIP equiv)	-	G
glyburide/metformin tab (GLUCOVANCE equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
sitagliptin phosphate-metformin hcl er tab (JANUMET equiv) (QL= 2 tabs/day)	QL	G
sitagliptin phosphate-metformin hcl tab (JANUMET equiv) (QL= 2 tabs/day)	QL	G
ACTOPLUS MET TAB	-	NC
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC
ALOGLIPTIN-METFORMIN TAB	-	NC
ALOGLIPTIN-PIOGILTAZONE TAB	-	NC
DUETACT TAB	-	NC
GLYXAMBI TAB	-	NC
INVOKAMET TAB	-	NC
INVOKAMET XR TAB	-	NC
JANUMET TAB	-	NC
JANUMET XR TAB	-	NC
KOMBIGLYZE XR TAB	-	NC
pioglitazone/glimepiride tab (DUETACT equiv)	-	NC
pioglitazone/metformin tab (ACTOPLUS MET equiv)	-	NC
PRANDIMET TAB	-	NC
QTERN TAB	-	NC
saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv)	-	NC
SEGLUROMET TAB	-	NC
SITAGLIPTIN/METFORMIN TAB	-	NC
STEGLUJAN TAB	-	NC
SYNJARDY TAB	-	NC
SYNJARDY XR TAB	-	NC
TRIJARDY XR TAB	-	NC
XIGDUO XR TAB	-	NC
ZITUVIMET XR TAB	-	NC
BIGUANIDES		
metformin ER tab (GLUCOPHAGE XR equiv)	-	G
metformin soln (RIOMET equiv)	-	G
metformin tab (GLUCOPHAGE equiv)	-	G
FORTAMET TAB	-	NC
GLUMETZA TAB 1000MG	-	NC
GLUMETZA TAB 500MG	-	NC
metformin ER osmotic tab (FORTAMET equiv)	-	NC
metformin ER osmotic tab (GLUMETZA equiv)	-	NC
metformin hcl tab 625MG	-	NC
metformin hcl tab 750MG	-	NC
METFORMIN TAB	-	NC
DIABETIC OTHER		
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	B
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	B
GLUCAGON INJ KIT (QL= 2 inj/fill)	QL	B
GVOKE INJ (QL= 2 inj/fill)	QL	B
GVOKE INJ KIT (QL= 2 inj/fill)	QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
GVOKE PFS INJ (QL= 2 inj/fill)	QL	B
ZEGALOGUE INJ (QL= 2 inj/fill)	QL	B
diazoxide susp (PROGLYCEM equiv)	-	G
glucagon (rdna) for inj kit (QL= 2 inj/fill)	QL	G
mifepristone tab (KORLYM equiv) (QL= 4 tabs/day)	LMSP-PA-QL	G
KORLYM TAB	-	NC
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
TRADJENTA TAB (QL= 1 tab/day)	QL	B
sitagliptin phosphate tab (JANUVIA equiv) (QL= 1 tab/day)	QL-¢	G
ALOGLIPTIN TAB	-	NC
ALOGLIPTIN TAB, NESINA TAB	-	NC
BRYNOVIN SOLN	-	NC
JANUVIA TAB	-	NC
ONGLYZA TAB	-	NC
saxagliptin hcl tab (ONGLYZA equiv)	-	NC
ZITUVIO TAB	-	NC
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB	-	B
INCRETIN MIMETIC AGENTS		
MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
liraglutide soln pen-injector (VICTOZA equiv) (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	G
VICTOZA INJ	-	NC
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
OZEMPIC TAB, RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11))	QL-RDX	B
BYDUREON BCISE AUTO INJ	-	NC
BYDUREON INJ	-	NC
BYDUREON PEN INJ	-	NC
EXENATIDE INJ (BYETTA INJ EQUIV)	-	NC
TANZEUM INJ	-	NC
INSULIN		
HUMALOG JR KWIKPEN INJ	-	B
HUMALOG KWIKPEN INJ	-	B
HUMALOG MIX INJ	-	B
HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN	-	B
HUMALOG PEN INJ	-	B
HUMALOG TEMPO PEN	-	B
HUMULIN MIX INJ	OTC	B
HUMULIN MIX PEN INJ	OTC	B
HUMULIN N INJ	OTC	B
HUMULIN N PEN INJ	OTC	B
HUMULIN R INJ	OTC	B
HUMULIN R INJ U-500	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
HUMULIN R U-500 KWIKPEN INJ	-	B
INSULIN GLARGINE SOLN PEN-INJ	-	B
INSULIN LISPRO JR KWIKPEN INJ	-	B
INSULIN LISPRO KWIKPEN INJ	-	B
LANTUS INJ	-	B
LANTUS SOLOSTAR INJ	-	B
LEVEMIR FLEXTOUCH INJ	-	B
LEVEMIR INJ	-	B
LYUMJEV INJ	-	B
LYUMJEV KWIKPEN INJ	-	B
LYUMJEV TEMPO PEN	-	B
SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ	-	B
SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN	-	B
TOUJEO MAX SOLOSTAR INJ	-	B
TOUJEO SOLOSTAR INJ	-	B
TRESIBA FLEXTOUCH INJ	-	B
TRESIBA INJ	-	B
INSULIN LISPRO INJ (HUMALOG equiv)	-	G
ADMELOG INJ, HUMALOG INJ	-	NC
ADMELOG SOLOSTAR, HUMALOG TEMPO PEN	-	NC
APIDRA INJ	-	NC
APIDRA SOLOSTAR INJ	-	NC
AWIQLI FLEX INJ	-	NC
BASAGLAR INJ, INSULIN GLARGINE SOLOSTAR INJ	-	NC
DEGLUDEC FLEXTOUCH INJ	-	NC
DEGLUDEC INJ	-	NC
FIASP FLEXTOUCH INJ	-	NC
FIASP INJ	-	NC
FIASP PENFILL INJ, FIASP PUMP CARTRIDGE	-	NC
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	NC
INSULIN ASPART PENFILL INJ	-	NC
INSULIN GLARGINE INJ	-	NC
INSULIN GLARGINE-YFGN (SINGLE PEN)	-	NC
INSULIN GLARGINE-YFGN PEN (CIVICA) 100UNIT/ML	-	NC
KIRSTY INJ	-	NC
LANGLARA INJ	-	NC
MERILOG INJ	-	NC
MERILOG SOLOSTAR INJ	-	NC
NOVOLIN 70/30 FLEXPEN INJ	OTC	NC
NOVOLIN 70/30 FLEXPEN RELION INJ	OTC	NC
NOVOLIN 70/30 INJ	OTC	NC
NOVOLIN 70/30 RELION INJ	OTC	NC
NOVOLIN N FLEXPEN INJ	OTC	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
NOVOLIN N INJ	OTC	NC
NOVOLIN N RELION 100UNIT/ML	OTC	NC
NOVOLIN R FLEXPEN INJ	OTC	NC
NOVOLIN R INJ	OTC	NC
NOVOLIN R RELION INJ	OTC	NC
NOVOLOG FLEXPEN INJ	-	NC
NOVOLOG FLEXPEN RELION INJ	-	NC
NOVOLOG INJ	-	NC
NOVOLOG MIX FLEXPEN INJ	-	NC
NOVOLOG MIX INJ	-	NC
NOVOLOG PENFILL INJ	-	NC
REZVOGLAR INJ	-	NC
SEMGLEE INJ (SINGLE PEN)	-	NC
SEMGLEE SOLN	-	NC
INSULIN SENSITIZING AGENTS		
pioglitazone tab (ACTOS equiv)	-	G
MEGLITINIDE ANALOGUES		
nateglinide tab (STARLIX equiv)	-	G
repaglinide tab (PRANDIN equiv)	-	G
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
dapagliflozin tab (FARXIGA equiv) (QL= 1 tab/day)	QL	G
BRENZAVVY TAB	-	NC
FARXIGA TAB	-	NC
INVOKANA TAB	-	NC
JARDIANCE TAB	-	NC
STEGLATRO TAB	-	NC
SULFONYLUREAS		
glimepiride tab (AMARYL equiv)	-	G
glipizide ER tab (GLUCOTROL XL equiv)	-	G
glipizide tab (GLUCOTROL equiv)	-	G
GLYBURID MCR TAB	-	G
glyburide tab (MICRONASE equiv)	-	G
GLIMEPIRIDE TAB	-	NC
GLIPIZIDE TAB	-	NC
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	B
loperamide hcl soln (LOPERAMIDE equiv)	OTC	NC
OPIUM TINCTURE	-	NC
ANTIDIARRHEALS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		
MYTESI TAB	-	NC
ANTIDIARRHEAL AGENTS - MISC.		
REZYST CHEW TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIDIARRHEALS Cont.		
VSL #3 CAP	-	NC
ANTIDIARRHEAL COMBINATIONS		
EVIVO LIQUID	-	NC
ANTIPERISTALTIC AGENTS		
diphenoxylate/atropine tab (LOMOTIL equiv)	-	G
loperamide cap (IMODIUM equiv)	-	NC
MOTOFEN TAB	-	NC
PAREGORIC TINCTURE	-	NC
ANTIDOTES		
ANTIDOTES		
VISTOGARD PAK	-	NC
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP	-	B
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B
OPIOID ANTAGONISTS		
VIVITROL INJ	LMSP	B
naltrexone tab (REVIA equiv)	-	G
EVZIO INJ	-	NC
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
deferasirox granules packet (JADENU equiv)	LMSP	G
deferasirox tab (JADENU equiv)	LMSP	G
deferasirox tab for oral susp (EXJADE equiv)	LMSP	G
deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553)	LD-PA	G
JADENU SPRINKLE	-	NC
ANTIDOTES AND SPECIFIC ANTAGONISTS		
CETYLEV TAB	-	NC
OPIOID ANTAGONISTS		
KLOXXADO NASAL SPRAY	-	B
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	B
OPVEE NASAL SPRAY	-	B
ZIMHI SOLN	-	B
ZURNAI INJ	-	B
naloxone hcl nasal spray (NARCAN equiv)	OTC	G
naloxone inj	-	G
naloxone prefilled inj	-	G
NARCAN NASAL SPRAY	OTC	G
RIVIVE, REXTOVY SPRAY	OTC	G
EVZIO INJ	-	NC
REZENOPY SPRAY 10MG/0.11ML	-	NC
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
ANZEMET TAB (QL= 9 tabs/fill)	QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
SANCUSO PATCH (QL= 4 patches/fill)	QL	B
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	G
ondansetron ODT (ZOFRAN equiv)	-	G
ondansetron soln (ZOFRAN equiv)	-	G
ondansetron tab (ZOFRAN equiv)	-	G
GRANISOL ORAL SOLN	-	NC
ONDANSETRON TAB	-	NC
ONDANSETRON TAB ODT	-	NC
SUSTOL INJ	-	NC
ZUPLENZ SL FILM	-	NC
ANTIEMETICS - ANTICHOLINERGIC		
scopolamine patch (TRANSDERM-SCOP equiv)	-	G
trimethobenzamide cap (TIGAN equiv)	-	G
MECLIZINE CHEW TAB	-	NC
meclizine tab (ANTIVERT equiv)	-	NC
TIGAN INJ	-	NC
trimethobenzamide hcl inj (TIGAN equiv)	-	NC
ANTIEMETICS - MISCELLANEOUS		
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	B
dronabinol cap (MARINOL equiv)	PA	G
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC
DRONABINOL SOLN, SYNDROS SOLN	-	NC
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist)	QL-RS	B
aprepitant cap (EMEND equiv) (QL= 3 caps/fill)	QL	G
aprepitant pak (EMEND equiv) (QL= 3 caps/fill)	QL	G
EMEND CAP	-	NC
EMEND SUSP	-	NC
NEREUS CAP	-	NC
ANTIFUNGALS		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)		
BREXAFEMME TAB	-	NC
ANTIFUNGALS		
flucytosine cap (ANCOBON equiv)	-	G
griseofulvin micro tab (GRIFULVIN V equiv)	-	G
griseofulvin susp (GRIFULVIN equiv)	-	G
griseofulvin tab (GRIS-PEG equiv)	-	G
nystatin tab	-	G
terbinafine tab (LAMISIL equiv)	-	G
FULVICIN P/G TAB	-	NC
FULVICIN P/G TAB, GRISEOFULVIN ULTRA MICRO TAB	-	NC
IMIDAZOLE-RELATED ANTIFUNGALS		
NOXAFIL PAK	-	B
SPORANOX SOLN	PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIFUNGALS Cont.		
fluconazole susp (DIFLUCAN equiv)	-	G
fluconazole tab (DIFLUCAN equiv)	-	G
itraconazole cap (SPORANOX equiv)	-	G
itraconazole soln (SPORANOX equiv)	PA	G
ketoconazole tab (NIZORAL equiv)	-	G
posaconazole DR tab (NOXAFIL equiv) (QL= 93 tabs/30 days)	PA-QL	G
posaconazole susp (NOXAFIL equiv) (QL= 525ml/26 days)	PA-QL	G
voriconazole susp (VFEND equiv)	-	G
voriconazole tab (VFEND equiv)	-	G
CRESEMBA CAP	-	NC
NOXAFIL TAB	-	NC
SPORANOX CAP	-	NC
TOLSURA CAP	-	NC
VFEND SUSP	-	NC
VIVJOA CAP	-	NC
ANTIHISTAMINES		
ANTIHISTAMINES - ALKYLAMINES		
CORPHENA ORAL SOLN, RYCLORA ORAL SOLN	-	NC
MICLARA LIQUID	OTC	NC
ANTIHISTAMINES - ETHANOLAMINES		
CARBINOXAMINE SOLN	-	G
carbinoxamine tab (PALGIC equiv)	-	G
diphenhydramine inj (BENADRYL equiv)	-	G
carbinoxamine maleate tab 6mg	-	NC
CARBZAH SOLN 4MG/5ML	-	NC
CLEMASTINE SYRUP	-	NC
CLEMASTINE TAB	-	NC
CLEMASTINE TAB, CLEMASZ TAB	-	NC
DIPHENHYDRAMINE ELIXIR	-	NC
KARBINAL ER SUSP	-	NC
ANTIHISTAMINES - NON-SEDATING		
CLARINEX SYRUP	-	EXC
CLARINEX TAB	-	EXC
CLARITIN CAP	OTC	EXC
CLARITIN CHEW TAB	OTC	EXC
DESLORATADINE ODT	-	EXC
DESLORATADINE SOLN	-	EXC
desloratadine tab (CLARINEX equiv)	-	EXC
levocetirizine soln (XYZAL equiv)	-	EXC
levocetirizine tab (XYZAL equiv)	-	EXC
loratadine cap (CLARITIN equiv)	OTC	EXC
XYZAL SOLN	-	EXC
XYZAL TAB	-	EXC
ZYRTEC CHILD CHEW ALLERGY	OTC	NC
ANTIHISTAMINES - PHENOTHIAZINES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHISTAMINES Cont.		
promethazine supp (PHENERGAN equiv)	-	G
promethazine syrup	-	G
promethazine tab (PHENERGAN equiv)	-	G
PROMETHEGAN SUPP	-	G
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine syrup	-	G
cyproheptadine tab	-	G
ANTIHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	B
ANTIHYPERLIPIDEMICS - COMBINATIONS		
EZETIMIBE/ATORVASTATIN TAB	-	NC
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (ezetimibe/simvastatin 10-80 mg is not covered)	-	NC
NEXLIZET TAB	-	NC
OMEGA-3 RX PAK COMPLETE	-	NC
ROSZET TAB	-	NC
ROSZET TAB, EZETIMIBE/ROSUVASTATIN TAB	-	NC
ANTIHYPERLIPIDEMICS - MISC.		
icosapent ethyl cap (VASCEPA equiv) (QL= 4 caps/day)	QL	G
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	G
KYNAMRO INJ	-	NC
VASCEPA CAP	-	NC
BILE ACID SEQUESTRANTS		
cholestyramine lite powder (QUESTRAN LITE equiv)	-	G
cholestyramine lite powder pack (QUESTRAN LITE equiv)	-	G
cholestyramine powder (QUESTRAN equiv)	-	G
cholestyramine powder pack (QUESTRAN equiv)	-	G
colesevelam pack (WELCHOL equiv)	-	G
colesevelam tab (WELCHOL equiv)	-	G
colestipol granule (COLESTID equiv)	-	G
colestipol powder packet (COLESTID equiv)	-	G
colestipol tab (COLESTID equiv)	-	G
WELCHOL PACK	-	NC
WELCHOL TAB	-	NC
FIBRIC ACID DERIVATIVES		
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	G
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	G
fenofibric acid DR cap (TRILIPIX equiv)	-	G
gemfibrozil tab (LOPID equiv)	-	G
ANTARA CAP, FENOFIBRATE MICRONIZED CAP	-	NC
ANTARA CAP, LOFIBRA CAP	-	NC
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERLIPIDEMICS Cont.		
FENOFIBRATE CAP, LIPOFEN CAP	-	NC
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC
FENOFIBRIC TAB	-	NC
FENOFIBRIC TAB, FIBRICOR TAB	-	NC
TRIGLIDE TAB	-	NC
TRILIPIX CAP	-	NC
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab (LIPITOR equiv)	-	$0
lovastatin tab (MEVACOR equiv)	-	$0
pravastatin tab (PRAVACHOL equiv)	-	$0
rosuvastatin tab (CRESTOR equiv)	-	$0
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	$0
ATORVALIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	B
EZALLOR SPRINKLE CAP (Prior Authorization required for members age 9 years and older)	PA	B
FLOLIPID SUSP (Prior Authorization required for members age 9 years and older)	PA	B
ADVICOR TAB	-	NC
ALTOPREV TAB	-	NC
CRESTOR TAB	-	NC
fluvastatin cap (LESCOL equiv)	-	NC
fluvastatin ER tab (LESCOL XL equiv)	-	NC
LESCOL XL TAB	-	NC
LIPITOR TAB	-	NC
LIVALO TAB	-	NC
pitavastatin calcium tab (LIVALO equiv)	-	NC
SIMCOR TAB	-	NC
simvastatin tab 80mg (ZOCOR equiv)	-	NC
ZOCOR TAB 80MG	-	NC
ZYPITAMAG TAB	-	NC
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab (ZETIA equiv)	-	G
ZETIA TAB	-	NC
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP	-	NC
NICOTINIC ACID DERIVATIVES		
niacin ER tab (NIASPAN equiv)	-	G
NIACOR TAB	-	NC
NIASPAN ER TAB	-	NC
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ (QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin)	QL-ST	B
LEROCHOL SOLN	-	NC
LIPFENDRA TAB	-	NC
ANTIHYPERTENSIVES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

ANTIHYPERTENSIVES Cont.

DrugName	Special Code	Tier
ACE INHIBITORS		
QBRELIS SOLN (Prior Authorization required for members age 9 years and older)	PA	B
benazepril tab (LOTENSIN equiv)	-	G
captopril tab (CAPOTEN equiv)	-	G
enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 years and older)	PA	G
enalapril tab (VASOTEC equiv)	-	G
fosinopril tab (MONOPRIL equiv)	-	G
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	G
moexipril tab (UNIVASC equiv)	-	G
PERINDOPRIL TAB	-	G
perindopril tab (ACEON equiv)	-	G
quinapril tab (ACCUPRIL equiv)	-	G
ramipril cap (ALTACE equiv)	-	G
trandolapril tab (MAVIK equiv)	-	G
AGENTS FOR PHEOCHROMOCYTOMA		
phenoxybenzamine cap (DIBENZYLINE equiv)	-	G
DEMSER CAP	-	NC
metyrosine cap (DEMSER equiv)	-	NC
ALDOSTERONE SYNTHASE INHIBITORS		
BAXFENDY TAB	-	NC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
ARBLI SUSP (QL= 330mL/30 days; Prior Authorization required for members age 9 years and older)	PA-QL	B
irbesartan tab (AVAPRO equiv)	-	G
losartan tab (COZAAR equiv)	-	G
olmesartan tab (BENICAR equiv)	-	G
telmisartan tab (MICARDIS equiv)	-	G
valsartan tab (DIOVAN equiv)	-	G
ATACAND TAB	-	NC
azilsartan medoxomil tab (EDARBI equiv)	-	NC
candesartan tab (ATACAND equiv)	-	NC
DIOVAN TAB	-	NC
EDARBI TAB	-	NC
valsartan oral soln (VALSARTAN equiv)	-	NC
ANTIADRENERGIC ANTIHYPERTENSIVES		
CATAPRES-TTS PATCH	-	B
METHYLDOPA TAB	-	B
clonidine patch (CATAPRES-TTS equiv)	-	G
clonidine tab (CATAPRES equiv)	-	G
doxazosin tab (CARDURA equiv)	-	G
guanfacine IR tab (TENEX equiv)	-	G
methyldopa tab (ALDOMET equiv)	-	G
prazosin cap (MINIPRESS equiv)	-	G
terazosin cap (HYTRIN equiv)	-	G
clonidine hcl tab 0.05mg	-	NC
JAVADIN SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
NEXICLON XR TAB	-	NC
TEZRULY SOLN	-	NC
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine/benazepril cap (LOTREL equiv)	-	G
amlodipine/valsartan tab (EXFORGE equiv)	-	G
atenolol/chlorthalidone tab (TENORETIC equiv)	-	G
benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv)	-	G
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	G
enalapril/hydrochlorothiazide tab (VASERETIC equiv)	-	G
fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv)	-	G
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	G
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	G
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	G
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	G
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	G
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	G
amlodipine/olmesartan tab (AZOR equiv)	-	NC
amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv)	-	NC
AZOR TAB	-	NC
BENICAR HCT TAB	-	NC
BYVALSON TAB	-	NC
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	NC
DUTOPROL TAB	-	NC
EDARBYCLOR TAB	-	NC
MICARDIS HCT TAB	-	NC
olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv)	-	NC
PRESTALIA TAB	-	NC
QUINAPRIL/HCTZ TAB	-	NC
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	NC
TELMISARTAN/AMLODIPINE TAB	-	NC
telmisartan/amlodipine tab (TWYNSTA equiv)	-	NC
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC
TRANDOLAPRIL/VERAPAMIL ER TAB	-	NC
TRIBENZOR TAB	-	NC
WIDAPLIK TAB	-	NC
ANTIHYPERTENSIVES - MISC.		
VECAMYL TAB	-	NC
DIRECT RENIN INHIBITORS		
aliskiren tab (TEKTURNA equiv)	-	G
ENDOTHELIN RECEPTOR ANTAGONISTS		
TRYVIO TAB	-	NC
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	-	G
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
minoxidil tab (LONITEN equiv)	-	G
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
FIRST METRONIDAZOLE SUSP	-	B
LIKMEZ SUSP (Prior Authorization required for members age 9 years and older)	PA	B
XIFAXAN TAB 200MG (QL= 9 tabs/3 days)	PA-QL	B
XIFAXAN TAB 550MG (QL= 2 tabs/day)	PA-QL	B
metronidazole tab (FLAGYL equiv)	-	G
pentamidine neb soln (NEBUPENT equiv)	-	G
tinidazole tab (TINDAMAX equiv)	-	G
TRIMETHOPRIM TAB	-	G
trimethoprim tab (PROLOPRIM equiv)	-	G
AEMCOLO TAB	-	NC
IMPAVIDO CAP	-	NC
metronidazole cap (FLAGYL equiv)	-	NC
METRONIDAZOLE TAB	-	NC
NUZOLVENCE GRANULE PACK	-	NC
ANTI-INFECTIVE MISC. - COMBINATIONS		
HYOPHEN TAB	-	B
hyophen tab (PROSED DS equiv)	-	G
smz/tmp (DS) tab (BACTRIM DS equiv)	-	G
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	G
UTA cap	-	NC
ANTIPROTOZOAL AGENTS		
LAMPIT TAB (Restricted to Infectious Disease Specialist)	RS	B
atovaquone susp (MEPRON equiv)	-	G
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	G
GLYCOPEPTIDES		
FIRVANQ SOLN 25MG/ML	-	G
FIRVANQ SOLN 50MG/ML	-	G
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	G
vancomycin hcl soln (VANCOMYCIN equiv)	-	NC
VANCOMYCIN ORAL SOLN	-	NC
VANCOMYCIN SOLN	-	NC
LEPROSTATICS		
dapsone tab	-	G
LINCOSAMIDES		
clindamycin cap (CLEOCIN equiv)	-	G
clindamycin soln (CLEOCIN equiv)	-	G
clindamycin cap 300mg (CLEOCIN equiv)	-	NC
MONOBACTAMS		
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B
OXAZOLIDINONES		
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist)	QL-RS	B
linezolid susp (Restricted to Infectious Disease Specialist)	RS	G
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	G
PENEMS		
ORLYNVAH TAB	-	NC
PLEUROMUTILINS		
XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist)	QL-RS	B
POLYMYXINS		
colistimethate inj (COLY-MYCIN M equiv)	LMSP	B
URINARY ANTI-INFECTIVES		
MONUROL GRANULE PACK	-	B
fosfomycin tromethamine powder pack (MONUROL equiv)	-	G
methenamine hippurate tab (HIPREX equiv)	-	G
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	G
nitrofurantoin monohydrate cap (MACROBID equiv)	-	G
nitrofurantoin susp (FURADANTIN equiv) (Covered for members age 9 years and younger)	-	G
BLUJEPA TAB	-	NC
METHENAM MAN TAB	-	NC
METHENAMINE ORAL SOLN	-	NC
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC
NITROFURANTOIN SUSP	-	NC
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
atovaquone/proguanil tab (MALARONE equiv)	-	G
MALARONE TAB	-	NC
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC
ANTIMALARIALS		
KRINTAFEL TAB	-	B
CHLOROQUINE TAB	-	G
chloroquine tab (ARALEN equiv)	-	G
HYDROXYCHLOROQUINE TAB	-	G
hydroxychloroquine tab (PLAQUENIL equiv)	-	G
mefloquine tab (LARIAM equiv)	-	G
primaquine tab (PRIMAQUINE equiv)	-	G
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	G
ARAKODA TAB	-	NC
QUALAQUIN CAP	-	NC
quinine sulfate cap (QUALAQUIN equiv)	-	NC
SOVUNA TAB 200MG	-	NC
SOVUNA TAB 300MG	-	NC
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
FIRDAPSE TAB (Only available through AnovoRx 844-288-5007)	LD-PA	B
pyridostigmine CR tab (MESTINON equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIMYASTHENIC/CHOLINERGIC AGENTS Cont.		
pyridostigmine tab (MESTINON equiv)	-	G
pyridstigmine soln (MESTINON equiv)	-	G
PYRIDOSTIGMINE TAB 30MG	-	NC
ANTIMYCOBACTERIAL AGENTS		
ANTIMYCOBACTERIAL AGENTS		
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	B
ethambutol tab (MYAMBUTOL equiv)	-	G
isoniazid syrup (ISONIAZID equiv)	-	G
isoniazid tab	-	G
pyrazinamide tab	-	G
rifabutin cap (MYCOBUTIN equiv)	-	G
rifampin cap (RIFADIN equiv)	-	G
rifapentine tab (PRIFTIN equiv)	-	G
CYCLOSERINE CAP	-	NC
PRIFTIN TAB	-	NC
SIRTURO TAB	-	NC
TRECATOR TAB	-	NC
ANTINEOPLASTICS		
ANTIMETABOLITES		
TABLOID TAB	-	B
mercaptopurine tab (PURINETHOL equiv)	-	G
methotrexate tab (TREXALL equiv)	-	G
TREXALL TAB	-	NC
ANTINEOPLASTIC ENZYME INHIBITORS		
ZOLINZA CAP	LMSP-PA-SF	B
ANTINEOPLASTICS MISC.		
ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA	B
MATULANE CAP (Only available through Walgreens 888-347-3416)	LD	B
hydroxyurea cap (HYDREA equiv)	-	G
tretinoin cap (VESANOID equiv)	LMSP	G
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
leucovorin tab	-	G
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	LMSP-PA	B
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
CYCLOPHOSPHAMIDE TAB	-	B
GLEOSTINE CAP	-	B
MYLERAN TAB	LMSP	B
cyclophosphamide cap	-	G
lomustine cap (GLEOSTINE equiv)	-	G
temozolomide cap (TEMODAR equiv)	LMSP	G
bendamustine hcl for iv soln (TREANDA equiv)	-	NC
LEUKERAN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
TREANDA INJ	-	NC
ANTIMETABOLITES		
azacitidine inj (VIDAZA equiv)	MSP	B
JYLAMVO SOLN, XATMEP SOLN (Prior Authorization required for members age 9 years and older)	PA	B
capecitabine tab (XELODA equiv)	LMSP	G
mercaptopurine susp (PURIXAN equiv) (Prior Authorization required for members age 9 years and older)	PA	G
methotrexate inj	-	G
ONUREG TAB	-	NC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
AVASTIN INJ	MSP-PA	B
FRUZAQLA CAP 1MG (QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
FRUZAQLA CAP 5MG (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
INLYTA TAB (QL=4 tabs/day)	MSP-PA-QL-SF	B
INLYTA TAB 1MG (QL= 8 tabs/day)	MSP-PA-QL-SF	B
LENVIMA CAP (QL= 3 caps/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	B
ANTINEOPLASTIC - ANTIBODIES		
RITUXAN INJ	MSP-PA	B
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
HERCEPTIN INJ	MSP-PA	B
HERNEXEOS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523 or Onco360 877-662-6633)	LD-PA-QL-SF	B
TUKYSA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK (Only available through Optum 877-445-6874)	LD-PA	B
VENCLEXTA TAB (Only available through Optum 877-445-6874)	LD-PA	B
BEQALZI TAB	-	NC
BEQALZI TAB STARTER PACK	-	NC
ANTINEOPLASTIC - EGFR INHIBITORS		
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
erlotinib tab (TARCEVA equiv) (QL= 1 tab/day)	LMSP-PA-QL	G
erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tabs/day)	LMSP-PA-QL	G
gefitinib tab (IRESSA equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G
LAZCLUZE TAB	-	NC
TARCEVA TAB	-	NC
ZEGFROVY TAB	-	NC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP (QL= 1 cap/day)	LMSP-PA-QL-SF	B
ODOMZO CAP (QL= 1 cap/day)	LMSP-PA-QL-SF	B
DAURISMO TAB	-	NC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0
exemestane tab (AROMASIN equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
tamoxifen tab (NOLVADEX equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0
ERLEADA TAB (QL= 4 tabs/day)	LMSP-PA-QL	B
ERLEADA TAB 240MG (QL= 1 tab/day)	LMSP-PA-QL	B
EULEXIN CAP	-	B
FIRMAGON INJ	MSP	B
FLUTAMIDE CAP	-	B
INLURIYO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Orsini 800-410-8575)	LD-PA-QL-SF	B
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	B
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B
ORGOVYX TAB (QL= 30 tabs/28 days; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
ORSERDU TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
ORSERDU TAB 345MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
ZOLADEX INJ	MSP	B
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day)	LMSP-QL	G
bicalutamide tab (CASODEX equiv)	-	G
flutamide cap (EULEXIN equiv)	-	G
letrozole tab (FEMARA equiv)	-	G
megestrol susp (MEGACE equiv)	-	G
megestrol tab (MEGACE equiv)	-	G
NILUTAMIDE TAB	LMSP	G
nilutamide tab (NILANDRON equiv)	LMSP	G
toremifene tab (FARESTON equiv)	-	G
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC
AKEEGA TAB	-	NC
ETCAMAH TAB	-	NC
HYDROXYPROGESTERONE CAPROATE INJ	-	NC
LIFYORLI CAP DOSE PACK	-	NC
MIMRYLO INJ	-	NC
VEPPANU TAB	-	NC
XTANDI CAP	-	NC
XTANDI TAB 40MG	-	NC
XTANDI TAB 80MG	-	NC
YONSA TAB	-	NC
ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS		
WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
ANTINEOPLASTIC - IMMUNOMODULATORS		
pomalidomide cap (POMALYST equiv) (QL= 21 caps/28 days)	MSP-PA-QL	G
POMALYST CAP	-	NC
ZENBEXUS CAP	-	NC
ANTINEOPLASTIC - MENIN INHIBITORS		
REVUFORJ TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
REVUFORJ TAB 110MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
REVUFORJ TAB 25MG (QL= 8 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
KOMZIFTI CAP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
ANTINEOPLASTIC - PROTEASE ACTIVATORS		
MODEYSO CAP (QL= 20 caps/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK (QL= 32 tabs/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
ANTINEOPLASTIC COMBINATIONS		
AVMAPKI FAKZYNJA CO-PACK (QL= 1 pack/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B
INQOVI TAB (QL= 5 tabs/28 days)	MSP-PA-QL	B
KISQALI PAK (QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
LONSURF TAB	MSP-PA	B
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP (QL= 8 caps/day)	LMSP-PA-QL	B
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
AUGTYRO CAP (QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
AUGTYRO CAP 160MG (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL-SF	B
BORTEZOMIB INJ	MSP-PA	B
bortezomib inj (VELCADE equiv)	MSP-PA	B
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
BRUKINSA CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B
BRUKINSA TAB (QL= 2 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL-SF	B
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B
CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
CAPRELSA TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
CAPRELSA TAB 300MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
COTELLIC TAB (QL= 3 tabs/day)	LMSP-PA-QL	B
ENSACOVE CAP (QL= 1 cap/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
ENSACOVE CAP 100MG (QL= 2 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
FOTIVDA CAP (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
GAVRETO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
GOMEKLI CAP (QL= 84 caps/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B
GOMEKLI CAP 1MG (QL= 168 caps/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B
GOMEKLI TAB FOR ORAL SUSP (QL= 168 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B
HYRNUO TAB (QL= 4 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
IBTROZI CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ICLUSIG TAB (QL= 1 tab/day; Only available through AcariaHealth 800-511-5144)	LD-PA-QL-SF	B
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	B
IMBRUVICA CAP 140MG (QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA TAB 420MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL-SF	B
JAKAFI XR TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B
JAYPIRCA TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
KISQALI TAB (QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
KOSELUGO SPRINKLE CAP (QL= 12 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
KOSELUGO SPRINKLE CAP 5MG (QL= 20 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LORBRENA TAB 25MG (QL= 1 tab/day)	MSP-PA-QL-SF	B
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	B
LUMAKRAS TAB (QL= 8 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LUMAKRAS TAB 240MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LUMAKRAS TAB 320MG (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LYNPARZA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
MEKINIST SOLN	LMSP-PA	B
MEKINIST TAB 0.5MG (QL= 3 tabs/day)	LMSP-PA-QL	B
MEKINIST TAB 2MG (QL= 1 tab/day)	LMSP-PA-QL	B
MEKTOVI TAB (QL= 6 tabs/day)	MSP-PA-QL	B
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566)	LD-PA	B
OGSIVEO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
OGSIVEO TAB 50MG (QL= 6 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
OJEMDA SUSP (QL= 96ml/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL-SF	B
OJEMDA TAB (QL= 24 tabs/28 days; Only available through Onco360 877-662-6633)	LD-PA-QL	B
OJJAARA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PIQRAY TAB (Only available through Biologics 800-850-4306)	LD-PA-SF	B
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
RETEVMO CAP (QL= 2 caps/day)	LMSP-PA-QL-SF	B
RETEVMO CAP 40MG (QL= 3 caps/day)	LMSP-PA-QL-SF	B
RETEVMO TAB (QL= 2 tabs/day)	LMSP-PA-QL-SF	B
RETEVMO TAB 40MG (QL= 3 tabs/day)	LMSP-PA-QL-SF	B
REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL-SF	B
ROMVIMZA CAP (QL= 8 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
ROZLYTREK CAP (QL= 3 caps/day)	LMSP-PA-QL	B
ROZLYTREK PAK (QL= 6 packs/day)	LMSP-PA-QL	B
RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874)	LD-PA-QL-SF	B
RYDAPT CAP (QL= 56 caps/28 days)	LMSP-PA-QL	B
SCEMBLIX TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
SCEMBLIX TAB 100 MG (QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
STIVARGA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B
TABRECTA TAB (QL= 4 tabs/day)	LMSP-PA-QL-SF	B
TAFINLAR CAP	LMSP-PA	B
TAFINLAR TAB	LMSP-PA	B
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	B
TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	B
temsirolimus inj (TORISEL equiv)	MSP-PA	B
TEPMETKO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
TIBSOVO TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
TORISEL INJ	MSP-PA	B
TRUQAP TAB (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
TRUQAP THERAPY PACK (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
VANFLYTA TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
VERZENIO TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
VORANIGO TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
VORANIGO TAB 10MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306)	LD-PA-QL	B
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	B
XALKORI SPRINKLE CAP (QL= 4 caps/day)	MSP-PA-QL-SF	B
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
ZELBORAF TAB (QL= 8 tabs/day)	LMSP-PA-QL	B
ZYKADIA TAB (QL= 3 tabs/day)	LMSP-PA-QL-SF	B
bosutinib tab (BOSULIF equiv)	MSP-PA	G
dasatinib tab (SPRYCEL equiv)	LMSP-PA	G
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL	G
everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day)	LMSP-PA-QL	G
imatinib tab (GLEEVEC equiv)	LMSP	G
lapatinib ditosylate tab (TYKERB equiv)	LMSP-PA	G
nilotinib hcl cap (TASIGNA equiv)	LMSP-PA	G
pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day)	LMSP-PA-QL	G
sorafenib tosylate tab (NEXAVAR equiv)	LMSP-PA	G
sunitinib malate cap (SUTENT equiv) (QL= 1 cap/day)	LMSP-PA-QL	G
AFINITOR DISPERZ TAB	-	NC
AFINITOR TAB	-	NC
ALUNBRIG PAK	-	NC
BOSULIF CAP	-	NC
BOSULIF TAB	-	NC
CAVHANZA TAB	-	NC
DANZITEN TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
IBRANCE CAP	-	NC
IBRANCE TAB	-	NC
IMBRUVICA TAB 140MG	-	NC
IMBRUVICA TAB 280MG	-	NC
IMKELDI SOLUTION	-	NC
INREBIC CAP	-	NC
ITOVEBI TAB	-	NC
JIDEYTRO TAB	-	NC
NILOTINB TAR CAP	-	NC
NILOTINIB D-TAR CAP	-	NC
PAZOPANIB TAB 400MG	-	NC
PHYRAGO TAB	-	NC
RASONQUE TAB	-	NC
SPRYCEL TAB	-	NC
SUTENT CAP	-	NC
TALZENNA CAP 0.1MG	-	NC
TALZENNA CAP 0.35MG	-	NC
TASIGNA CAP	-	NC
TYKERB TAB	-	NC
VOTRIENT TAB	-	NC
ZYDELIG TAB	-	NC
ANTINEOPLASTICS MISC.		
BESREMI INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
BESREMI PEN INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633)	LD-PA-QL	B
bexarotene cap (TARGRETIN equiv) (QL= 10 caps/day)	LMSP-QL	G
SYLATRON INJ	-	NC
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
IWILFIN TAB (QL= 8 tabs/day; Only available through CurantHealth 866-437-8040)	LD-PA-QL-SF	B
mesna tab (MESNEX equiv)	LMSP	G
LEUCOVORIN CA TAB	-	NC
MESNEX TAB	-	NC
MITOTIC INHIBITORS		
etoposide cap (VEPESID equiv)	LMSP	B
VEPESID CAP	LMSP	B
ANTIPARKINSON AGENTS		
ANTIPARKINSON ADJUVANTS		
carbidopa tab (LODOSYN equiv)	-	G
ANTIPARKINSON ANTICHOLINERGICS		
benztropine tab	-	G
trihexyphenidyl tab (ARTANE equiv)	-	G
ANTIPARKINSON COMT INHIBITORS		
entacapone tab (COMTAN equiv)	-	G
tolcapone tab (TASMAR equiv)	-	G
ANTIPARKINSON DOPAMINERGICS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPARKINSON AGENTS Cont.		
CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	B
NEUPRO PATCH	PA	B
amantadine cap (SYMMETREL equiv)	-	G
amantadine tab	-	G
bromocriptine cap (PARLODEL equiv)	-	G
bromocriptine tab (PARLODEL equiv)	-	G
carbidopa/levodopa ER tab (SINEMET CR equiv)	-	G
carbidopa/levodopa ODT (PARCOPA equiv)	-	G
carbidopa/levodopa tab (SINEMET equiv)	-	G
pramipexole ER tab (MIRAPEX ER equiv)	-	G
pramipexole tab (MIRAPEX equiv)	-	G
ropinirole ER tab (REQUIP XL equiv)	-	G
ropinirole tab (REQUIP equiv)	-	G
CREXONT CAP	-	NC
DUOPA ENTERAL SUSP	-	NC
GOCOVRI CAP	-	NC
MIRAPEX ER TAB	-	NC
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
XADAGO TAB (QL= 1 tab/day)	PA-QL	B
rasagiline tab (AZILECT equiv)	-	G
selegiline cap (ELDEPRYL equiv)	-	G
selegiline tab (ELDEPRYL equiv)	-	G
ZELAPAR ODT	-	NC
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ANTICHOLINERGICS		
trihexyphenidyl elixir (ARTANE equiv)	-	G
ANTIPARKINSON COMT INHIBITORS		
ONGENTYS CAP (QL= 1 tab/day, 30 tabs per fill)	PA-QL	B
ANTIPARKINSON DOPAMINERGICS		
INBRIJA INH POWDER (QL= 10 caps/day; Only available through Sterling 888-618-4126 or Walgreens 888-347-3416)	LD-PA-QL	B
amantadine soln (AMANTADINE equiv)	-	G
carbidopa-levodopa-entacapone tab (STALEVO equiv)	-	G
APOKYN INJ	-	NC
apomorphine inj (APOKYN equiv)	-	NC
CARBIDOPA/LEVODOPA CAP, RYTARY CAP	-	NC
DHIVY TAB	-	NC
JUVMO TAB	-	NC
JUVMO TAB TITRATION PACK	-	NC
KYNMOBI FILM	-	NC
KYNMOBI TITRATION KIT	-	NC
ONAPGO INJ	-	NC
OSMOLEX ER TAB	-	NC
REQUIP XL TAB	-	NC
VYALEV INJ	-	NC
ANTIPSYCHOTICS/ANTIMANIC AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.

DrugName	Special Code	Tier
ANTIMANIC AGENTS		
lithium carbonate cap (ESKALITH ER equiv)	-	G
lithium carbonate ER tab (LITHOBID equiv)	-	G
lithium carbonate tab	-	G
lithium oral solution (LITHIUM equiv) (Prior Authorization required for members age 9 years and older)	PA	G
ANTIPSYCHOTICS - MISC.		
EQUETRO CAP	-	B
lurasidone hcl tab (LATUDA equiv)	-	G
ziprasidone cap (GEODON equiv)	-	G
CAPLYTA CAP	-	NC
LATUDA TAB	-	NC
NUPLAZID CAP	-	NC
NUPLAZID TAB	-	NC
VRAYLAR CAP	-	NC
VRAYLAR PACK	-	NC
BENZISOXAZOLES		
RISPERIDONE ODT	-	B
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of aripiprazole or quetiapine ER)	ST	G
risperidone ODT (RISPERDAL M equiv)	-	G
risperidone soln (RISPERDAL equiv)	-	G
risperidone tab (RISPERDAL equiv)	-	G
BYSANTI TAB	-	NC
BYSANTI TITRATION PACK	-	NC
FANAPT TAB	-	NC
FANAPT TITRATION PACK	-	NC
FANAPT TITRATION PACK 1MG/2MG/6MG/8MG	-	NC
INVEGA TAB	-	NC
BUTYROPHENONES		
haloperidol lactate conc (HALDOL equiv)	-	G
haloperidol tab (HALDOL equiv)	-	G
DIBENZAPINES		
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day; Step Therapy requires trial of aripiprazole or quetiapine ER)	QL-ST	G
clozapine tab (CLOZARIL equiv)	-	G
loxapine cap (LOXITANE equiv)	-	G
olanzapine ODT (ZYPREXA equiv)	-	G
olanzapine tab (ZYPREXA equiv)	-	G
quetiapine tab (SEROQUEL equiv)	-	G
quetiapine XR tab (SEROQUEL XR equiv)	-	G
ADASUVE INHALER	-	NC
clozapine odt tab (CLOZAPINE, FAZACLO equiv)	-	NC
CLOZAPINE ODT, FAZACLO ODT	-	NC
QUETIAPINE TAB	-	NC
SECUADO PATCH	-	NC
SEROQUEL XR TAB	-	NC
VERSACLOZ SUSP	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
DIHYDROINDOLONES		
MOLINDONE TAB	-	NC
MUSCARINIC AGENTS		
COBENFY CAP	-	NC
COBENFY CAP STARTER PACK	-	NC
PHENOTHIAZINES		
chlorpromazine tab (THORAZINE equiv)	-	G
fluphenazine tab (PROLIXIN equiv)	-	G
perphenazine tab (TRILAFON equiv)	-	G
prochlorperazine supp (COMPAZINE equiv)	-	G
prochlorperazine tab (COMPAZINE equiv)	-	G
thioridazine hcl tab (THIORIDAZINE equiv)	-	G
trifluoperazine tab (STELAZINE equiv)	-	G
CHLORPROMAZINE CONC	-	NC
chlorpromazine hcl conc	-	NC
QUINOLINONE DERIVATIVES		
aripiprazole soln (ABILIFY equiv)	-	G
aripiprazole tab (ABILIFY equiv)	-	G
ABILIFY MYCITE PACK	-	NC
ABILIFY MYCITE TAB	-	NC
aripiprazole ODT (ABILIFY equiv)	-	NC
OPIPZA FILM	-	NC
REXULTI TAB	-	NC
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	G
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
HYLAMEND GEL FIRST AID	-	NC
IODINE ANTISEPTICS		
IODOFLEX PAD	-	NC
ANTIVIRALS		
ANTIRETROVIRALS		
APRETUDE SUSP (QL= 7 inj/year)	PA-QL	$0
DESCOVY TAB	PA	$0
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	$0
YEZTUGO INJ (QL= 2 inj/180 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	$0
YEZTUGO TAB (QL= 4 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	$0
APTIVUS CAP	-	B
BIKTARVY TAB	-	B
BIXLENVO TAB	-	B
CABENUVA IM SUSP (QL= 1 kit/30 days)	LMSP-QL	B
CABENUVA SUSP 600MG-900MG/3ML (QL= 1 kit/30 days)	LMSP-QL	B
CIMDUO TAB	-	B
COMPLERA TAB	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
DELSTRIGO TAB	-	B
DOVATO TAB	-	B
EDURANT PED TAB	-	B
EDURANT TAB	-	B
EMTRIVA CAP	-	B
EMTRIVA SOLN	-	B
EVOTAZ TAB	-	B
GENVOYA TAB	-	B
INTELENCE TAB	-	B
ISENTRESS (HD) TAB	-	B
ISENTRESS CHEW TAB	-	B
ISENTRESS POWDER PACK	-	B
JULUCA TAB	-	B
KALETRA SOLN	-	B
KALETRA TAB	-	B
NORVIR POWDER PACK	-	B
ODEFSEY TAB	-	B
PIFELTRO TAB	-	B
PREZCOBIX TAB	-	B
PREZISTA SUSP	-	B
PREZISTA TAB	-	B
REYATAZ POWDER PACK	-	B
RUKOBIA ER TAB (Restricted to Infectious Disease Specialist)	RS	B
SELZENTRY SOLN	-	B
SELZENTRY TAB	-	B
STRIBILD TAB	-	B
SUSTIVA TAB	-	B
SYMFI (LO) TAB	-	B
SYMTUZA TAB	-	B
TIVICAY PD TAB	-	B
TIVICAY TAB	-	B
TRIUMEQ PD TAB	-	B
TRIUMEQ TAB	-	B
TYBOST TAB	-	B
VIRACEPT TAB	-	B
VIREAD TAB	-	B
abacavir soln (ZIAGEN equiv)	-	G
abacavir tab (ZIAGEN equiv)	-	G
abacavir/lamivudine tab (EPZICOM equiv)	-	G
atazanavir cap (REYATAZ equiv)	-	G
darunavir tab (PREZISTA equiv)	-	G
efavirenz tab (SUSTIVA equiv)	-	G
efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv)	-	G
efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv)	-	G
EFAVIRENZ/LAMIVUDINE/TENOFOVIR TAB	-	G
emtricitabine cap (EMTRIVA equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
emtricitabine-rilpivirine-tenofovir df tab (COMPLERA equiv)	-	G
etravirine tab (INTELENCE equiv)	-	G
fosamprenavir tab (LEXIVA equiv)	-	G
lamivudine soln (EPIVIR equiv)	-	G
lamivudine tab (EPIVIR equiv)	-	G
lamivudine/zidovudine tab (COMBIVIR equiv)	-	G
lopinavir/ritonavir soln (KALETRA equiv)	-	G
lopinavir/ritonavir tab (KALETRA equiv)	-	G
maraviroc tab (SELZENTRY equiv)	-	G
NEVIRAPINE ER TAB (Step Therapy requires trial of nevirapine)	ST	G
nevirapine ER tab (VIRAMUNE XR equiv) (Step Therapy requires trial of nevirapine)	ST	G
NEVIRAPINE SUSP	-	G
nevirapine tab (VIRAMUNE equiv)	-	G
rilpivirine hcl tab (EDURANT equiv)	-	G
ritonavir tab (NORVIR equiv)	-	G
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	G
zidovudine cap (RETROVIR equiv)	-	G
zidovudine syrup (RETROVIR equiv)	-	G
zidovudine tab (RETROVIR equiv)	-	G
ATRIPLA TAB	-	NC
BIXLENVO/SUNLENCA STARTER PACK	-	NC
FUZEON INJ	-	NC
IDVYNSO TAB	-	NC
SUNLENCA INJ	-	NC
SUNLENCA TAB	-	NC
SUNLENCA TAB 300MG	-	NC
VIRAMUNE XR TAB	-	NC
ANTIVIRAL COMBINATIONS		
PAXLOVID PAK (QL= 11 tabs/90 days)	QL	B
PAXLOVID TAB 150-100MG (QL= 20 tabs/90 days)	QL	B
PAXLOVID TAB 300-100MG (QL= 30 tabs/90 days)	QL	B
CMV AGENTS		
GANCICLOVIR INJ	MSP	B
ganciclovir inj (CYTOVENE equiv)	MSP	B
LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PREVYMIS PAK (QL= 4 packets/day; Limit 800 packets/365 days)	LMSP-PA-QL	B
PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days)	LMSP-PA-QL	B
valganciclovir soln (VALCYTE equiv)	-	G
valganciclovir tab (VALCYTE equiv)	-	G
HEPATITIS AGENTS		
BARACLUDE SOLN (Prior Authorization required for members age 9 years and older)	PA	B
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
MAVYRET PAK (QL= 5 packs/day)	LMSP-PA-QL	B
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	B
PEGASYS INJ	LMSP	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
RIBAVIRIN CAP	LMSP	B
RIBAVIRIN TAB	LMSP	B
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
VEMLIDY TAB	PA	B
VOSEVI TAB (QL= 1 tab/day)	LMSP-PA-QL	B
adefovir dipivoxil tab (HEPSERA equiv)	-	G
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	G
lamivudine tab 100mg (EPIVIR HBV equiv)	-	G
ribavirin cap (REBETOL equiv)	LMSP	G
EPCLUSA PAK	-	NC
EPCLUSA TAB	-	NC
HARVONI PELLET PAK	-	NC
HARVONI TAB	-	NC
HEPCLUDEX INJ	-	NC
SOVALDI PELLET PAK	-	NC
SOVALDI TAB	-	NC
ZEPATIER TAB	-	NC
HERPES AGENTS		
acyclovir cap (ZOVIRAX equiv)	-	G
acyclovir susp (ZOVIRAX equiv)	-	G
acyclovir tab (ZOVIRAX equiv)	-	G
famciclovir tab (FAMVIR equiv)	-	G
valacyclovir tab (VALTREX equiv)	-	G
SITAVIG TAB	-	NC
INFLUENZA AGENTS		
RELENZA DISKHALER (QL= 1 inhaler/calendar year)	QL	B
oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill, 1 fill/calendar year)	QL	G
oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill, 1 fill/calendar year)	QL	G
oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill, 1 fill per calendar year)	QL	G
RIMANTADINE TAB	-	NC
XOFLUZA TAB	-	NC
MISC. ANTIVIRALS		
LAGEVRIO CAP (EUA) (QL= 40 caps/fill)	QL	$0
LAGEVRIO CAP 200MG (QL= 40 caps/fill)	QL	B
VEKLURY INJ	-	B
XOCOVA TAB	-	NC
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS		
RIBAVIRIN INH	-	NC
ribavirin inh soln (VIRAZOLE equiv)	-	NC
ASSORTED CLASSES		
ENZYMES		
XIAFLEX INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B
IMMUNOMODULATORS		
THALOMID CAP	MSP	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ASSORTED CLASSES Cont.		
IMMUNOSUPPRESSIVE AGENTS		
SANDIMMUNE SOLN 100MG/ML	-	B
azathioprine tab (IMURAN equiv)	-	G
cyclosporine cap (SANDIMMUNE equiv)	-	G
cyclosporine modified cap (NEORAL equiv)	-	G
cyclosporine modified soln (NEORAL equiv)	-	G
mycophenolate DR tab (MYFORTIC equiv)	-	G
mycophenolate mofetil cap (CELLCEPT equiv)	-	G
mycophenolate mofetil susp (CELLCEPT SUSP equiv)	-	G
mycophenolate mofetil tab (CELLCEPT equiv)	-	G
sirolimus tab (RAPAMUNE equiv)	-	G
tacrolimus cap (PROGRAF equiv)	-	G
ENVARSUS XR TAB	-	NC
POTASSIUM REMOVING RESINS		
VELTASSA POWDER (QL= 1 packet/day)	PA-QL	B
sodium polystyrene powder (KAYEXALATE equiv)	-	G
sodium polystyrene susp (SPS equiv)	-	G
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
carvedilol tab (COREG equiv)	-	G
labetalol tab (NORMODYNE equiv)	-	G
carvedilol phosphate ER cap (COREG CR equiv)	-	NC
labetalol hcl tab 400mg	-	NC
BETA BLOCKERS CARDIO-SELECTIVE		
LOPRESSOR SOLN (QL= 45ml/day; Prior Authorization required for members age 9 years and older)	PA-QL	B
acebutolol cap (SECTRAL equiv)	-	G
atenolol tab (TENORMIN equiv)	-	G
betaxolol tab (KERLONE equiv)	-	G
bisoprolol tab (ZEBETA equiv)	-	G
metoprolol ER tab (TOPROL XL equiv)	-	G
metoprolol tab (LOPRESSOR equiv)	-	G
nebivolol hcl tab (BYSTOLIC equiv)	-	G
BISOPROLOL FUMARATE TAB	-	NC
BYSTOLIC TAB	-	NC
KAPSPARGO CAP	-	NC
METOPROLOL TARTRATE TAB	-	NC
BETA BLOCKERS NON-SELECTIVE		
HEMANGEOL ORAL SOLN (QL= 9.6mL/day; 1750mL/365 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B
HEMANGEOL SOLN (QL= 9.6mL/day; 1750mL/365 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B
SOTYLIZE SOLN 5MG/ML (Prior Authorization required for members age 9 years and older)	PA	B
nadolol tab (CORGARD equiv)	-	G
pindolol tab (VISKEN equiv)	-	G
propranolol ER cap (INDERAL LA equiv)	-	G
propranolol hcl oral soln 20mg/5ml	-	G
PROPRANOLOL SOLN	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
BETA BLOCKERS Cont.		
propranolol tab (INDERAL equiv)	-	G
sotalol AF tab (BETAPACE AF equiv)	-	G
sotalol tab (BETAPACE equiv)	-	G
TIMOLOL MALEATE TAB	-	G
timolol maleate tab (BLOCADREN equiv)	-	G
INDERAL XL CAP, INNOPRAN XL CAP	-	NC
SOTYLIZE SOLN	-	NC
BIOLOGICALS MISC		
ALLERGENIC EXTRACTS		
GRASTEK SL TAB	-	NC
ORALAIR SL TAB	-	NC
RAGWITEK SL TAB	-	NC
BIOLOGICALS MISC		
ADAGEN INJ	MSP-PA	B
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKER COMBINATIONS		
CONSENSI TAB	-	NC
CALCIUM CHANNEL BLOCKERS		
KATERZIA SUSP (Prior Authorization required for members age 9 years and older)	PA	B
NORLIQVA ORAL SOLN (Prior Authorization required for members age 9 years and older)	PA	B
SULAR ER TAB 17MG	-	B
SULAR ER TAB 34MG	-	B
SULAR ER TAB 8.5MG	-	B
amlodipine tab (NORVASC equiv)	-	G
diltiazem ER cap (CARDIZEM CD equiv)	-	G
diltiazem ER cap (CARDIZEM SR equiv)	-	G
diltiazem ER cap (DILACOR XR equiv)	-	G
diltiazem ER cap (TIAZAC equiv)	-	G
DILTIAZEM HCL COATED BEADS CAP ER 24HR 120MG	-	G
DILTIAZEM HCL EXTENDED RELEASE BEADS CAP ER 24HR 120MG	-	G
diltiazem tab (CARDIZEM equiv)	-	G
felodipine ER tab (PLENDIL equiv)	-	G
isradipine cap (DYNACIRC equiv)	-	G
nifedipine cap (PROCARDIA equiv)	-	G
nifedipine ER tab (ADALAT CC equiv)	-	G
nimodipine cap (NIMOTOP equiv)	-	G
nisoldipine ER tab (SULAR equiv)	-	G
NISOLDIPINE ER TAB 20MG, 30MG, 40MG	-	G
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	G
verapamil tab (CALAN equiv)	-	G
CARDAMYST NASAL SPRAY	-	NC
CONJUPRI TAB, LEVAMLODIPINE TAB	-	NC
diltiazem ER cap 120mg (CARDIZEM SR equiv)	-	NC
diltiazem ER tab (CARDIZEM LA equiv)	-	NC
nicardipine cap (CARDENE equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
NYMALIZE SOLN	-	NC
SDAMLO SOLN	-	NC
VERAPAMIL CR CAP, VERELAN CAP	-	NC
VERAPAMIL ER CAP	-	NC
verapamil SR cap (VERELAN equiv)	-	NC
VERELAN CAP	-	NC
CARDIOTONICS		
CARDIAC GLYCOSIDES		
digoxin soln (LANOXIN equiv)	-	G
DIGOXIN SOLN 0.05MG/ML	-	G
digoxin tab (LANOXIN equiv)	-	G
digoxin tab 62.5mcg (LANOXIN equiv)	-	NC
LANOXIN INJ	-	NC
LANOXIN TAB 62.5MCG	-	NC
CARDIOVASCULAR AGENTS - MISC.		
CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
MYQORZO TAB	-	NC
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
sacubitril-valsartan tab (ENTRESTO equiv) (QL= 2 tabs/day)	QL	G
amlodipine/atorvastatin tab (CADUET equiv)	-	NC
BIDIL TAB	-	NC
ENTRESTO CAP	-	NC
ENTRESTO TAB	-	NC
isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv)	-	NC
OPSYNVI TAB	-	NC
CARDIOVASCULAR ANTI-INFLAMMATORY/IMMUNE MODULATORS		
LODOCO TAB	-	NC
CARDIOVASCULAR SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS		
INPEFA TAB	-	NC
IMPOTENCE AGENTS		
CAVERJECT INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B
EDEX INJ (QL= 6 inj/30 days; Step therapy requires trial of sildenafil)	QL-ST	B
sildenafil tab (VIAGRA equiv) (QL=6 tabs/30 days)	QL	G
tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day)	QL	G
avanafil tab (STENDRA equiv)	-	NC
LEVITRA TAB	-	NC
STENDRA TAB	-	NC
tadalafil tab (CIALIS equiv)	-	NC
vardenafil ODT (STAXYN equiv)	-	NC
vardenafil tab (LEVITRA equiv)	-	NC
VYBRIQUE ORAL FILM	-	NC
PROSTAGLANDIN VASODILATORS		
REMODULIN SOLN 8MG/20ML (Only available through Accredo 800-803-2523)	LD-PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
treprostinil inj 10mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
treprostinil inj 1mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
treprostinil inj 2.5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
treprostinil inj 5mg/ml (REMODULIN equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER 48-80MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
YUTREPIA CAP (QL= 112 caps/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
ORENITRAM TAB	-	NC
ORENITRAM TAB MONTH PAK	-	NC
PULMONARY HYPERTENSION - ACTIVIN SIGNALING INHIBITOR		
WINREVAIR INJ (Only available through Accredo 800-803-2523)	LD-PA	B
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	G
bosentan tab for oral susp (TRACLEER equiv) (QL= 4 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	G
macitentan tab (OPSUMIT equiv) (QL= 1 tab/day)	LMSP-PA-QL	G
OPSUMIT TAB	-	NC
TRACLEER TAB	-	NC
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
TADLIQ SUSP (Prior Authorization required for members age 9 years and older)	PA	B
sildenafil susp (REVATIO equiv) (Prior Authorization required for members age 9 years and older)	PA	G
sildenafil tab 20mg (REVATIO equiv)	PA	G
tadalafil tab (PAH) (ADCIRCA equiv)	PA	G
ADCIRCA TAB	-	NC
LIQREV SUSP	-	NC
REVATIO SUSP	-	NC
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
UPTRAVI THERAPY PACK (QL= 1 pack/year; Only available through Accredo 800-803-2523)	LD-PA-QL	B
UPTRAVI INJ	-	NC
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
riociguat tab (ADEMPAS equiv) (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	G
ADEMPAS TAB	-	NC
SINUS NODE INHIBITORS		
CORLANOR SOLN (Prior Authorization required for members age 9 years and older)	PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
ivabradine hcl tab (CORLANOR equiv)	PA	G
CORLANOR TAB	-	NC
TRANSTHYRETIN STABILIZERS		
ATTRUBY PACK (QL= 4 tabs/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B
VYNDAMAX CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist)	QL-RS	B
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap (DURICEF equiv)	-	G
cefadroxil susp (DURICEF equiv)	-	G
cefadroxil tab (DURICEF equiv)	-	G
cephalexin cap (KEFLEX equiv)	-	G
cephalexin susp (KEFLEX equiv)	-	G
CEFADROXIL TAB	-	NC
cephalexin cap 750mg (KEFLEX equiv)	-	NC
cephalexin tab	-	NC
KEFLEX CAP 750MG	-	NC
CEPHALOSPORINS - 2ND GENERATION		
CEFACLOR ER TAB	-	B
CEFACLOR SUSP	-	B
CEFACLOR CAP	-	G
cefaclor cap (CECLOR equiv)	-	G
cefprozil susp (CEFZIL equiv)	-	G
cefprozil tab (CEFZIL equiv)	-	G
cefuroxime tab (CEFTIN equiv)	-	G
CEPHALOSPORINS - 3RD GENERATION		
SUPRAX CAP	-	B
SUPRAX SUSP 500MG/5ML	-	B
cefdinir cap (OMNICEF equiv)	-	G
cefdinir susp (OMNICEF equiv)	-	G
cefixime cap (SUPRAX equiv)	-	G
cefixime susp (SUPRAX equiv)	-	G
CEFPODOXIME PROXETIL SUSP	-	G
cefpodoxime proxetil tab (VANTIN equiv)	-	G
CEFIXIME TAB	-	NC
CONTRACEPTIVES		
COMBINATION CONTRACEPTIVES - ORAL		
amethyst tab (LYBREL equiv)	-	$0
ARANELLE TAB	-	$0
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	$0
cryselle tab	-	$0
enpresse tab (TRI-LEVELEN equiv)	-	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	$0
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	$0
kelnor tab (DEMULEN equiv)	-	$0
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	$0
norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv)	-	$0
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	$0
nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv)	-	$0
nortrel tab (OVCON 35 equiv)	-	$0
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	$0
tri-legest tab (ESTROSTEP FE equiv)	-	$0
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	$0
TYBLUME TAB	-	$0
VALTYA 1/50 TAB	-	$0
VELIVET PAK	-	$0
velivet tab (CYCLESSA equiv)	-	$0
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	$0
viorele tab, kariva tab (MIRCETTE equiv)	-	$0
AVERI TAB	-	NC
BALCOLTRA TAB	-	NC
drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	NC
FEMLYV TAB	-	NC
levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv)	-	NC
LO LOESTRIN TAB	-	NC
loestrin 21 tab	-	NC
loestrin tab	-	NC
NATAZIA TAB	-	NC
NEXTSTELLIS TAB	-	NC
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	NC
norethindrone acetate/ethinyl estradial FE chew tab (MINASTRIN equiv)	-	NC
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	NC
SAFYRAL TAB	-	NC
TAYTULLA CAP	-	NC
YAZ TAB, YASMIN 28 TAB	-	NC
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
zafemy patch (XULANE equiv)	-	$0
GWYN LO PATCH	-	NC
TWIRLA PATCH	-	NC
COMBINATION CONTRACEPTIVES - VAGINAL		
eluryng vaginal ring (NUVARING equiv)	-	$0
ANNOVERA RING	-	NC
NUVARING	-	NC
COPPER CONTRACEPTIVES - IUD		
MIDUELLA, PARAGARD IUD	-	$0
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
levonorgestrel tab (PLAN B equiv)	OTC	$0
PLAN B TAB	OTC	$0
PROGESTIN CONTRACEPTIVES - IMPLANTS		
NEXPLANON IMPLANT	-	$0
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days)	QL	$0
medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days)	QL	$0
DEPO-PROVERA INJ	-	NC
PROGESTIN CONTRACEPTIVES - IUD		
MIRENA IUD	-	$0
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab (NORA-QD equiv)	-	$0
OPILL TAB	OTC	$0
SLYND TAB	-	NC
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	B
ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	B
CORTISONE ACETATE TAB	-	B
KHINDIVI SOLN (QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older)	LD-PA-QL	B
PREDNISOLONE SOLN	-	B
PREDNISONE SOLN	-	B
SOLU-CORTEF INJ (QL= 1 vial/fill)	QL	B
SOLU-CORTEF INJ 100MG (QL= 2 vials/fill)	QL	B
SOLU-MEDROL INJ 2GM	-	B
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	G
budesonide SR cap (ENTOCORT EC equiv)	-	G
DEXAMETHASONE CONC	-	G
dexamethasone elixir	-	G
DEXAMETHASONE PHOSPHATE INJ	-	G
DEXAMETHASONE SODIUM PHOSPHATE INJ	-	G
DEXAMETHASONE SOLN	-	G
dexamethasone tab (DECADRON equiv)	-	G
hydrocortisone succinate inj 100mg (SOLU-CORTEF equiv) (QL= 2 vials/fill)	QL	G
hydrocortisone tab (CORTEF equiv)	-	G
methylprednisolone acetate inj (DEPO-MEDROL equiv)	-	G
methylprednisolone dose pack (MEDROL equiv)	-	G
methylprednisolone tab (MEDROL equiv)	-	G
methylprenisolone sod succinate inj (SOLU-MEDROL equiv)	-	G
prednisolone soln	-	G
prednisolone soln (PEDIAPRED equiv)	-	G
prednisone tab (DELTASONE equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
triamcinolone acetonide inj (KENALOG equiv)	-	G
AGAMREE SUSP	-	NC
ALKINDI SPRINKLE CAP	-	NC
CORTEF TAB	-	NC
deflazacort susp (EMFLAZA equiv)	-	NC
deflazacort tab (EMFLAZA equiv)	-	NC
DEPO-MEDROL INJ	-	NC
DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ	-	NC
dexamethasone pak (DEXPAK equiv)	-	NC
DEXAMETHASONE TAB	-	NC
DEXPAK TAB	-	NC
DXEVO 11-DAY PAK	-	NC
EMFLAZA SUSP	-	NC
EMFLAZA TAB	-	NC
EOHILIA SUSP	-	NC
FLO-PRED SUSP	-	NC
HEMADY TAB	-	NC
KENALOG INJ	-	NC
KENALOG INJ, TRIAMCINOLONE ACE INJ	-	NC
LIDOLOG KIT	-	NC
MEDROL TAB	-	NC
MILLIPRED DP PAK	-	NC
MILLIPRED TAB	-	NC
ORAPRED ODT TAB, PREDNISOLONE ODT TAB	-	NC
ORTIKOS ER CAP	-	NC
prednisolone ODT (ORAPRED equiv)	-	NC
prednisolone tab (MILLIPRED equiv)	-	NC
PREDNISONE DR TAB	-	NC
PREDNISONE DR TAB, RAYOS DR TAB	-	NC
prednisone pack	-	NC
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC
SOLU-MEDROL INJ	-	NC
SOLU-MEDROL PF INJ	-	NC
TARPEYO CAP	-	NC
MINERALOCORTICOIDS		
fludrocortisone tab (FLORINEF equiv)	-	G
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
HYCODAN SYRUP	-	B
benzonatate cap (TESSALON equiv)	-	G
hydrocodone/homatropine syrup (HYCODAN equiv)	-	G
tussigon tab (HYCODAN equiv)	-	G
BENZONATATE CAP 150MG	-	NC
benzonatate cap 150mg (ZONATUSS equiv)	-	NC
ZONATUSS CAP 150MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
COUGH/COLD/ALLERGY Cont.		
COUGH/COLD/ALLERGY COMBINATIONS		
CLARINEX-D TAB	-	EXC
SEMPREX-D CAP	-	EXC
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	G
HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days)	QL	G
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	G
promethazine DM syrup	-	G
PROMETHAZINE VC SYRUP	-	G
promethazine VC syrup (PHENERGAN VC equiv)	-	G
PROMETHAZINE VC/CODEINE SYRUP	-	G
promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv)	-	G
promethazine/codeine syrup (PHENERGAN/CODEINE equiv)	-	G
DURAVENT PE TAB	-	NC
guaifenesin-DM oral liquid (ROBITUSSIN equiv)	-	NC
HYCOFENIX SOLN	-	NC
INTENSE COUGH LIQUID	-	NC
MUCINEX LIQUID	-	NC
POLY-TUSSIN DM SYRUP	-	NC
TUSSICAPS	-	NC
TUXARIN ER TAB	-	NC
TUZISTRA XR SUSP	-	NC
EXPECTORANTS		
GUAIFENESEN SYRUP	-	NC
POTASSIUM IODIDE ORAL SOLN	-	NC
MISC. RESPIRATORY INHALANTS		
HYPER-SAL NEB SOLN 7%	-	B
NEBUSAL NEB SOLN	-	B
MUCOLYTICS		
acetylcysteine soln (MUCOMYST equiv)	-	G
DERMATOLOGICALS		
ACNE PRODUCTS		
dapsone gel 5% (ACZONE equiv)	-	B
adapalene gel 0.3% (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older)	PA	G
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	G
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv)	-	G
AVAR CLEANSE LIQ 10-5%	-	G
clindamycin gel (CLEOCIN GEL equiv)	-	G
clindamycin lotion (CLEOCIN- T equiv)	-	G
clindamycin pad (CLEOCIN-T equiv)	-	G
clindamycin topical soln (CLEOCIN-T equiv)	-	G
clindamycin/benzoyl peroxide gel (DUAC GEL equiv)	-	G
erythromycin gel	-	G
erythromycin pad	-	G
erythromycin soln	-	G
erythromycin/benzoyl peroxide gel	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
SOD SUL/SULF LIQ 9-4.5%	-	G
sodium sulfacetamide lotion (KLARON equiv)	-	G
sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv)	-	G
sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv)	-	G
tretinoin cream (QL= 20gm/fill; Acne Only - Prior Authorization required for members age 35 years and older)	PA-QL	G
tretinoin gel (RETIN-A GEL equiv) (QL= 15gm/fill; Acne Only - Prior Authorization required for members age 35 years and older)	PA-QL	G
ABSORICA CAP	-	NC
ABSORICA LD CAP	-	NC
ADAPALENE SOLN	-	NC
adapalene cream (DIFFERIN equiv)	-	NC
adapalene gel (DIFFERIN equiv)	-	NC
ADAPALENE PAD	-	NC
adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv)	-	NC
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC
AKLIEF CREAM	-	NC
ALTRENO LOTION	-	NC
AMZEEQ FOAM	-	NC
ARAZLO LOTION	-	NC
ATRALIN GEL 0.05%	-	NC
AVAR AEROSOL FOAM	-	NC
AVAR PAD	-	NC
AVAR-E EMOLL CREAM	-	NC
AVAR-E LS CREAM 10-2%	-	NC
AZELEX CREAM	-	NC
BENZOYL PEROXIDE LOTION	-	NC
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC
BP 10-1 EMU	-	NC
CLENIA PLUS SUSP	-	NC
CLINDACIN KIT	-	NC
clindamycin foam (EVOCLIN equiv)	-	NC
clindamycin gel 1% (CLEOCIN GEL equiv)	-	NC
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv)	-	NC
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	NC
clindamycin/tretinoin gel (ZIANA equiv)	-	NC
CLINDAVIX KIT	-	NC
dapsone gel (ACZONE equiv)	-	NC
EPIDUO FORTE GEL 0.3-2.5%	-	NC
EPIDUO GEL 0.1-2.5%	-	NC
EPSOLAY CREAM	-	NC
ERY PAD	-	NC
EVOCLIN FOAM	-	NC
FABIOR AEROSOL FOAM	-	NC
isotretinoin cap 25mg (ABSORICA equiv)	-	NC
isotretinoin cap 35mg (ABSORICA equiv)	-	NC
NUCARACLINPA KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
NUCARARXPAK KIT	-	NC
ONEXTON GEL 1.2-3.75%	-	NC
PLEXION CREAM 9.8-4.8%	-	NC
RETIN-A CREAM	-	NC
RETIN-A GEL	-	NC
RETIN-A MICRO GEL/GEL PUMP	-	NC
RETIN-A MICRO GEL/GEL PUMP, TRETINOIN MICROSPHERE GEL/GEL PUMP	-	NC
SOD SUL/SULF SUSP 10-5%	-	NC
SOD SUL/SULF SUSP 8-4%	-	NC
SODIUM SULFACETAMIDE/SULFUR CREAM 10-2%	-	NC
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC
SODIUM SULFACETAMIDE/SULFUR LOTION	-	NC
sodium sulfacetamide/sulfur lotion (SULFACET R equiv)	-	NC
sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv)	-	NC
SODIUM SULFACETAMIDE/SULFUR SUSP	-	NC
SODIUM SULFACETAMIDE/SULFUR WASH	-	NC
sodium sulfacetamide/sulfur wash (SUMAXIN equiv)	-	NC
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC
sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv)	-	NC
sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv)	-	NC
SULFACETAMIDE SODIUM/SULFUR CREAM 9.8-4.8%	-	NC
SUMADAN WASH 9-4.5%	-	NC
SUMADEN XLT KIT	-	NC
SUMAXIN WASH	-	NC
tretinoin gel 0.05% (ATRALIN equiv)	-	NC
tretinoin microsphere gel	-	NC
TWYNEO CREAM	-	NC
WINLEVI CREAM	-	NC
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS		
VEREGEN OINT	-	B
AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES		
RENOVA CREAM	-	EXC
KYBELLA INJ	-	NC
ANALGESICS - TOPICAL		
BACLOFEN CREAM COMPOUND KIT	-	B
TRAMADOL COMPOUND KIT	-	NC
ANTIBIOTICS - TOPICAL		
gentamicin sulfate cream	-	G
gentamicin sulfate oint	-	G
mupirocin oint (BACTROBAN OINT equiv)	-	G
ALTABAX OINT	-	NC
BACTROBAN CREAM	-	NC
CENTANY OINT	-	NC
mupirocin cream (BACTROBAN CREAM equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer

generic = small letters

BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
NEO-SYNALAR CREAM	-	NC
XEPI CREAM	-	NC
ANTIFUNGALS - TOPICAL		
ciclopirox cream (LOPROX CREAM equiv)	-	G
ciclopirox nail soln (PENLAC equiv)	-	G
ciclopirox shampoo (LOPROX equiv) (Step Therapy requires trial of ketoconazole shampoo)	ST	G
econazole cream (SPECTAZOLE equiv) (QL= 30gm/30 days)	QL	G
ketoconazole cream (NIZORAL CREAM equiv)	-	G
ketoconazole shampoo (NIZORAL equiv)	-	G
nystatin cream (MYCOSTATIN CREAM equiv)	-	G
nystatin oint	-	G
nystatin topical powder	-	G
ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv)	-	NC
ALOQUIN GEL	-	NC
CICLODAN KIT	-	NC
ciclopirox gel (LOPROX equiv)	-	NC
ciclopirox topical susp (LOPROX equiv)	-	NC
clotrimazole cream (LOTRIMIN AF equiv)	-	NC
clotrimazole soln	-	NC
clotrimazole/betamethasone cream (LOTRISONE equiv)	-	NC
CLOTRIMAZOLE/BETAMETHASONE LOTION	-	NC
clotrimazole/betamethasone lotion (LOTRISONE equiv)	-	NC
ECONASIL KIT	-	NC
ECONAZOLE NITRATE FOAM, ECOZA FOAM	-	NC
ECOZA FOAM	-	NC
ERTACZO CREAM	-	NC
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC
HC/IODOQUIN CREAM	-	NC
HIXDEFRIMA SOLN	-	NC
IODOQUINOL/HC ALOE GEL	-	NC
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	NC
IODOQUINOL-HYDROCORTISONE CREAM	-	NC
JUBLIA SOLN	-	NC
KERYDIN SOLN	-	NC
LOTRIMIN AF CREAM	-	NC
LOTRISONE CREAM	-	NC
LULICONAZOLE CREAM, LUZU CREAM	-	NC
MENTAX CREAM	-	NC
NAFTIFINE CREAM	-	NC
naftifine cream (NAFTIN equiv)	-	NC
naftifine hcl gel 2% (NAFTIN equiv)	-	NC
NAFTIN GEL 2%	-	NC
nystatin/triamcinolone cream	-	NC
nystatin/triamcinolone oint	-	NC
ONYCHO-MED KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
oxiconazole nitrate cream (OXISTAT equiv)	-	NC
OXISTAT CREAM	-	NC
OXISTAT LOTION	-	NC
PEDIZOLPAK THERAPY PACK	-	NC
PENLAC SOLN	-	NC
tavaborole soln (KERYDIN equiv)	-	NC
VYTONE CREAM 1.9-1%	-	NC
XOLEGEL	-	NC
ZOLPAK KIT	-	NC
ANTI-INFLAMMATORY AGENTS - TOPICAL		
VOPAC 5 CREAM	-	B
diclofenac soln 1.5% (PENNSAID equiv)	-	G
diclofenac gel 1% (VOLTAREN equiv)	-	NC
DICLOFENAC PATCH, FLECTOR PATCH	-	NC
diclofenac sodium gel kit (VENNGEL equiv)	-	NC
diclofenac sodium soln 2% (PENNSAID SOLN equiv)	-	NC
DICLONA GEL	-	NC
DICLOTREX PAK	-	NC
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC
LEXTOL PAK	-	NC
LICART PATCH	-	NC
NAPROXEN CREAM COMPOUND KIT	-	NC
PENNSAID SOLN	-	NC
PROFINAC PAK	-	NC
REXAPHENAC CREAM	-	NC
VENNGEL ONE KIT	-	NC
VOPAC CREAM	-	NC
VOPAC GB CREAM	-	NC
XRYLIX PAK	-	NC
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
FLUOROURACIL SOLN	-	B
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
bexarotene gel (TARGRETIN equiv) (QL= 60 grams/30 days)	LMSP-PA-QL	G
diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days)	PA-QL	G
fluorouracil cream (EFUDEX CREAM equiv)	-	G
fluorouracil soln (FLUOROURACIL equiv)	-	G
CARAC CREAM	-	NC
FLUORAC CREAM	-	NC
FLUOROURACIL CREAM 0.5%	-	NC
KLISYRI OINT	-	NC
ROAOXIA GEL	-	NC
SOLARAVIX PAK	-	NC
TARGRETIN GEL	-	NC
ANTIPRURITICS - TOPICAL		
doxepin hcl cream	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DERMATOLOGICALS Cont.

ANTIPSORIATICS

DrugName	Special Code	Tier
BIMZELX INJ (QL= 1 mL/28 days)	LMSP-PA-QL	B
BIMZELX INJ 320MG/2ML (QL= 2 mL/56 days)	LMSP-PA-QL	B
BIMZELX SYRINGE (QL= 1 mL/28 days)	LMSP-PA-QL	B
BIMZELX SYRINGE 320MG/2ML (QL= 2 mL/56 days)	LMSP-PA-QL	B
METHOXSALEN CAP	-	B
SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days)	LMSP-PA-QL	B
SKYRIZI INJ 55MG/0.37ML (QL= 1 inj/84 days)	LMSP-PA-QL	B
SPEVIGO INJ (QL= 2ml/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
STEQEYMA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B
STEQEYMA INJ 90MG (QL= 1 inj/84 days)	LMSP-PA-QL	B
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
TALTZ INJ 20MG/0.25ML (QL= 1 inj/28 days)	LMSP-PA-QL	B
TALTZ INJ 40 MG/0.5ML (QL= 1 inj/28 days)	LMSP-PA-QL	B
TREMFYA INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B
USTEKINUMAB-AEKN 45MG/0.5ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B
USTEKINUMAB-AEKN 90MG/ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553)	LD-PA-QL	B
YESINTEK INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B
YESINTEK SYRINGE (QL= 1 inj/84 days)	LMSP-PA-QL	B
YESINTEK SYRINGE 90MG (QL= 1 inj/84 days)	LMSP-PA-QL	B
acitretin cap (SORIATANE equiv)	-	G
calcipotriene cream (DOVONEX CREAM equiv)	-	G
calcipotriene oint	-	G
calcipotriene soln (DOVONEX SOLN equiv)	-	G
CALCIPOTRIENE SOLN 0.005%	-	G
methoxsalen cap (OXSORALEN ULTRA equiv)	-	G
tazarotene cream 0.05% (TAZORAC equiv)	PA	G
tazarotene cream 0.1% (TAZORAC equiv)	PA	G
calcipotriene cream (TRIONEX equiv)	-	NC
CALCIPOTRIENE FOAM	-	NC
CALCIPOTRIENE FOAM, SORILUX FOAM	-	NC
CALCITRIOL OINT	-	NC
CALSODORE PAK	-	NC
COSENTYX INJ (1-PACK)	-	NC
COSENTYX INJ (2-PACK)	-	NC
COSENTYX INJ 300MG/2ML	-	NC
COSENTYX UNO INJ	-	NC
ICOTYDE TAB	-	NC
IMULDOSA SYRINGE	-	NC
OTULFI INJ	-	NC
OTULFI, USTEKINUMAB-AAUZ SYRINGE	-	NC
PELLIX SOLN	-	NC
PYZCHIVA INJ	-	NC
SELARSDI INJ	-	NC
SILIQ INJ	-	NC
SOTYKTU TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
STARJEMZA INJ	-	NC
STARJEMZA PFS INJ	-	NC
STELARA INJ	-	NC
STEQEYMA VIAL	-	NC
tazarotene gel (TAZORAC equiv)	-	NC
TAZORAC CREAM	-	NC
TRIONEX PAK	-	NC
USTEKINUMAB INJ 45/0.5ML	-	NC
USTEKINUMAB INJ 90MG/ML	-	NC
VECTICAL OINT	-	NC
VTAMA CREAM	-	NC
WEZLANA INJ	-	NC
WEZLANA SYRINGE	-	NC
ANTISEBORRHEIC PRODUCTS		
OVACE PLUS LIQ WASH 10%	-	B
SELENIUM SUL SHA	-	G
SELENIUM SULFIDE LOTION	-	G
selenium sulfide lotion 2.5% (SELSUN equiv)	-	G
selenium sulfide shampoo (SELSEB equiv)	-	G
SODIUM SULFA LIQ WASH	-	G
sodium sulfacetamide wash (OVACE WASH equiv)	-	G
ESKATA SOLN	-	NC
OVACE PLUS CREAM	-	NC
OVACE PLUS LOTION	-	NC
OVACE PLUS SHAMPOO	-	NC
OVACE PLUS FOAM	-	NC
PROMISEB CREAM	-	NC
SELENIUM SUL SHA 2%	-	NC
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC
sodium sulfacetamide shampoo (OVACE equiv)	-	NC
SODIUM SULFACETAMIDE WASH, OVACE PLUS GEL WASH	-	NC
ANTIVIRALS - TOPICAL		
ZELSUVMI GEL (QL= 1 carton/fill, 2 fills/365 days)	PA-QL	B
acyclovir oint (ZOVIRAX OINT equiv)	-	G
acyclovir cream (ZOVIRAX equiv)	-	NC
DENAVIR CREAM	-	NC
penciclovir cream (DENAVIR equiv)	-	NC
XERESE CREAM	-	NC
ZOVIRAX CREAM	-	NC
ZOVIRAX OINT	-	NC
BURN PRODUCTS		
SULFAMYLON CREAM	-	B
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	G
MAFENIDE ACETATE SOLN PACK	-	NC
CORTICOSTEROIDS - TOPICAL		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
BETAMETHASONE AUGMENTED GEL	-	B
EPIFOAM AEROSOL	-	B
ALCLOMETASONE CREAM	-	G
alclometasone cream (ACLOVATE equiv)	-	G
ALCLOMETASONE OINT	-	G
alclometasone oint (ACLOVATE OINT equiv)	-	G
BETAMETH VALERATE LOTION	-	G
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	G
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	G
betamethasone augmented oint (DIPROLENE OINT equiv)	-	G
betamethasone diproprionate cream (DIPROSONE CREAM equiv)	-	G
betamethasone diproprionate lotion	-	G
betamethasone diproprionate oint (DIPROSONE OINT equiv)	-	G
betamethasone valerate cream	-	G
betamethasone valerate lotion	-	G
betamethasone valerate oint	-	G
clobetasol foam (OLUX equiv)	PA	G
clobetasol lotion (CLOBEX equiv)	PA	G
clobetasol propionate cream (TEMOVATE equiv)	-	G
clobetasol propionate emollient cream (TEMOVATE E equiv)	-	G
clobetasol propionate gel (TEMOVATE GEL equiv)	-	G
clobetasol propionate oint (TEMOVATE equiv)	-	G
clobetasol propionate soln (TEMOVATE equiv)	-	G
clobetasol shampoo (CLOBEX equiv)	-	G
clobetasol spray (CLOBEX equiv)	-	G
desonide cream (DESOWEN equiv)	-	G
desonide oint (DESOWEN equiv)	-	G
desoximetasone oint 0.25% (TOPICORT equiv)	-	G
fluocinolone acetonide cream	-	G
fluocinolone acetonide oil	-	G
fluocinolone acetonide oint	-	G
fluocinolone acetonide soln	-	G
fluocinonide cream 0.05% (LIDEX equiv)	-	G
fluocinonide emollient cream	-	G
fluocinonide gel	-	G
fluocinonide oint	-	G
fluocinonide soln	-	G
fluticasone propionate cream (CUTIVATE equiv)	-	G
fluticasone propionate oint (CUTIVATE equiv)	-	G
halobetasol propionate cream (ULTRAVATE equiv)	-	G
halobetasol propionate oint (ULTRAVATE equiv)	-	G
HC PRAMOXINE CREAM 1-2.5%	-	G
hydrocortisone cream (PROCTOCORT equiv)	-	G
hydrocortisone lotion (HYTONE equiv)	-	G
HYDROCORTISONE LOTION 2.5%	-	G
hydrocortisone oint	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	G
mometasone cream (ELOCON equiv)	-	G
mometasone oint (ELOCON equiv)	-	G
mometasone soln (ELOCON equiv)	-	G
triamcinolone cream	-	G
TRIAMCINOLONE LOTION	-	G
triamcinolone oint	-	G
ALA-SCALP LOTION	-	NC
AMCINONIDE CREAM 0.1%	-	NC
AMCINONIDE LOTION	-	NC
AMCINONIDE OINTMENT	-	NC
APEXICON E CREAM (PSORCON E equiv)	-	NC
BESER KIT 0.05%	-	NC
betamethasone augmented gel	-	NC
betamethasone valerate foam (LUXIQ equiv)	-	NC
BRYHALI LOTION	-	NC
calcipotriene/betamethasone dipropionate susp (TACLONEX equiv)	-	NC
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC
CAPEX SHAMPOO	-	NC
clobetasol E foam (OLUX E equiv)	-	NC
CLOBETASOL PROPIONATE CREAM, IMPOYZ CREAM	-	NC
CLOBETAVIX KIT	-	NC
CLOBEX LOTION	-	NC
CLOBEX SHAMPOO	-	NC
CLOCORTOLONE CREAM	-	NC
CLODERM CREAM	-	NC
CORDRAN CREAM 0.025%	-	NC
CORDRAN OINTMENT	-	NC
CORDRAN TAPE	-	NC
CUTIVATE LOTION	-	NC
DERMACINRX KIT	-	NC
DESONATE GEL	-	NC
desonide gel	-	NC
desonide lotion (DESOWEN equiv)	-	NC
DESOWEN CREAM	-	NC
DESOWEN CREAM KIT	-	NC
DESOWEN LOTION	-	NC
DESOWEN LOTION KIT	-	NC
DESOWEN OINT	-	NC
DESOWEN OINT KIT	-	NC
desoximetasone cream (TOPICORT CREAM equiv)	-	NC
desoximetasone cream 0.05% (TOPICORT equiv)	-	NC
DESOXIMETASONE GEL	-	NC
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC
DIFLORASONE CREAM	-	NC
DIFLORASONE CREAM, PSORCON CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
diflorasone oint	-	NC
DUOBRII LOTION	-	NC
ENSTILAR FOAM	-	NC
fluocinonide cream 0.1%	-	NC
FLUOPAR KIT	-	NC
FLUOVIX PAK	-	NC
FLURANDRENOL LOTION	-	NC
flurandrenolide cream (CORDRAN equiv)	-	NC
flurandrenolide oint (CORDRAN equiv)	-	NC
FLUTICASONE LOTION	-	NC
fluticasone propionate lotion (CUTIVATE equiv)	-	NC
halcinonide cream (HALOG equiv)	-	NC
HALCINONIDE SOLN	-	NC
halcinonide soln (HALOG equiv)	-	NC
HALOBETASOL AER	-	NC
HALOBETASOL AERO	-	NC
HALOG CREAM	-	NC
HALOG OINT	-	NC
HALOG SOLN	-	NC
halonate pac kit (ULTRAVATE KIT equiv)	-	NC
HC BUTYRATE CREAM	-	NC
HC BUTYRATE SOLN	-	NC
HC/PRAMOXINE CREAM 1-2.35%	-	NC
HC-LIDOCAINE CREAM	-	NC
HYDROCORTISONE ACETATE CREAM, MICORT-HC CREAM	-	NC
hydrocortisone butyrate cream (LOCOID equiv)	-	NC
HYDROCORTISONE BUTYRATE LIPO CREAM	-	NC
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC
HYDROCORTISONE BUTYRATE OINT	-	NC
hydrocortisone butyrate oint (LOCOID equiv)	-	NC
hydrocortisone butyrate soln (LOCOID equiv)	-	NC
hydrocortisone lotion (LOCOID equiv)	-	NC
hydrocortisone lotion 2% (ALA SCALP equiv)	-	NC
HYDROCORTISONE PAK	-	NC
hydrocortisone valerate cream (WESTCORT equiv)	-	NC
hydrocortisone valerate oint (WESTCORT equiv)	-	NC
HYDROXYM GEL	-	NC
IMPEKLO LOTION	-	NC
IMPOYZ CREAM	-	NC
LOCOID CREAM	-	NC
LOCOID LIPOCREAM	-	NC
LOCOID OINT	-	NC
LOCOID SOLN	-	NC
LUXIQ FOAM	-	NC
MEXPAROX HC CREAM	-	NC
NOVACORT GEL	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
OLUX E FOAM	-	NC
OLUX FOAM	-	NC
PANDEL CREAM	-	NC
paramox hc gel (NOVACORT GEL equiv)	-	NC
PRAMOSONE CREAM 1-1%	-	NC
PRAMOSONE CREAM 1-2.5%	-	NC
PRAMOSONE LOTION	-	NC
PRAMOSONE OINT	-	NC
QUINIXIL PAK	-	NC
SERNIVO SPRAY	-	NC
SILALITE PAK MIS	-	NC
TACLONEX SUSP	-	NC
TASOPROL CREAM KIT	-	NC
TEMOVATE CREAM	-	NC
TEMOVATE OINT	-	NC
TEXACORT SOLN	-	NC
TOPICORT CREAM	-	NC
TOPICORT CREAM 0.05%	-	NC
TOPICORT GEL	-	NC
TOPICORT OINT	-	NC
TOPICORT OINT 0.05%	-	NC
TOVET KIT	-	NC
triamcinolone acetonide oint (TRIANEX equiv)	-	NC
TRIAMCINOLONE SPRAY	-	NC
triamcinolone spray (KENALOG equiv)	-	NC
TRIAMVEX KIT	-	NC
TRIANEX OINT	-	NC
TRILOCICLO KIT	-	NC
ULTRAVATE LOTION	-	NC
ULTRAVATE PAC KIT	-	NC
VANOS CREAM	-	NC
VERDESO FOAM	-	NC
WESTCORT OINT	-	NC
WYNZORA CREAM	-	NC
DERMATOMYOSITIS AGENTS		
LISRAYA TAB	-	NC
ECZEMA AGENTS		
ADBRY INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
ADBRY INJ (QL= 4 inj/28 days)	LMSP-PA-QL	B
CIBINQO TAB (QL= 1 tab/day)	LMSP-PA-QL	B
DUPIXENT INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
DUPIXENT PEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
EBGLYSS INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
EBGLYSS PEN INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
OPZELURA CREAM (QL= 4 tubes/30 days for the first two months; then QL= 12 tubes/year thereafter)	PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
ANZUPGO CREAM	-	NC
EMOLLIENT/KERATOLYTIC AGENTS		
DERMASORB XM KIT	-	B
CARMOL LOTION	-	NC
KERAFOAM	-	NC
KERALAC CREAM	-	NC
UMECTA EMULSION	-	NC
UMECTA PD EMULSION	-	NC
UMECTA SUSP	-	NC
URAMAXIN CREAM	-	NC
URAMAXIN GEL	-	NC
urea cream	-	NC
UREA EMULSION	-	NC
urea gel (URAMAXIN equiv)	-	NC
UREA LOT	-	NC
UREA NAIL KIT	-	NC
UREA SUSP	-	NC
urea susp 40% (UMECTA equiv)	-	NC
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv) (Rx Only)	-	G
ammonium lactate lotion (LAC-HYDRIN equiv) (Rx Only)	-	G
HYLINATE LOTION	-	NC
ENZYMES - TOPICAL		
SANTYL OINT (QL= 90gm/30 days)	QL	B
vasolex oint (XENADERM equiv)	-	NC
XENADERM OINT	-	NC
HAIR GROWTH AGENTS		
LEQSELVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523 or Optum 877-445-6874)	LD-PA-QL	B
LITFULO CAP (QL= 1 cap/day; Only available through Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B
bimatoprost ophth soln (LATISSE equiv)	-	EXC
finasteride tab (PROPECIA equiv)	-	EXC
LATISSE SOLN	-	NC
IMMUNOMODULATING AGENTS - SYSTEMIC		
NEMLUVIO INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	G
IMIQUIMOD CREAM 3.75%	-	NC
imiquimod cream 3.75% (IMIQUIMOD equiv)	-	NC
ZYCLARA CREAM	-	NC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
pimecrolimus cream (ELIDEL equiv) (Covered for members age 2 years and older)	-	G
tacrolimus oint (PROTOPIC OINT equiv)	-	G
OXIANUJO CREAM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DERMATOLOGICALS Cont.

DrugName	Special Code	Tier
KERATOLYTIC/ANTIMITOTIC AGENTS		
CONDYLOX GEL	-	B
PODOCON SOLN	-	B
podofilox gel (CONDYLOX equiv)	-	G
PODOFILOX SOLN	-	G
podofilox soln (CONDYLOX equiv)	-	G
GEAMETDRAY GEL	-	NC
METDRAY GEL	-	NC
SALEX LOTION KIT	-	NC
SALEX SHAMPOO	-	NC
SALICATE LIQUID	-	NC
SALICYLIC AC SOLN ER, XALIX SOLN	-	NC
SALIMEZ FORTE CREAM	-	NC
UREA/SALICYLIC CREAM	-	NC
LOCAL ANESTHETICS - TOPICAL		
LIDOCAINE JELLY 2%	-	B
lidocaine gel (GLYDO equiv)	-	G
LIDOCAINE OINT (QL= 36gm/fill)	QL	G
lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day)	PA-QL	G
lidocaine soln (XYLOCAINE equiv)	-	G
lidocaine/prilocaine cream (EMLA equiv)	-	G
ADAZIN CREAM	-	NC
ANASTIA LOTION	-	NC
APRIZIO PAK KIT	-	NC
capsaicin/menthol topical patch (SINELEE equiv)	-	NC
DERMALID PAK	-	NC
GEN7T LOTION	-	NC
GEN7T PAD 3.5%	-	NC
GEN7T PLUS LOTION	-	NC
GEN7T PLUS PAD	-	NC
L.E.T. GEL	-	NC
LIDO/MENTHOL SPRAY	-	NC
LIDO/RAC/TET GEL	-	NC
LIDOCAINE CREAM	-	NC
LIDOCAINE GEL	-	NC
lidocaine oint/transparent dressing kit	-	NC
lidocaine patch 3.5% (GEN7T equiv)	OTC	NC
lidocaine patch 4% (LIDODERM equiv)	-	NC
LIDOCIN GEL	-	NC
LIDO-EP-TETR SOLN	-	NC
LIDOSTREAM KIT	-	NC
LIDOTREX GEL	-	NC
LIDOVEX CREAM	-	NC
MEDI-PATCH W/LIDOCAINE PATCH	-	NC
MENTHOREAL10 THERAPY PACK	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
MICROVIX LP PAK	-	NC
NENDRUX GEL	-	NC
nulido pad (NULIDO equiv)	-	NC
NUVAKAAN II KIT	-	NC
PLIAGLIS CREAM	-	NC
PLIAGLIS KIT	-	NC
PROZENA PAD	-	NC
SILVERA PAD	-	NC
SOLAICE PATCH	-	NC
WPR PLUS	-	NC
ZILACAINE PAK	-	NC
ZYLOTROL-L KIT	-	NC
MISC. DERMATOLOGICAL PRODUCTS		
NEOSALUS FOAM	-	NC
NEOSALUS LOTION	-	NC
MISC. TOPICAL		
DRYSOL SOLN	-	G
DERMACINRX CREAM	-	NC
HYCLODEX SOLN	-	NC
QBREXZA PAD	-	NC
SOFDRA GEL	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
ZORYVE CREAM (QL= 60 grams/30 days)	PA-QL	B
ZORYVE FOAM (QL= 60 grams/30 days)	PA-QL	B
ADQUEY OINT	-	NC
EUCRISA OINT	-	NC
ZORYVE CREAM 0.05%	-	NC
ZORYVE CREAM 0.15%	-	NC
PIGMENTING-DEPIGMENTING AGENTS		
BLANCHE CREAM	-	EXC
TRI-LUMA CREAM	-	EXC
EPIQUIN MICRO CREAM	-	NC
hydroquinone cream/sunscreen (LUSTRA ULTRA equiv)	-	NC
hydroquinone micro cream (EPIQUIN MICRO equiv)	-	NC
MELQUIN 3 SOLN	-	NC
NUQUIN HP CREAM	-	NC
ROSACEA AGENTS		
FINACEA FOAM	-	B
DAZOMON GEL	-	EXC
MIRVASO GEL	-	EXC
oxymetazoline hcl cream (RHOFADE equiv)	-	EXC
RHOFADE CREAM	-	EXC
azelaic acid gel (FINACEA equiv)	-	G
metronidazole cream (METROCREAM equiv)	-	G
metronidazole gel 0.75% (METROGEL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
metronidazole gel 1% (METROGEL equiv) (Step Therapy requires trial of metronidazole gel 0.75%)	ST	G
metronidazole lotion (METROLOTION equiv)	-	G
doxycycline (rosacea) cap delayed release (ORACEA equiv)	-	NC
EMROSI CAP	-	NC
IVERMECTIN CREAM	-	NC
ivermectin cream (SOOLANTRA equiv)	-	NC
NORITATE CREAM	-	NC
ORACEA CAP	-	NC
ROSADAN KIT	-	NC
SOOLANTRA CREAM	-	NC
ZILXI FOAM	-	NC
SCABICIDES & PEDICULICIDES		
NATROBA SUSP (QL= 1 bottle/fill)	QL	B
NATROBA SUSP 0.90% (QL= 1 bottle/fill)	QL	B
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	B
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	G
permethrin cream (ELIMITE CREAM equiv)	-	G
CROTAN LOTION	-	NC
EURAX CREAM	-	NC
IVERMECTIN LOTION	-	NC
SKLICE LOTION	-	NC
SCAR TREATMENT PRODUCTS		
SCARCIN GEL	-	NC
SCARCIN LIQUID ROLL-ON	-	NC
SILIPAC KIT	-	NC
WOUND CARE PRODUCTS		
FILSUVEZ GEL 10%	MSP-PA	B
VYJUVEK GEL (QL= 4 vials/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
ALEVICYN SOLN DERMAL	-	NC
BIAFINE EMULSION	-	NC
COLLANEX EXTERNAL POWDER	-	NC
KERAMATRIX	-	NC
KERASTAT CREAM	-	NC
KERASTAT GEL	-	NC
REXASIL KIT	-	NC
WOUND-DRESSING GELS	-	NC
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC BIOLOGICALS		
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC
DIAGNOSTIC DRUGS		
GLUCAGON DIAGNOSTIC INJ	-	NC
MACRILEN PACK	-	NC
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIAGNOSTIC PRODUCTS Cont.		
DIAGNOSTIC TESTS		
COVID-19 TEST	OTC	EXC
CUE COVID-19 INJ TEST CARTRIDGE	OTC	EXC
CUE HEALTH MONITOR	OTC	EXC
ACCU-CHEK GUIDE TEST STRIP	OTC	G
CLINISTIX TEST STRIP	OTC	G
FREESTYLE INSULINX TEST STRIP	OTC	G
FREESTYLE PRECISION NEO TEST STRIP	OTC	G
FREESTYLE TEST STRIP	OTC	G
KETO-DIASTIX TEST STRIP	OTC	G
KETOSTIX	OTC	G
PRECISION XTRA TEST STRIP	OTC	G
PRECISION XTRA KETONE TEST STRIP	OTC	NC
TEST STRIP (all other test strips)	OTC	NC
RADIOGRAPHIC CONTRAST MEDIA		
iohexol inj (OMNIPAQUE equiv)	-	NC
OMNIPAQUE INJ	-	NC
OMNIPAQUE SOLN	-	NC
SITZMARKS CAP	-	NC
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
ASTAMED MYO CAP	-	EXC
DEPLIN CAP	-	EXC
ELIGEN B12 TAB	-	EXC
FALESSA TAB	-	EXC
FOLTANX TAB	-	EXC
GLYGEST PAK	-	EXC
L-METHYLFOLATE TAB	-	EXC
LUVIRA CAP	-	EXC
METANX CAP	-	EXC
OLLIZAC POWDER	-	EXC
PODIAPN CAP	-	EXC
XYZBAC TAB	-	EXC
NUTRITIONAL SUPPLEMENTS		
TYR EASY TAB PLUS, HCU EASY TAB PLUS	-	EXC
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	B
ZENPEP CAP	-	B
PANCREAZE CAP, PERTZYE CAP	-	NC
SUCRAID SOLN	-	NC
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
DIURETICS Cont.		
acetazolamide tab	-	G
methazolamide tab (NEPTAZANE equiv)	-	G
dichlorphenamide tab (KEVEYIS equiv)	-	NC
KEVEYIS TAB	-	NC
DIURETIC COMBINATIONS		
AMILORIDE/HCTZ TAB	-	G
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	G
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	G
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	G
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	G
LOOP DIURETICS		
ENBUMYST SOLN 0.5MG/0.1ML (QL= 12 devices/fill; Only available through Carepoint Pharmacy 855-237-9112)	LD-QL	B
LASIX ONYU INJ 80MG/2.67ML (QL= 6 cartridges/fill)	QL	B
bumetanide tab (BUMEX equiv)	-	G
FUROSEMIDE SOLN	-	G
furosemide soln (LASIX equiv)	-	G
furosemide tab (LASIX equiv)	-	G
torsemide tab (DEMADEX equiv)	-	G
EDECRIN TAB	-	NC
ethacrynic tab (EDECRIN equiv)	-	NC
FUROSCIX KIT	-	NC
FUROSCIX READYFLOW INJ	-	NC
SOAANZ TAB	-	NC
POTASSIUM SPARING DIURETICS		
DYRENIUM CAP	-	B
amiloride tab (MIDAMOR equiv)	-	G
spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 years and older)	PA	G
spironolactone tab (ALDACTONE equiv)	-	G
triamterene cap (DYRENIUM equiv)	-	NC
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
DIURIL SUSP	-	B
INZIRQO SUSP (Prior Authorization required for members age 9 years and older)	PA	B
chlorthalidone tab	-	G
hydrochlorothiazide cap (MICROZIDE equiv)	-	G
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	G
indapamide tab (LOZOL equiv)	-	G
metolazone tab (ZAROXOLYN equiv)	-	G
THALITONE TAB	-	NC
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB (QL= 12 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
RECORLEV TAB	-	NC
BONE DENSITY REGULATORS		
ALENDRONATE TAB 40MG	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
PROLIA INJ (QL= 1 fill/6 months)	LMSP-QL	B
TYMLOS INJ	LMSP	B
XGEVA INJ	MSP	B
alendronate sodium oral soln (FOSAMAX equiv)	-	G
alendronate tab (FOSAMAX equiv)	-	G
calcitonin nasal spray (MIACALCIN equiv)	-	G
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	G
risedronate tab (ACTONEL equiv)	-	G
teriparatide (recombinant) soln pen-inj (FORTEO equiv)	LMSP	G
BINOSTO TAB	-	NC
BONSITY INJ	-	NC
calcitonin inj (MIACALCIN equiv)	-	NC
FORTEO INJ	-	NC
FOSAMAX+D TAB	-	NC
risedronate DR tab (ATELVIA equiv)	-	NC
CORTICOTROPIN		
ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
ACTHAR GEL AUTO-INJECTOR	-	NC
CORTROPHIN INJ	-	NC
CORTROPHIN INJ GEL	-	NC
CORTICOTROPIN-RELEASING FACTOR (CRF) RECEPTOR ANTAGONISTS		
CRENESSITY CAP (QL= 2 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
CRENESSITY SOLN (QL= 2ml/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
FERTILITY REGULATORS		
clomiphene citrate tab (CLOMID equiv)	INF	EXC
CLOMIPHENE TAB	INF	EXC
OVIDREL INJ	INF	EXC
GNRH/LHRH ANTAGONISTS		
ORILISSA TAB 150MG (QL= 1 tab/day)	PA-QL	B
ORILISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	B
cetrorelix acetate for inj kit (CETROTIDE equiv)	INF	EXC
CETROTIDE KIT	INF	EXC
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ	-	NC
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	EXC
EGRIFTA WR KIT	-	EXC
GROWTH HORMONES		
GENOTROPIN INJ	LMSP-PA	B
GENOTROPIN INJ 5MG	LMSP-PA	B
GENOTROPIN MINIQUICK INJ	LMSP-PA	B
OMNITROPE INJ	LMSP-PA	B
SKYTROFA INJ	LMSP-PA	B
HUMATROPE INJ, ZOMACTON INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
NGENLA INJ	-	NC
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC
SOGROYA INJ	-	NC
ZOMACTON INJ	-	NC
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) ($0 copay for female members only age 35 years and older; All other members covered at generic copay)	-	$0
OSPHENA TAB	-	NC
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ (Only available through AnovoRx 844-288-5007)	LD	B
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
LUPRON DEPOT PED INJ	MSP	B
LUPRON DEPOT-PED INJ	MSP	B
SUPPRELIN LA INJ	MSP-PA	B
SYNAREL NASAL SOLN	-	B
MENOPAUSAL SYMPTOMS SUPPRESSANTS		
VEOZAH TAB (QL= 1 tab/day)	PA-QL	B
LYNKUET CAP	-	NC
METABOLIC MODIFIERS		
ALDURAZYME INJ	MSP-PA	B
CALCITRIOL INJ	LMSP	B
CYSTADANE POWDER	MSP-PA	B
CYSTADANE POWDER (Only available through AnovoRx 844-288-5007)	MSP-PA-LD	B
ELAPRASE INJ	MSP-PA	B
FABRAZYME INJ	MSP-PA	B
GALAFOLD CAP (QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416)	LD-PA-QL	B
IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
LUMIZYME/MYOZYME INJ	MSP-PA	B
NAGLAZYME INJ	MSP-PA	B
PALYNZIQ INJ (QL= 1 inj/day; Only available through Accredo 800-803-2523)	LD-PA-QL-SF	B
PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523)	LD	B
REDEMPLO PFS INJ (QL= 1 inj/84 days; Only available through Vanscoy Rare Pharmacy 855-826-7269)	LD-PA-QL	B
SEPHIENCE POWDER (Only available through Optum Frontier Therapies 855-768-9727 or Orsini 800-410-8575)	LD-PA	B
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	B
TRYNGOLZA INJ (QL= 1 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
VYKAT XR TAB (QL= 4 tabs/day; Only available through PantherRx 855-726-8479)	LD-PA-QL	B
VYKAT XR TAB 150MG (QL= 3 tabs/day; Only available through PantherRx 855-726-8479)	LD-PA-QL	B
VYKAT XR TAB 75MG (QL= 7 tabs/day; Only available through PantherRx 855-726-8479)	LD-PA-QL	B
XPHOZAH TAB (QL= 2 tabs/day)	MSP-PA-QL	B
YORVIPATH INJ (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B
YORVIPATH INJ 294MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B
YORVIPATH INJ 420MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B
calcitriol cap (ROCALTROL equiv)	-	G
calcitriol soln (ROCALTROL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007)	LD-PA	G
cinacalcet tab (SENSIPAR equiv)	-	G
DOXERCALCIFEROL CAP	-	G
doxercalciferol cap (HECTOROL equiv)	-	G
levocarnitine soln (CARNITOR equiv)	-	G
levocarnitine tab (CARNITOR equiv)	-	G
nitisinone cap (ORFADIN equiv)	LMSP-PA	G
paricalcitol cap (ZEMPLAR equiv)	-	G
sapropterin dihydrochloride powder packet (KUVAN equiv)	LMSP-PA	G
sapropterin dihydrochloride soluble tab (KUVAN equiv)	LMSP-PA	G
sodium phenylbutyrate powder (BUPHENYL equiv)	-	G
sodium phenylbutyrate tab (BUPHENYL equiv)	-	G
betaine powder for oral solution (CYSTADANE equiv)	-	NC
CARBAGLU TAB	-	NC
CITRULLINE EASY TAB	-	NC
FORZINITY INJ	-	NC
glycerol phenylbutyrate liquid (RAVICTI equiv)	-	NC
HARLIKU TAB	-	NC
KUVAN POWDER PACK	-	NC
KUVAN TAB	-	NC
KYGEVVI POWDER	-	NC
LOARGYS INJ	-	NC
MYALEPT INJ	-	NC
NITYR TAB	-	NC
OLPRUVA PACK	-	NC
ORFADIN CAP	-	NC
ORFADIN SUSP	-	NC
RAVICTI LIQUID	-	NC
RAYALDEE CAP	-	NC
SENSIPAR TAB	-	NC
XURIDEN POWDER	-	NC
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB (QL= 1 tab/day)	PA-QL	B
NATRIURETIC PEPTIDES		
VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376)	LD-PA-QL	B
YUVIWEL INJ	-	NC
POSTERIOR PITUITARY HORMONES		
DESMOPRESSIN NASAL SOLN 1.5MG/ML	-	B
desmopressin acetate nasal spray (DDAVP equiv)	-	G
desmopressin acetate tab (DDAVP equiv)	-	G
DESMOPRESSIN NASAL SPRAY	-	G
DESMODA SOLN	-	NC
NOCDURNA SL TAB	-	NC
NOCTIVA EMULSION SPRAY	-	NC
PROGESTERONE RECEPTOR ANTAGONISTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
mifepristone tab 200mg (MIFIPREX equiv)	-	G
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	G
SOMATOSTATIC AGENTS		
OCTREOTIDE INJ 100MCG	LMSP	B
PALSONIFY TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Orsini 800-410-8575)	LD-PA-QL	B
SIGNIFOR INJ (QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
octreotide inj (SANDOSTATIN equiv)	LMSP	G
BYNFEZIA PEN INJ	-	NC
MYCAPSSA CAP	-	NC
VASOPRESSIN RECEPTOR ANTAGONISTS		
tolvaptan tab (JYNARQUE equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G
tolvaptan tab therapy pack (JYNARQUE equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G
JYNARQUE PAK	-	NC
tolvaptan tab (SAMSCA equiv)	-	NC
ESTROGENS		
ESTROGEN COMBINATIONS		
DUAVEE TAB	-	B
MYFEMBREE TAB (QL= 1 tab/day)	PA-QL	B
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	B
PREMPHASE TAB, PREMPRO TAB	-	B
COVARYX HS TAB	-	G
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	G
estradiol/norethindrone tab (ACTIVELLA equiv)	-	G
jinteli tab (FEMHRT equiv)	-	G
ANGELIQ TAB	-	NC
BIJUVA CAP	-	NC
CLIMARA PRO PATCH	-	NC
COMBIPATCH	-	NC
FEMHRT TAB	-	NC
ESTROGENS		
EVAMIST SPRAY	-	B
MENEST TAB	-	B
PREMARIN TAB	-	B
estradiol patch (CLIMARA equiv)	-	G
estradiol patch (VIVELLE-DOT, MINIVELLE equiv)	-	G
estradiol tab (ESTRACE equiv)	-	G
estradiol td gel (DIVIGEL, ESTROGEL equiv) (QL= 1 packet/day)	QL	G
estradiol td gel 1.25mg (DIVIGEL equiv) (QL= 1 packet/day)	QL	G
estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill)	QL	G
estrogens, conjugated tab (PREMARIN equiv)	-	G
ALORA PATCH	-	NC
CLIMARA PATCH	-	NC
DELESTROGEN INJ	-	NC
DEPO-ESTRADIOL IM	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ESTROGENS Cont.		
DIVIGEL GEL, ESTROGEL GEL	-	NC
ELESTRIN GEL	-	NC
estradiol gel 0.06% (ESTROGEL equiv)	-	NC
MENOSTAR PATCH	-	NC
VIVELLE-DOT, MINIVELLE PATCH	-	NC
FLUOROQUINOLONES		
FLUOROQUINOLONES		
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	B
CIPRO SUSP	-	B
CIPROFLOXACIN 100MG TAB	-	B
ciprofloxacin susp (CIPRO equiv)	-	G
ciprofloxacin tab (CIPRO equiv)	-	G
levofloxacin soln (LEVAQUIN equiv)	-	G
levofloxacin tab (LEVAQUIN equiv)	-	G
moxifloxacin tab (AVELOX equiv)	-	G
OFLOXACIN TAB	-	G
FACTIVE TAB	-	NC
PROQUIN XR TAB	-	NC
GASTROINTESTINAL AGENTS - MISC.		
5-HT4 RECEPTOR AGONISTS		
prucalopride succinate tab (MOTEGRITY equiv) (QL= 1 tab/day)	QL	G
MOTEGRITY TAB	-	NC
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB (QL= 1 tab/day)	PA-QL	B
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	B
CHENODAL TAB, CTEXLI TAB	-	NC
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	G
ursodiol tab (URSO (FORTE) equiv)	-	G
CHENODAL TAB, CTEXLI TAB	-	NC
RELTONE CAP	-	NC
URSODIOL CAP	-	NC
URSOLIGN CAP	-	NC
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	G
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day)	QL	G
AMITIZA CAP	-	NC
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	G
metoclopramide tab (REGLAN equiv)	-	G
GIMOTI NASAL SPRAY	-	NC
METOZOLV ODT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

GASTROINTESTINAL AGENTS - MISC. Cont.

DrugName	Special Code	Tier
HEPATOTROPICS		
REZDIFFRA TAB (QL= 1 tab/day; Only available through Optum 877-445-6874)	LD-PA-QL	B
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481)	LD-PA-QL	B
LIVMARLI TAB (QL= 2 tabs/day; Only available through Eversana 866-849-4481)	LD-PA-QL	B
LIVMARLI TAB 30MG (QL= 1 tab/day; Only available through Eversana 866-849-4481)	LD-PA-QL	B
LIVMARLI SOLN	-	NC
LYNAVOY TAB	-	NC
INFLAMMATORY BOWEL AGENTS		
AVSOLA INJ	MSP-PA	B
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
CIMZIA INJ 200MG/ML (QL= 2 inj/28 days)	LMSP-PA-QL	B
DIPENTUM CAP	-	B
ENTYVIO SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
RENFLEXIS INJ	MSP-PA	B
SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days)	LMSP-PA-QL	B
SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days)	LMSP-PA-QL	B
TREMFYA INDUCTION INJ 200MG/ML (QL= 2 inj/28 days; 6 inj/year)	LMSP-PA-QL	B
TREMFYA INJ 200MG/2ML (QL= 1 inj/28 days)	LMSP-PA-QL	B
balsalazide cap (COLAZAL equiv)	-	G
mesalamine DR tab (LIALDA equiv)	-	G
mesalamine enema (ROWASA equiv)	-	G
mesalamine enema kit (ROWASA equiv)	-	G
mesalamine ER cap (APRISO equiv)	-	G
mesalamine supp (CANASA equiv)	-	G
sulfasalazine EC tab (AZULFIDINE equiv)	-	G
sulfasalazine tab (AZULFIDINE equiv)	-	G
APRISO CAP	-	NC
ASACOL HD TAB	-	NC
ASACOL HD TAB, MESALAMINE TAB	-	NC
DELZICOL CAP	-	NC
LIALDA TAB	-	NC
MESALAMINE DR CAP	-	NC
mesalamine DR cap (DELZICOL equiv)	-	NC
mesalamine ER cap (PENTASA CR equiv)	-	NC
mesalamine tab (ASACOL equiv)	-	NC
OMVOH INJ	-	NC
PENTASA CR CAP	-	NC
REMICADE INJ	-	NC
ROWASA KIT	-	NC
VELSIPITY TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer

generic = small letters

BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
ZYMFENTRA INJ	-	NC
INTESTINAL ACIDIFIERS		
lactulose soln	-	G
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
LINZESS CAP (QL= 1 cap/day)	PA-QL	B
alosetron tab (LOTRONEX equiv)	-	G
IBSRELA TAB	-	NC
VIBERZI TAB	-	NC
LIVE FECAL MICROBIOTA		
VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575)	LD-PA-QL	B
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB (QL= 1 tab/day)	PA-QL	B
SYMPROIC TAB (QL= 1 tab/day)	PA-QL	B
alvimopan cap (ENTEREG equiv)	-	NC
ENTEREG CAP	-	NC
RELISTOR INJ	-	NC
RELISTOR INJ KIT	-	NC
RELISTOR TAB	-	NC
PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR(PPAR) AGONISTS		
IQIRVO TAB (QL= 1 tab/day; Only available through Caremark/CVS Specialty 800-378-0695 or Walgreens 888-347-3416)	LD-PA-QL	B
LIVDELZI CAP (QL= 1 cap/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479)	LD-PA-QL	B
PHOSPHATE BINDER AGENTS		
AURYXIA TAB (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B
ferric citrate tab (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B
FOSRENOL CHEW TAB	-	B
FOSRENOL POWDER PACK	-	B
RENVELA TAB	-	B
calcium acetate cap (PHOSLO equiv)	-	G
lanthanum carbonate chew tab (FOSRENOL equiv)	-	G
sevelamer powder pak (RENVELA equiv)	-	G
sevelamer tab (RENVELA TAB equiv)	-	G
RENAGEL TAB 800MG	-	NC
sevelamer hydrochloride tab (RENAGEL equiv)	-	NC
VELPHORO CHEW TAB	-	NC
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT	-	NC
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB	-	NC
GENERAL ANESTHETICS		
ANESTHETICS - MISC.		
KETAMINE HCL TROCHES	-	NC
GENITOURINARY AGENTS - MISCELLANEOUS		
ALKALINIZERS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
CYTRA K CRYSTALS	-	G
CYTRA-3 SYRUP	-	G
K CITRATE SOLN CITR ACD	-	G
K/NA CITRATE SOL CITR ACD	-	G
ORACIT SOLN	-	G
potassium citrate CR tab (UROCIT-K TAB equiv)	-	G
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	G
sodium citrate/citric acid soln (BICITRA equiv)	-	G
CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	B
PROCYSBI CAP	-	NC
PROCYSBI GRANULES PACKET	-	NC
GENITOURINARY IRRIGANTS		
RENACIDIN SOLN	-	NC
HYPEROXALURIA AGENTS		
RIVFLOZA INJ (QL= 1 inj/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
RIVFLOZA INJ 160MG (QL= 1 inj/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
RIVFLOZA VIAL (QL= 2 vials/30 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
IGA NEPHROPATHY (IGAN) AGENTS		
FILSPARI TAB (QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CVS Specialty 800-378-0695)	LD-PA-QL	B
VANRAFIA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or CareMed 877-227-3405)	LD-PA-QL	B
TRUTAKNA INJ	-	NC
VOYXACT INJ	-	NC
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	NC
PENTOSAN CAP	-	NC
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	G
dutasteride cap (AVODART equiv)	-	G
finasteride tab (PROSCAR equiv)	-	G
silodosin cap (RAPAFLO equiv)	-	G
tamsulosin cap (FLOMAX equiv)	-	G
CARDURA XL TAB	-	NC
dutasteride/tamsulosin cap (JALYN equiv)	-	NC
ENTADFI CAP	-	NC
URINARY ANALGESICS		
PHENAZOPYRIDINE TAB	-	NC
phenazopyridine tab (PYRIDIUM equiv)	-	NC
PYRIDIUM TAB 100MG	-	NC
PYRIDIUM TAB 200MG	-	NC
URINARY STONE AGENTS		
LITHOSTAT TAB	-	B
tiopronin tab (THIOLA equiv)	LMSP-PA	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
GENITOURINARY AGENTS - MISCELLANEOUS Cont.		
tiopronin tab delayed release (THIOLA EC equiv)	LMSP-PA	G
THIOLA EC TAB	-	NC
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	G
DUZALLO TAB	-	NC
GOUT AGENTS		
GLOPERBA SOLN (Prior Authorization required for members age 9 years and older)	PA	B
allopurinol tab (ZYLOPRIM equiv)	-	G
colchicine tab (COLCRYS equiv)	-	G
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST	G
allopurinol tab 200mg	-	NC
colchicine cap (MITIGARE equiv)	-	NC
COLCRYS TAB	-	NC
ULORIC TAB	-	NC
ZURAMPIC TAB	-	NC
URICOSURICS		
probenecid tab (BENEMID equiv)	-	G
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
ADVATE, KOVALTRY INJ	LMSP-PA	B
AFSTYLA KIT	LMSP-PA	B
ALHEMO INJ	LMSP-PA	B
ALPHANATE, HUMATE-P INJ	LMSP-PA	B
ALPHANINE SD/MONONINE INJ	MSP-PA	B
ALPROLIX INJ	LMSP-PA	B
ALTUVIIIO INJ	LMSP-PA	B
BENEFIX INJ	LMSP-PA	B
COAGADEX INJ (Only available through CVS/Caremark 800-237-2767 or OptionCare 877-686-2622)	LD-PA	B
CORIFACT KIT	LMSP-PA	B
ELOCTATE INJ	LMSP-PA	B
ESPEROCT INJ	LMSP-PA	B
FESILTY INJ	LMSP-PA	B
FIBRYGA INJ	MSP-PA	B
HELIXATE/KOGENATE INJ	MSP-PA	B
HEMLIBRA INJ	LMSP-PA	B
HEMOFIL M, KOATE INJ	LMSP-PA	B
JIVI INJ	LMSP-PA	B
MONOCLATE-P INJ	MSP-PA	B
NOVOEIGHT INJ	LMSP-PA	B
NOVOSEVEN RT INJ	LMSP-PA	B
NUWIQ INJ	LMSP-PA	B
PROFILNINE INJ	LMSP-PA	B
RECOMBINATE INJ	LMSP-PA	B
RIXUBIS INJ	LMSP-PA	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
SEVENFACT INJ	LMSP-PA	B
VONVENDI INJ	LMSP-PA	B
WILATE INJ	LMSP-PA	B
XYNTHA INJ	LMSP-PA	B
ADYNOVATE INJ	-	NC
FEIBA INJ	-	NC
HYMPAVZI INJ	-	NC
IDELVION INJ	-	NC
IXINITY INJ	-	NC
KOGENATE FS INJ	-	NC
OBIZUR INJ	-	NC
QFITLIA INJ	-	NC
REBINYN INJ	-	NC
RIASTAP INJ	-	NC
TRETTEN INJ	-	NC
BRADYKININ B2 RECEPTOR ANTAGONISTS		
icatibant inj (FIRAZYR equiv)	LMSP-PA	G
FIRAZYR INJ	-	NC
COMPLEMENT INHIBITORS		
BERINERT INJ (Only available through Accredo 800-803-2523)	LD-PA	B
CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
HAEGARDA INJ (Only available through Accredo 800-803-2523)	LD-PA	B
RUCONEST INJ (Only available through Accredo 800-803-2523)	LD-PA	B
TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
VOYDEYA TAB (QL= 6 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
VOYDEYA TAB THERAPY PACK (QL= 6 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
ZILBRYSQ INJ (QL= 1 inj/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
ZILBRYSQ INJ 23MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
ZILBRYSQ INJ 32.4MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
FABHALTA CAP	-	NC
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB	-	NC
WAYRILZ TAB	-	NC
HEMATORHEOLOGIC AGENTS		
pentoxifylline ER tab (TRENTAL equiv)	-	G
PLASMA FACTOR XIIA INHIBITORS		
ANDEMBRY INJ	-	NC
PLASMA KALLIKREIN INHIBITORS		
EKTERLY TAB (QL= 8 tabs/fill; Only available through Accredo 800-803-2523 or Optum 877-445-6874)	LD-PA-QL	B
ORLADEYO CAP (QL= 1 cap/day; Only available through CareMed 877-227-3405 or Onco360 877-662-6633)	LD-PA-QL	B
ORLADEYO PACK (QL= 1 packet/day; Only available through CareMed 877-227-3405 or Onco360 877-662-6633)	LD-PA-QL	B
TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
PLATELET AGGREGATION INHIBITORS		
CABLIVI INJ KIT (QL= 1 vial/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	B
anagrelide cap (AGRYLIN equiv)	-	G
aspirin/dipyridamole cap (AGGRENOX equiv)	-	G
cilostazol tab (PLETAL equiv)	-	G
clopidogrel tab 75mg (PLAVIX equiv)	-	G
dipyridamole tab (PERSANTINE equiv)	-	G
prasugrel tab (EFFIENT equiv)	-	G
ticagrelor tab (BRILINTA equiv)	-	G
ASPIRIN/OMEPRAZOLE ER TAB	-	NC
BRILINTA TAB	-	NC
CLOPIDOGREL THERAPY PACK	-	NC
PLAVIX TAB 300MG	-	NC
YOSPRALA TAB	-	NC
PREKALLIKREIN-DIRECTED ANTISENSE OLIGONUCLEOTIDES (ASO)		
DAWNZERA INJ (QL= 1 inj/28 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
PYRUVATE KINASE ACTIVATORS		
AQVESME TAB 100MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP (QL= 2 caps/day)	LMSP-PA-QL	B
CEREZYME INJ	MSP-PA	B
VPRIV INJ	MSP-PA	B
miglustat cap (ZAVESCA equiv) (QL= 3 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	G
ZAVESCA CAP	-	NC
AGENTS FOR SICKLE CELL ANEMIA		
DROXIA CAP	-	B
OXBRYTA TAB	-	NC
SIKLOS TAB	-	NC
AGENTS FOR SICKLE CELL DISEASE		
XROMI SOLN (Prior Authorization required for members age 9 years and older)	PA	B
l-glutamine powder packet (ENDARI equiv) (QL= 6 packets/day)	LMSP-PA-QL	G
ENDARI POWDER PACKET	-	NC
OXBRYTA TAB FOR ORAL SUSP	-	NC
COBALAMINS		
cyanocobalamin inj	-	G
cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv)	-	NC
NASCOBAL SPRAY	-	NC
FOLIC ACID/FOLATES		
folic acid tab 1mg ($0 copay for female members only; All other members covered at generic copay)	-	$0
folic acid tab 400mcg (Covered for female members only)	OTC	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
folic acid tab 800mcg (Covered for female members only)	OTC	$0
QUIOFIC SOLN	-	NC
HEMATOPOIETIC GROWTH FACTORS		
DOPTELET SPRINKLE CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
FULPHILA INJ	LMSP	B
NIVESTYM INJ	LMSP	B
NPLATE INJ	MSP-PA	B
NYVEPRIA INJ	LMSP	B
RETACRIT INJ	LMSP	B
ZARXIO INJ	LMSP	B
eltrombopag olamine powder pack for susp (PROMACTA equiv) (QL= 1 packet/day)	LMSP-PA-QL	G
eltrombopag olamine tab (PROMACTA equiv) (QL= 1 tab/day)	LMSP-PA-QL	G
eltrombopag olamine tab 50MG (PROMACTA equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G
eltrombopag olamine tab 75MG (PROMACTA equiv) (QL= 2 tabs/day)	LMSP-PA-QL	G
ALVAIZ TAB	-	NC
ARANESP INJ	-	NC
ARMLUPEG INJ	-	NC
FILKRI INJ	-	NC
FYLNETRA INJ	-	NC
GRANIX INJ	-	NC
LEUKINE INJ	-	NC
MULPLETA TAB	-	NC
NEULASTA INJ	-	NC
NEUPOGEN INJ	-	NC
NYPOZI INJ	-	NC
PROCRIT INJ	-	NC
PROMACTA POWDER	-	NC
PROMACTA TAB 12.5MG, 25MG	-	NC
RELEUKO INJ	-	NC
RELEUKO PREFILLED SYRINGE INJ	-	NC
STIMUFEND INJ	-	NC
UDENYCA INJ	-	NC
VAFSEO TAB	-	NC
ZIEXTENZO INJ	-	NC
HEMATOPOIETIC MIXTURES		
ICAR-C PLUS TAB 100-250-0.025-1 MG	-	B
NEPHRON FA TAB	-	B
FEROTRINSIC CAP	-	G
ferrex 150 forte cap	-	G
MULTIGEN FOLIC TAB	-	G
MULTIGEN PLUS TAB	-	G
MULTIGEN TAB	-	G
POLY-IRON CAP 150 FORTE	-	G
BENTIVITE TAB	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
BIFERARX TAB	-	NC
B-SERENE PAD	-	NC
CORVITA 150 TAB	-	NC
CYFOLEX CAP	-	NC
FEONYX TAB	-	NC
FERIVA 21/7 TAB	-	NC
FERRO-PLEX TAB	-	NC
folbee tab (FOLGARD RX equiv)	-	NC
FOLGARD RX TAB	-	NC
FOLITE TAB	-	NC
FOLVITE-FE TAB	-	NC
OVEEZA CAP	-	NC
PUREFOLIX TAB	-	NC
IRON		
ACCRUFER CAP	-	NC
ferrous sulfate elixir	OTC	NC
FERROUS SULFATE LIQUID	OTC	NC
ferrous sulfate soln	OTC	NC
STEM CELL MOBILIZERS		
MOZOBIL INJ	MSP-PA	B
plerixafor subcutaneous inj (MOZOBIL INJ equiv)	MSP-PA	B
XOLREMDI CAP (QL= 4 caps/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid soln (AMICAR equiv)	-	G
aminocaproic acid tab (AMICAR equiv)	-	G
tranexamic acid tab (LYSTEDA equiv)	-	G
HYPNOTICS		
NON-BARBITURATE HYPNOTICS		
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	G
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB	-	NC
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir	-	G
PHENOBARBITAL ELXIR	-	G
phenobarbital tab	-	G
PHENOBARBITAL TAB 100MG	-	NC
PHENOBARBITAL TAB 15MG	-	NC
PHENOBARBITAL TAB 16.2MG	-	NC
PHENOBARBITAL TAB 30MG	-	NC
PHENOBARBITAL TAB 32.4MG	-	NC
PHENOBARBITAL TAB 60MG	-	NC
PHENOBARBITAL TAB 64.8MG	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont.		
PHENOBARBITAL TAB 97.2MG	-	NC
HYPNOTICS - TRICYCLIC AGENTS		
doxepin tab (SILENOR equiv)	-	NC
NON-BARBITURATE HYPNOTICS		
estazolam tab (PROSOM equiv)	-	G
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	G
midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist)	RS	G
temazepam cap 15mg (RESTORIL equiv)	-	G
temazepam cap 22.5mg (RESTORIL equiv)	-	G
temazepam cap 30mg (RESTORIL equiv)	-	G
temazepam cap 7.5mg (RESTORIL equiv)	-	G
triazolam tab (HALCION equiv)	-	G
zaleplon cap (SONATA equiv) (QL= 1 cap/day)	QL	G
AMBIEN CR TAB	-	NC
EDLUAR SL TAB	-	NC
FLURAZEPAM CAP	-	NC
INTERMEZZO SL TAB	-	NC
QUAZEPAM TAB	-	NC
ZOLPIDEM CAP	-	NC
zolpidem ER tab (AMBIEN CR equiv)	-	NC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC
ZOLPIDEM TARTRATE SL TAB 1.75MG	-	NC
ZOLPIDEM TARTRATE SL TAB 3.5MG	-	NC
ZOLPIMIST SPRAY	-	NC
OREXIN RECEPTOR ANTAGONISTS		
DAYVIGO TAB	-	NC
QUVIVIQ TAB	-	NC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ramelteon tab (ROZEREM equiv) (QL= 1 tab/day)	PA-QL	G
HETLIOZ CAP	-	NC
HETLIOZ SUSP	-	NC
ROZEREM TAB	-	NC
tasimelteon cap (HETLIOZ equiv)	-	NC
LAXATIVES		
LAXATIVE COMBINATIONS		
GAVILYTE-C SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	$0
GOLYTELY SOLN (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay)	QL	$0
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	$0
peg 3350/electrolytes soln (COLYTE equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	$0
peg 3350/electrolytes soln (NULYTELY equiv) (QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay)	QL	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
LAXATIVES Cont.		
sodium/magnesium/potassium soln (SUPREP equiv) ($0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year)	QL	$0
PEG-PREP KIT	PA	B
SUFLAVE SOLN (QL= 2 fills/365 days)	QL	B
CLENPIQ SOLN	-	NC
MOVIPREP SOLN	-	NC
PLENVU SOLN	-	NC
SUPREP BOWEL PREP PACK	-	NC
SUTAB TAB	-	NC
LAXATIVES - MISCELLANEOUS		
lactulose soln	-	G
GIALAX KIT	-	NC
lactulose oral crystal packet	-	NC
SALINE LAXATIVES		
OSMOPREP TAB	-	NC
LOCAL ANESTHETICS-PARENTERAL		
LOCAL ANESTHETIC COMBINATIONS		
ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC
MACROLIDES		
AZITHROMYCIN		
ZITHROMAX POWDER PACK	-	B
azithromycin susp (ZITHROMAX equiv)	-	G
azithromycin tab (ZITHROMAX equiv)	-	G
CLARITHROMYCIN		
CLARITHROMYC SUSP	-	B
clarithromycin tab (BIAXIN equiv)	-	G
clarithromycin ER tab (BIAXIN XL equiv)	-	NC
ERYTHROMYCINS		
ERYTHROMYCIN CAP DR (Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	B
ERYTHROMYCIN EC CAP (Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	B
erythromycin DR cap (Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	G
erythromycin ethylsuccinate susp (ERYPED equiv) (Step Therapy requires trial of azithromycin or clarithromycin)	ST	G
erythromycin tab (ERY-TAB equiv) (Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg)	ST	G
erythromycin tab (ERYTHROMYCIN equiv) (Step Therapy require trial of azithromycin, clarithromycin, or doycycline hyclate 100mg)	ST	G
E.E.S. TAB	-	NC
ERYPED SUSP	-	NC
erythromycin ethylsuccinate tab (E.E.S. equiv)	-	NC
FIDAXOMICIN		
DIFICID SUSP (QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	B
fidaxomicin tab (DIFICID equiv) (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution)	QL-ST	G
DIFICID TAB	-	NC
MEDICAL DEVICES AND SUPPLIES		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

MEDICAL DEVICES AND SUPPLIES Cont.

DrugName	Special Code	Tier
CONTRACEPTIVES		
CERVICAL CAP	-	$0
DIAPHRAGM	-	$0
FEMALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	$0
MALE CONDOMS (QL= 12 condoms/fill)	OTC-QL	$0
DIABETIC SUPPLIES		
ACCU-CHEK GUIDE CARE METER	OTC	$0
ACCU-CHEK GUIDE ME KIT	OTC	$0
FREESTYLE FREEDOM LITE METER	OTC	$0
FREESTYLE LITE METER	OTC	$0
FREESTYLE PRECISION NEO METER	OTC	$0
PRECISION XTRA METER	OTC	$0
OMNIPOD 5 DEX G7G6 INTRO KIT (QL= 1 kit/year)	QL	B
OMNIPOD 5 DEX G7G6 PODS (QL= 10 pods/month)	QL	B
OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year)	QL	B
OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days)	QL	B
OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT (QL= 1 kit/year)	QL	B
OMNIPOD 5 LIBRE2 PLUS G6 PODS (QL= 10 pods/30 days)	QL	B
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	B
OMNIPOD DASH INTRO KIT (QL= 1 kit/year)	QL	B
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	B
OMNIPOD GO KIT (QL= 10 pods/month)	QL	B
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	B
TEMPO SMART BUTTON (QL= 1 button/8 months)	QL	B
TWIIST REFILL KIT (QL= 1 kit/month)	QL	B
TWIIST STARTER KIT (QL= 1 kit/month)	QL	B
CALIBRATION LIQUID	OTC	G
DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G6 SENSOR (QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
DEXCOM G7 SENSOR (15-DAY) (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MEDICAL DEVICES AND SUPPLIES Cont.		
FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE 3-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin)	QL-ST	G
LANCET KIT	OTC	G
LANCETS	OTC	G
DIABETIC METER (all other diabetic meters)	OTC	NC
MINT REFILL KIT	-	NC
MINT STARTER KIT	-	NC
OMNIPOD DASH PDM KIT	-	NC
PIVOT INSULIN PUMP STARTER KIT	-	NC
PIVOT SUPPLY KIT	-	NC
V-GO INJ KIT	-	NC
MISC. DEVICES		
ALCOHOL SWABS	OTC	NC
ORAL HYGIENE PRODUCTS		
HURRISEAL MIS SNAP	-	NC
PARENTERAL THERAPY SUPPLIES		
LASIX ONYU REUSABLE UNIT (QL= 1 device/year)	QL	B
NOVOPEN ECHO	-	B
B-D INSULIN SYRINGE	--OTC	G
B-D PEN NEEDLE	OTC	G
EMBECTA INSULIN SYRINGE	--OTC	G
EMBECTA PEN NEEDLE	OTC	G
NOVOFINE PEN NEEDLE	OTC	G
CEQUR SIMPLICITY	-	NC
INPEN INSULIN INJECTION DEVICE	-	NC
INSULIN SYRINGE	OTC	NC
PEN NEEDLE	OTC	NC
RESPIRATORY THERAPY SUPPLIES		
AEROCHAMBER	OTC	B
PEAK FLOW METER	OTC	G
MIGRAINE PRODUCTS		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	B
ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days)	PA-QL	B
NURTEC ODT	-	NC
QULIPTA TAB	-	NC
MIGRAINE COMBINATIONS		
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB	-	NC
CAFERGOT TAB, ERGOTAMINE/CAFFEINE TAB 1-100MG	-	NC
MIGERGOT SUPP	-	NC
PRODRIN TAB	-	NC
SUMANSETRON PAK	-	NC
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC
SYMBRAVO TAB	-	NC
TREXIMET TAB	-	NC
MIGRAINE PRODUCTS		
dihydroergotamine mesylate nasal spray (MIGRANAL equiv) (QL= 8 sprays/fill, 2 fills/30 days)	PA-QL	G
BREKIYA INJ	-	NC
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC
ERGOMAR SL TAB	-	NC
TRUDHESA NASAL SPRAY	-	NC
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES		
AIMOVIG INJ (QL= 1 pack/28 days)	PA-QL	B
AJOVY INJ (QL= 1 pack/28 days)	PA-QL	B
EMGALITY INJ (QL= 1 inj/28 days)	PA-QL	B
EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year)	PA-QL	B
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POWDER	-	NC
diclofenac potassium (migraine) packet (CAMBIA equiv)	-	NC
ELYXYB SOLN	-	NC
SEROTONIN AGONISTS		
REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B
ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B
ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	B
naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G
rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G
sumatriptan inj (IMITREX equiv) (QL= 6 inj/fill, 3 fills/30 days)	QL	G
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 3 fills/30 days)	QL	G
sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G
sumatriptan vial inj (IMITREX equiv) (QL= 10 vials/fill, 2 fills/30 days)	QL	G
zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray)	QL-ST	G
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days; Step Therapy Requires trial of the following sumatriptan, naratriptan, rizatriptan and zolmitriptan)	QL-ST	G
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	QL	G
almotriptan tab (AXERT equiv)	-	NC
AXERT TAB	-	NC
eletriptan tab (RELPAX equiv)	-	NC
FROVA TAB	-	NC
frovatriptan tab (FROVA equiv)	-	NC
IMITREX 4MG INJ, ZEMBRACE INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
IMITREX INJ	-	NC
IMITREX TAB	-	NC
MAXALT MLT TAB	-	NC
MAXALT TAB	-	NC
ONZETRA XSAIL	-	NC
RELPAX TAB	-	NC
RIZAFILM MIS	-	NC
SUMAVEL DOSEPRO INJ	-	NC
TOSYMRA SOLN	-	NC
ZECUITY PAD	-	NC
ZOMIG TAB	-	NC
MINERALS & ELECTROLYTES		
FLUORIDE		
FLUORABON SOLN ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	$0
FLUORIDE CHW 0.25MG ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0
sodium fluoride chew tab (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0
sodium fluoride soln (LURIDE equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0
SODIUM FLUORIDE TAB ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0
PHOSPHATE		
K-PHOS NEUTRAL TAB 155-852-130MG	-	B
K-PHOS TAB	-	B
PHOSPHA 250 NEUTRAL TAB	-	G
PHOSPHO-TRIN K500 TAB	-	G
POTASSIUM		
EFFER-K TAB	-	G
K-TAB	-	G
potassium bicarbonate effer tab (K-LYTE equiv)	-	G
potassium chloride ER cap (MICRO-K equiv)	-	G
potassium chloride ER tab (K-TAB equiv)	-	G
potassium chloride micro tab (K-DUR equiv)	-	G
potassium chloride powder packet (KLOR-CON equiv)	-	G
potassium chloride soln	-	G
POTASSIUM CHLORIDE TAB ER	-	G
POKONZA ORAL SOLN	-	NC
POKONZA POWDER	-	NC
TRACE MINERALS		
ZYCUBO INJ	-	NC
ZINC		
zinc gluconate tab	OTC	G
GALZIN CAP	-	NC
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MISCELLANEOUS THERAPEUTIC CLASSES Cont.		
penicillamine tab (DEPEN TITRATAB equiv)	-	G
trientine cap (SYPRINE equiv)	LMSP-PA	G
CUVRIOR TAB	-	NC
penicillamine cap (CUPRIMINE equiv)	-	NC
TRIENTINE CAP	-	NC
IMMUNOMODULATORS		
JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553)	LD-PA-QL	B
VYVGART HYTRULO INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	G
REVLIMID CAP	-	NC
RHAPSIDO TAB	-	NC
IMMUNOSUPPRESSIVE AGENTS		
ENSPRYNG INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
everolimus tab (ZORTRESS equiv)	PA	G
sirolimus soln (RAPAMUNE equiv)	-	G
ASTAGRAF XL CAP	-	NC
azathioprine tab 100mg (AZASAN equiv)	-	NC
azathioprine tab 75mg (AZASAN equiv)	-	NC
MYHIBBIN SUSP	-	NC
PROGRAF PACKET	-	NC
tacrolimus cap er (ASTAGRAF XL equiv)	-	NC
PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS		
VIJOICE GRANULES PACKET (QL= 1 packet/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
VIJOICE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
VIJOICE TAB 250MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
POTASSIUM REMOVING AGENTS		
LOKELMA PAK (QL= 1 packet/day)	PA-QL	B
VELTASSA POWDER 1GM (QL= 4 packets/day)	PA-QL	B
LOKELMA PAK 10GM	-	NC
LOKELMA PAK 5GM	-	NC
SPS	-	NC
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day)	LMSP-PA-QL	B
BENLYSTA INJ (QL= 4 inj/28 day)	LMSP-PA-QL	B
SAPHNELO INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
SAPHNELO PEN INJ (QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
FIRST MOUTHWASH BLM	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv)	-	G
LIDOCAINE ORAL SOLN	-	NC
ANTI-INFECTIVES - THROAT		
clotrimazole troches (MYCELEX TROCHES equiv)	-	G
nystatin susp	-	G
NYSTATIN SUSP	-	NC
ORAVIG TAB	-	NC
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	G
DENTAL PRODUCTS		
DENTA 5000 CREAM PLUS ($0 copay for members age 5 years and younger; All other members covered at preferred brand copay)	-	$0
sodium fluoride cream (PREVIDENT equiv) ($0 copay for members age 5 years and younger; All other members covered at generic copay)	-	$0
PREVIDENT 5000 PASTE 1.1%	-	B
PREVIDENT GEL	-	B
PREVIDENT SOLN 0.2%	-	B
FLUORIDEX SENSITIVITY PASTE	-	G
SODIUM FLUORIDE GEL	-	G
SODIUM FLUORIDE PASTE	-	G
SODIUM FLUORIDE SOLN	-	G
FRAICHE 5000 SENSITIVE GEL	-	NC
STEROIDS - MOUTH/THROAT		
triamcinolone in orabase paste (KENALOG/ORABASE equiv)	-	G
THROAT PRODUCTS - MISC.		
GELCLAIR GEL	-	B
cevimeline cap (EVOXAC equiv)	-	G
pilocarpine tab (SALAGEN equiv)	-	G
PROTHELIAL PASTE	-	NC
SILATRIX GEL	-	NC
MULTIVITAMINS		
B-COMPLEX VITAMINS		
EB-N3 DR CAP	-	NC
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	G
DIALYVITE/ZINC TAB	-	G
FOLBEE PLUS CZ TAB	-	G
ACTIVITE TAB	-	NC
dialyvite tab (NEPHRO-VITE equiv)	-	NC
FIBRIK CAP	-	NC
MYNEPHRON CAP	-	NC
renaphro cap (NEPHROCAP equiv)	-	NC
TERAVAX CAP	-	NC
MULTIPLE VITAMINS W/ MINERALS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
multivitamin/minerals tab (STROVITE equiv)	-	NC
V-C FORTE CAP	-	NC
v-c forte cap (V-C FORTE equiv)	-	NC
MULTIVITAMINS		
FOLIKA-V TAB	-	NC
PED MULTI VITAMINS W/FL & FE		
MULTIPLE-VITAMIN/FL-FE DROPS	-	NC
pediatric multiple vitamins/fluoride/iron soln	-	NC
PED MV W/ FLUORIDE		
FLORIVA PLUS DROPS	-	NC
MULTIVITAMIN CHEW TAB	-	NC
pediatric multiple vitamins/fluoride soln	-	NC
POLY-VI-FLOR SUSP	-	NC
TRI-VITAMIN FLUORIDE DROPS	-	NC
PEDIATRIC MULTIPLE VITAMINS & MINERALS W/ FLUORIDE		
FLORIVA CHEW TAB	-	NC
PRENATAL VITAMINS		
NEONATAL 19 TAB	-	B
NEONATAL FE TAB	-	B
PRENATAL VITAMINS (NON-PREFERRED)	-	B
VITAFOL STRIPS	-	B
COMPLETE NATAL DHA	-	G
CONCEPT DHA CAP	-	G
PRENATA	-	G
PRENATABS RX TAB	-	G
PRENATAL 19 CHEW TAB	-	G
PRENATAL 19 TAB	-	G
PRENATAL FORMULA, PRENATAL MULTI + DHA	-	G
PRENATAL MULTIVITAMIN + D	-	G
PRENATAL PLUS IRON	-	G
VINATE II	-	G
VP-PNV-DHA CAP	-	G
ACTIVE OB	-	NC
AZESCHEW TAB	-	NC
AZESCO TAB	-	NC
CITRANATAL 90 DHA, CITRANATAL ASSURE	-	NC
CITRANATAL B CALM	-	NC
CITRANATAL BLOOM	-	NC
CITRANATAL CAP MEDLEY	-	NC
CITRANATAL HARMONY	-	NC
CITRANATAL RX	-	NC
DUET	-	NC
DUET DHA 400, DUET DHA BALANCED	-	NC
ENBRACE HR	-	NC
FOLET ONE	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
JENLIVA CAP	-	NC
MATERVIA CAP	-	NC
MATRONEX TAB 27-1 MG	-	NC
MULTI-MAC TAB	-	NC
MYNATAL-Z TAB	-	NC
NATACHEW	-	NC
NEEVO DHA	-	NC
NESTABS DHA	-	NC
NESTABS ONE	-	NC
NUTRICHEW CHEW 29-1 MG	-	NC
OB COMPLETE ONE	-	NC
OB COMPLETE PETITE	-	NC
OB COMPLETE PREMIER	-	NC
PNV PRENATOL TAB 27-1 MG	-	NC
PREGEN DHA CAP	-	NC
PREGENNA TAB	-	NC
PRENA1 CHEW	-	NC
PRENA1 PEARL, VITAPEARL	-	NC
PRENA1 TRUE, VITATRUE	-	NC
PRENACHEW CHEW	-	NC
PRENARA CAP	-	NC
PRENATE AM	-	NC
PRENATE CHEWABLE	-	NC
PRENATE DHA	-	NC
PRENATE ELITE	-	NC
PRENATE ESSENTIAL	-	NC
PRENATE MAX TAB	-	NC
PRENATE MINI	-	NC
PRENATE MINI, TRISTART DHA	-	NC
PRENATE TAB	-	NC
PRENATOL-M TAB 27-1.2MG	-	NC
PRENATRIX TAB	-	NC
PRENATRYL TAB	-	NC
PRIMACARE	-	NC
PROVIDA OB	-	NC
RELEVIA TAB 27-1MG	-	NC
SELECT OB + DHA	-	NC
THRIVITE RX	-	NC
VITAFOL GUMMIES	-	NC
VITAFOL OB	-	NC
VITAFOL ULTRA	-	NC
VITAFOL-OB + DHA	-	NC
VITAFOL-ONE, VITAFOL FE+	-	NC

MUSCULOSKELETAL THERAPY AGENTS

CENTRAL MUSCLE RELAXANTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
BACLOFEN ORAL SOLN 10MG/5ML (Prior Authorization required for members age 9 years and older)	PA	B
LYVISPAH GRANULE PACKET (Prior Authorization required for members age 9 years and older)	PA	B
baclofen oral soln 10mg/5ml (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older)	PA	G
baclofen oral soln 5mg/5ml (Prior Authorization required for members age 9 years and older)	PA	G
baclofen susp (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older)	PA	G
baclofen tab (BACLOFEN equiv)	-	G
carisoprodol tab (SOMA equiv) (QL= 90 tabs/90 days)	QL	G
chlorzoxazone tab 500mg	-	G
cyclobenzaprine tab (FLEXERIL equiv)	-	G
methocarbamol tab (ROBAXIN equiv)	-	G
orphenadrine citrate ER tab (NORFLEX equiv)	-	G
tizanidine cap (ZANAFLEX equiv)	-	G
tizanidine tab (ZANAFLEX equiv)	-	G
ATMEKSI SUSP	-	NC
BACLOFEN ORAL SOLN 5 MG/5ML	-	NC
baclofen tab 15mg	-	NC
carisoprodol tab 250mg (SOMA equiv)	-	NC
chlorzoxazone tab	-	NC
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC
CYCLOBENZAPRINE COMPOUND KIT	-	NC
cyclobenzaprine ER cap (AMRIX equiv)	-	NC
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	NC
METAXALONE TAB	-	NC
metaxalone tab (SKELAXIN equiv)	-	NC
methocarbamol tab 1000mg (ROBAXIN equiv)	-	NC
ONTRALFY ORAL SOLN	-	NC
SOMA TAB 250MG	-	NC
ZANAFLEX CAP	-	NC
DIRECT MUSCLE RELAXANTS		
dantrolene cap (DANTRIUM equiv)	-	G
FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS		
SOHONOS CAP 1.5MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
SOHONOS CAP 10MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
SOHONOS CAP 1MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
SOHONOS CAP 2.5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
SOHONOS CAP 5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828)	LD-PA-QL	B
ATEBRIOZ TAB	-	NC
MUSCLE RELAXANT COMBINATIONS		
CARISOPRODOL/ASPIRIN TAB	-	NC
carisoprodol/aspirin tab (SOMA COMPOUND equiv)	-	NC
CARISOPRODOL/ASPIRIN/CODEINE TAB	-	NC
carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv)	-	NC
LORVATUS PHARMAPAK KIT	-	NC
NORGESIC TAB FORTE	-	NC
TIZANIDINE COMFORT KIT	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
MUSCULOSKELETAL THERAPY AGENTS Cont.		
VISCOSUPPLEMENTS		
DUROLANE INJ	LMSP-PA	B
GENVISC 850 INJ	-	NC
HYALGAN INJ	-	NC
HYMOVIS INJ	-	NC
ORTHOVISC/MONOVISC INJ	-	NC
SODIUM HYALU INJ	-	NC
TRIVISC INJ	-	NC
VISCO-3 INJ	-	NC
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
azelastine/fluticasone nasal spray (DYMISTA equiv)	-	NC
AZENASE PAK	-	NC
RYALTRIS SPRAY	-	NC
NASAL AGENTS - MISC.		
ALZAIR NASAL SPRAY	-	NC
TICANASE PAK	-	NC
NASAL ANESTHETICS		
COCAINE HCL SOLN	-	NC
NASAL ANTIALLERGY		
ASTEPRO NASAL SPRAY (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	B
azelastine nasal spray 0.1% (ASTELIN equiv)	-	G
azelastine nasal spray 0.15% (ASTEPRO equiv) (Step therapy requires trial of azelastine nasal spray 0.1%)	ST	G
olopatadine nasal spray (PATANASE equiv)	-	NC
NASAL ANTICHOLINERGICS		
ipratropium nasal spray (ATROVENT equiv)	-	G
NASAL STEROIDS		
BECONASE AQ NASAL SPRAY	-	EXC
budesonide nasal spray (RHINOCORT AQUA equiv)	OTC	EXC
FLONASE SENSIMIST NASAL SPRAY	OTC	EXC
fluticasone nasal spray (FLONASE equiv)	-	EXC
OMNARIS NASAL SPRAY	-	EXC
QNASL NASAL SPRAY	-	EXC
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	EXC
XHANCE NASAL EXHALER	-	EXC
flunisolide nasal soln (QL= 2 bottles/fill)	QL	G
mometasone nasal spray (NASONEX equiv) (QL= 2 bottles/fill)	QL	G
SYMPATHOMIMETIC DECONGESTANTS		
ADRENALIN SOLN	-	NC
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC
NEUROMUSCULAR AGENTS		
ALS AGENTS		
RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B
RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
NEUROMUSCULAR AGENTS Cont.		
riluzole tab (RILUTEK equiv)	-	G
TIGLUTIK SUSP	-	NC
FRIEDRICH'S ATAXIA AGENTS		
SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
MUSCULAR DYSTROPHY AGENTS		
DUVYZAT ORAL SUSP	-	NC
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS		
BOTOX INJ	MSP-PA	B
DYSPORT INJ	MSP-PA	B
XEOMIN INJ	MSP-PA	B
RETT SYNDROME AGENTS		
DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B
DAYBUE STIX POWDER (QL= 4 packets/day; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B
DAYBUE STIX POWDER 8000MG (QL= 2 packets/day; Only available through AnovoRx 844-288-5007)	LD-PA-QL	B
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
EVRYSDI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
NUTRIENTS		
LIPIDS		
DOJOLVI ORAL LIQUID	-	NC
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT OPHTH INSERT	-	NC
BETA-BLOCKERS - OPHTHALMIC		
BETIMOL OPHTH SOLN 0.25%	-	B
BETOPTIC-S OPHTH SOLN	-	B
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	B
ISTALOL OPHTH SOLN	-	B
BETAXOLOL OPHTH SOLN	-	G
betaxolol ophth soln (BETOPTIC-S equiv)	-	G
brimonidine/timolol ophth soln (COMBIGAN OPHTH SOLN equiv)	-	G
CARTEOLOL OPHTH SOLN	-	G
carteolol ophth soln (OCUPRESS equiv)	-	G
dorzolamide/timolol (pf) ophth soln (COSOPT equiv)	-	G
LEVOBUNOLOL OPHTH SOLN	-	G
levobunolol ophth soln (BETAGAN equiv)	-	G
timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv)	-	G
timolol maleate ophth gel (TIMOPTIC-XE equiv)	-	G
timolol maleate ophth soln (TIMOPTIC equiv)	-	G
timolol maleate ophth soln 0.5% (ISTALOL equiv)	-	G
timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv)	-	G
timolol ophth soln (BETIMOL equiv)	-	G
COMBIGAN OPHTH SOLN	-	NC
CHOLINERGIC AGONISTS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
TYRVAYA NASAL SPRAY (QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist; Step Therapy Requires trial of cyclosporine opth emulsion)	QL-RS-ST	B
CYCLOPLEGIC MYDRIATICS		
CYCLOGYL OPHTH SOLN	-	B
CYCLOMYDRIL OPHTH SOLN	-	B
HOMATROPINE OPHTH SOLN	-	B
ALTAFRIN OPHTH SOLN	-	G
atropine ophth oint	-	G
atropine ophth soln (ISOPTO ATROPINE equiv)	-	G
ATROPINE SUL SOLN 1% OPHTH	-	G
ATROPINE SULFATE OPHTH OINT	-	G
cyclopentolate ophth soln (CYCLOGYL equiv)	-	G
phenylephrine ophth soln (MYDFRIN equiv)	-	G
tropicamide ophth soln (MYDRIACYL equiv)	-	G
MYDCOMBI OPHTH SOLN	-	NC
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC
MIOTICS		
QLOSI OPHTH SOLN, VUITY OPHTH SOLN	-	EXC
VIZZ OPHTH SOLN	-	EXC
VUITY OPHTH SOLN 1.25%	-	EXC
YUVEZZI SOLN	-	EXC
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	G
PHOSPHOLINE OPHTH SOLN	-	NC
OPHTHALMIC - ANGIOGENESIS INHIBITORS		
LUCENTIS INJ	MSP-PA	B
OPHTHALMIC ADRENERGIC AGENTS		
APRACLONIDINE OPHTH SOLN	-	B
IOPIDINE OPHTH SOLN	-	B
SIMBRINZA OPHTH SUSP	-	B
apraclonidine ophth soln (IOPIDINE equiv)	-	G
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	G
brimonidine ophth soln 0.2%	-	G
brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv)	-	G
ALPHAGAN P OPHTH SOLN 0.15%	-	NC
OPHTHALMIC ANTI-INFECTIVES		
AZASITE SOLN	-	B
BACITRACIN OPHTH OINT	-	B
CILOXAN OPHTH OINT	-	B
NATACYN OPHTH SUSP (QL= 15ml/fill)	QL	B
TOBREX OPHTH OINT	-	B
XDEMVY DROP (QL= 1 bottle/42 days; Only available through CVS Specialty 800-238-7828 or Walgreens 888-347-3416)	LD-PA-QL	B
ZIRGAN OPHTH GEL	-	B
BACIT/POLYMY OPHTH OINT	-	G
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	G
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ciprofloxacin ophth soln (CILOXAN equiv)	-	G
erythromycin ophth oint	-	G
gatifloxacin ophth soln (ZYMAXID equiv)	-	G
GENTAK OPHTH OINT	-	G
gentamicin ophth soln (GARAMYCIN equiv)	-	G
levofloxacin ophth soln (QUIXIN equiv)	-	G
LEVOFLOXACIN OPHTH SOLN 0.5%	-	G
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	G
NEO/BAC/POLY OPHTH OINT	-	G
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	G
ofloxacin ophth soln (OCUFLOX equiv)	-	G
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	G
SULFACETAMIDE SOD OPHTH SOLN	-	G
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	G
tobramycin ophth soln (TOBREX equiv)	-	G
TRIFLURIDINE OPHTH SOLN	-	G
BESIFLOXACIN OPHTH SUSP, BESIVANCE OPHTH SUSP	-	NC
ERYTHROMYCIN OPHTH OINT	-	NC
LEVOFLOXACIN OPHTH SOLN	-	NC
MOXEZA OPHTH SOLN 0.5%	-	NC
MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOLN	-	NC
MOXIFLOXACIN SOLN	-	NC
VIGAMOX OPHTH SOLN	-	NC
OPHTHALMIC IMMUNOMODULATORS		
CEQUA OPHTH SOLN (Restricted to Ophthalmology or Optometry Specialist; Step Therapy requires trial of cyclosporine ophth emulsion)	QL-RS-ST	B
cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days)	PA-QL	G
CYCLOSPORINE OPHTH EMULSION 0.1%	-	NC
RESTASIS OPHTH EMULSION	-	NC
VEVYE OPHTH SOLN	-	NC
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA OPHTH SOLN	-	NC
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA OPHTH SOLN	-	NC
ROCKLATAN OPHTH SOLN	-	NC
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	G
tetracaine hcl ophth soln	-	G
TETRACAINE OPHTH SOLN	-	G
IHEEZO GEL	-	NC
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	B
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA OP KIT	-	NC
PHOTREXA VISCOUS OPHTH SOLN	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

OPHTHALMIC AGENTS Cont.

DrugName	Special Code	Tier
OPHTHALMIC STEROIDS		
ALREX OPHTH SUSP	-	B
ALREX OPHTH SUSP 0.2%	-	B
FLAREX OPHTH SUSP	-	B
FML FORTE OPHTH SUSP	-	B
LOTEMAX OPHTH OINT	-	B
MAXIDEX OPHTH SOLN	-	B
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	B
PRED FORTE OPHTH SUSP	-	B
PRED MILD OPHTH SOLN	-	B
TOBRADEX OPHTH OINT	-	B
TOBRADEX ST OPHTH SUSP	-	B
difluprednate ophth emulsion (DUREZOL equiv)	-	G
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	G
loteprednol etabonate ophth gel (LOTEMAX equiv)	-	G
loteprednol ophth susp (LOTEMAX, ALREX equiv)	-	G
NEO/POLY/BAC/HC OPHTH OINT	-	G
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	G
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	G
prednisolone acetate ophth susp (PRED FORTE equiv)	-	G
PREDNISOLONE OPHTH SUSP	-	G
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	G
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	G
tobramycin/dexamethasone ophth soln (TOBRADEX equiv)	-	G
BYQLOVI OPHTH SUSP	-	NC
BYQLOVI SUSP	-	NC
DEXTENZA OPHTH INSERT	-	NC
EYSUVIS OPHTH SUSP	-	NC
INVELTYS OPHTH SUSP	-	NC
KLARITY-B DROPS	-	NC
KLARITY-L DROPS	-	NC
LOTEMAX SM GEL 0.38%	-	NC
loteprednol etabonate-tobramycin ophth susp (ZYLET equiv)	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP	-	NC
PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN	-	NC
PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP	-	NC
PREDNISOLONE/NEPAFENAC OPHTH SUSP	-	NC
ZYLET OPHTH SUSP	-	NC
OPHTHALMIC SURGICAL AIDS		
DUOVISC KIT	-	NC
OPHTHALMICS - MISC.		
ACULAR (LS) OPHTH SOLN 0.4%	-	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
ACUVAIL OPHTH SOLN	-	B
AZOPT OPHTH SUSP	-	B
CYSTADROPS SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-QL-RS	B
CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B
ILEVRO OPHTH SUSP	-	B
NEVANAC OPHTH SUSP	-	B
olopatadine hcl ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days)	OTC-QL	B
UPNEEQ SOLN	-	EXC
azelastine ophth soln (OPTIVAR equiv)	-	G
brinzolamide ophth susp (AZOPT equiv)	-	G
bromfenac ophth soln (BROMDAY equiv)	-	G
cromolyn ophth soln (CROLOM equiv)	-	G
CROMOLYN SODIUM OPHTH SOLN	-	G
diclofenac sodium ophth soln (VOLTAREN equiv)	-	G
dorzolamide ophth soln (TRUSOPT equiv)	-	G
epinastine ophth soln (ELESTAT equiv)	-	G
ketorolac ophth soln (ACULAR (LS) equiv)	-	G
KETOROLAC TROMETHAMINE OPHTH SOLN	-	G
ALOCRIL OPHTH SOLN	-	NC
bepotastine ophth soln (BEPREVE equiv)	-	NC
FLURBIPROFEN OPHTH SOLN	-	NC
MIEBO OPHTH SOLN	-	NC
olopatadine ophth soln (PATANOL equiv)	-	NC
OMLONTI OPHTH SOLN	-	NC
PROLENSA OPHTH SOLN	-	NC
TRYPTYR SOLN	-	NC
ZERVIATE OPHTH SOLN	-	NC
PROSTAGLANDINS - OPHTHALMIC		
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	G
travoprost ophth soln (TRAVATAN Z equiv) (QL= 5ml/30 days; Step Therapy requires trial of latanoprost)	QL-ST	G
BIMATOPROST OPHTH SOLN	-	NC
bimatoprost ophth soln (LUMIGAN equiv)	-	NC
IYUZEH OPHTH DROPS	-	NC
LUMIGAN OPHTH SOLN	-	NC
tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv)	-	NC
VYZULTA SOLN	-	NC
XELPROS OPHTH EMULSION	-	NC
ZIOPTAN OPHTH SOLN	-	NC
ZOLYMBUS OPHTH GEL	-	NC
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	G
OTIC ANTIFUNGALS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
OTIC AGENTS Cont.		
CLOTIC SOLN	-	NC
OTIC ANTI-INFECTIVES		
ciprofloxacin hcl otic soln (CETRAXAL equiv)	-	G
ofloxacin otic soln (FLOXIN equiv)	-	G
XTORO OTIC SUSP	-	NC
OTIC COMBINATIONS		
CIPRO HC OTIC SUSP (Step Therapy requires trial of CIPRODEX)	ST	B
COLY-MYCIN S OTIC SUSP	-	B
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	G
ciprofloxacin-hydrocortisone otic susp (CIPRO HC equiv) (Step Therapy requires trial of CIPRODEX)	ST	G
neomycin/polymixin/hydrocoritisone otic soln (CORTISPORIN equiv)	-	G
neomycin/polymixin/hydrocoritisone otic susp (CORTISPORIN equiv)	-	G
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC
CORTANE-B OTIC SOLN	-	NC
CORTIC-ND DROPS	-	NC
otomax-HC otic soln (CORTANE-B equiv)	-	NC
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC
OTIC STEROIDS		
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	G
fluocinolone otic oil (DERMOTIC equiv)	-	G
OXYTOCICS		
ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
MPM PAK	-	NC
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	G
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
CARIMUNE INJ	MSP-PA	B
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	MSP-PA	B
GAMUNEX INJ	MSP-PA	B
HIZENTRA INJ	MSP-PA	B
CUVITRU INJ	-	NC
PASSIVE IMMUNIZING AGENTS - COMBINATIONS		
HYQVIA INJ	MSP-PA	B
PASSIVE IMMUNIZING AND TREATMENT AGENTS		
IMMUNE SERUMS		
GAMASTAN S/D INJ	MSP-PA	B
HIZENTRA INJ	MSP-PA	B
XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
CUTAQUIG INJ	-	NC
MONOCLONAL ANTIBODIES		
BEYFORTUS INJ	VAC	$0
ENFLONSIA INJ	VAC	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PENICILLINS		
AMIDINOPENICILLINS		
PIVYA TAB	-	NC
AMINOPENICILLINS		
amoxicillin cap (TRIMOX equiv)	-	G
AMOXICILLIN CHEW	-	G
amoxicillin susp (TRIMOX equiv)	-	G
amoxicillin tab (AMOXIL equiv)	-	G
ampicillin cap (AMPICILLIN equiv)	-	G
MOXATAG TAB	-	NC
MOXATAG TAB 775MG	-	NC
NATURAL PENICILLINS		
penicillin vk tab (VEETIDS equiv)	-	G
PENICILLN VK SOLN	-	G
PENICILLN VK SOLN 125MG/5ML	-	NC
PENICILLN VK SOLN 250MG/5ML	-	NC
PENICILLIN COMBINATIONS		
AMOXICILLIN/CLAVULANATE CHEW TAB	-	B
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	G
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	G
amoxicillin/k clavulanate er tab (AMOXICILLIN/CLAVULANATE equiv)	-	G
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	G
PHARMACEUTICAL ADJUVANTS		
LIQUID VEHICLES		
TRICHOSOL SOLN	-	NC
SEMI SOLID VEHICLES		
POLYETHYLENE GLYCOL 8000 GRANULES	-	B
VERSAPENN AL GEL ANHYDROU	-	NC
PROGESTINS		
PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	G
megestrol ES susp (MEGACE ES equiv)	-	G
MEGESTROL SUSP	-	G
norethindrone tab (AYGESTIN equiv)	-	G
progesterone cap (PROMETRIUM equiv)	-	G
progesterone oil inj	-	G
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
LUCEMYRA TAB (QL= 96 tabs/7 days)	PA-QL	B
acamprosate calcium DR tab (CAMPRAL equiv)	-	G
disulfiram tab (ANTABUSE equiv)	-	G
lofexidine hcl tab (LUCEMYRA equiv) (QL= 96 tabs/7 days)	PA-QL	G
disulfiram tab 500mg	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer

generic = small letters

BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
ANTI-CATAPLECTIC AGENTS		
SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688)	LD-PA-QL	B
sodium oxybate oral soln (XYREM equiv) (QL= 540ml/30 days)	LMSP-PA-QL	G
LUMRYZ PACK	-	NC
LUMRYZ STARTER PACK	-	NC
XYREM SOLN	-	NC
XYWAV SOLN	-	NC
ANTIDEMENTIA AGENTS		
LEQEMBI IQLIK INJ 250MG/1.25ML (QL= 8 inj/28 days; Only available through Caremed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	B
LEQEMBI IQLK INJ (QL= 4 inj/28 days; Only available through CareMed 877-227-3405 or Walgreens 888-347-3416)	LD-PA-QL	B
donepezil ODT (ARICEPT equiv) (QL= 1 tab/day)	QL	G
donepezil tab (ARICEPT equiv) (QL= 2 tabs/day)	QL	G
donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day)	QL	G
galantamine ER cap (RAZADYNE ER equiv)	-	G
GALANTAMINE SOLN	-	G
galantamine tab (RAZADYNE equiv)	-	G
memantine soln (NAMENDA equiv)	-	G
memantine tab (NAMENDA equiv)	-	G
MEMANTINE TITRATION PAK	-	G
rivastigmine cap (EXELON equiv)	-	G
rivastigmine patch (EXELON equiv)	-	G
ADLARITY PATCH	-	NC
memantine ER cap (NAMENDA XR equiv)	-	NC
memantine hcl-donepezil hcl 24hr er cap (NAMZARIC equiv)	-	NC
NAMENDA XR CAP	-	NC
NAMENDA XR TITRATION PACK	-	NC
NAMZARIC CAP	-	NC
NAMZARIC STARTER PACK	-	NC
ZUNVEYL TAB	-	NC
COMBINATION PSYCHOTHERAPEUTICS		
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	G
PERPHENAZINE/ AMITRIPTYLINE TAB	-	G
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	NC
DULOXICAINE PACK	-	NC
LYBALVI TAB	-	NC
FIBROMYALGIA AGENTS		
SAVELLA PAK	-	B
SAVELLA TAB (QL= 2 tabs/day)	QL	B
milnacipran hcl tab (SAVELLA equiv) (QL= 2 tabs/day)	QL	G
milnacipran hcl tab pak (SAVELLA equiv)	-	G
TONMYA SL TAB	-	NC
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB	-	NC
VYLEESI INJ	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB (QL= 4 tabs/day)	LMSP-PA-QL	B
AUSTEDO XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days)	LMSP-PA-QL	B
AUSTEDO XR TITRATION PACK (QL= 1 pack/28 days)	LMSP-PA-QL	B
INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
INGREZZA PACK 40-80MG (QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479)	LD-PA-QL	B
INGREZZA SPRINKLE CAP (QL= 1 cap/day; Only available through PantheRx 855-726-8479)	LD-PA-QL	B
tetrabenazine tab (XENAZINE equiv)	LMSP	G
AUSTEDO TITRATION PACK	-	NC
XENAZINE TAB	-	NC
MULTIPLE SCLEROSIS AGENTS		
AVONEX INJ	LMSP-PA	B
BETASERON INJ	LMSP-PA	B
GILENYA CAP 0.25MG (QL= 1 cap/day)	LMSP-PA-QL	B
KESIMPTA INJ	LMSP-PA	B
MAYZENT TAB	LMSP-PA	B
MAYZENT TAB STARTER PACK	LMSP-PA	B
PLEGRIDY INJ	LMSP-PA	B
PLEGRIDY PEN INJ	LMSP-PA	B
REBIF INJ	LMSP-PA	B
TYSABRI INJ	MSP-PA	B
ZEPOSIA CAP (QL= 1 cap/day)	LMSP-PA-QL	B
ZEPOSIA STARTER PACK (QL= 1 cap/day)	LMSP-PA-QL	B
cladribine tab therapy pack (MAVENCLAD equiv)	LMSP-PA	G
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist)	LMSP-QL-RS	G
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	G
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	G
fingolimod hcl cap 0.5mg (GILENYA equiv) (QL= 1 cap/day)	LMSP-QL	G
glatiramer inj (COPAXONE equiv)	LMSP-PA	G
teriflunomide tab (AUBAGIO equiv)	LMSP	G
AUBAGIO TAB	-	NC
BAFIERTAM CAP	-	NC
EXTAVIA INJ	-	NC
GILENYA CAP 0.5MG	-	NC
MAVENCLAD THERAPY PAK	-	NC
PONVORY TAB	-	NC
PONVORY TAB STARTER PACK	-	NC
TASCENSO ODT TAB	-	NC
TECFIDERA CAP	-	NC
TECFIDERA STARTER PACK	-	NC
VUMERITY CAP	-	NC
ZINBRYTA INJ	-	NC
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
gabapentin (once-daily) tab (GRALISE equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
GRALISE TAB	-	NC
LIDOTIN PAK	-	NC
pregabalin ER tab (LYRICA CR equiv)	-	NC
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
FLUOXETINE CAP (PMDD)	-	NC
SARAFEM TAB	-	NC
PSEUDOBULBAR AFFECT (PBA) AGENTS		
dextromethorphan hbr-quinidine sulfate cap (NUEDEXTA equiv) (QL= 2 caps/day)	PA-QL	G
NUEDEXTA CAP	-	NC
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AQNEURSA PACKET FOR SUSPENSION (QL= 4 packets/day; Only available through CurantHealth 866-437-8040)	LD-PA-QL	B
pimozide tab (ORAP equiv)	-	G
ERGOLOID MESYLATES TAB	-	NC
MIPLYFFA CAP	-	NC
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB	-	NC
SMOKING DETERRENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	$0
nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	$0
NICOTINE KIT	OTC-QL-SMKG	$0
nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	$0
nicotine patch (NICODERM equiv) (Limited to 180 days/plan year)	OTC-QL-SMKG	$0
NICOTROL INHALER (Limited to 180 days/plan year)	QL-SMKG	$0
NICOTROL NASAL SPRAY (Limited to 180 days/plan year)	QL-SMKG	$0
VARENICLINE TAB (Limited to 180 days/plan year)	QL-SMKG	$0
varenicline tartrate tab (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	$0
varenicline tartrate tab starter pack (CHANTIX equiv) (Limited to 180 days/plan year)	QL-SMKG	$0
CHANTIX STARTER PACK	SMKG	NC
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
WAINUA INJ (QL= 1 inj/28 days; Only available through Orsini 800-410-8575)	LD-PA-QL	B
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP	-	NC
paroxetine cap (BRISDELLE equiv)	-	NC
RESPIRATORY AGENTS - MISC.		
ALPHA-PROTEINASE INHIBITOR (HUMAN)		
ARALAST/PROLASTIN/ZEMAIRA INJ (Only available through Walgreens 888-347-3416)	LD-PA	B
GLASSIA INJ	MSP-PA	B
CYSTIC FIBROSIS AGENTS		
ALYFTREK TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
ALYFTREK TAB 4-20-50MG (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
RESPIRATORY AGENTS - MISC. Cont.		
PULMOZYME INH SOLN	LMSP	B
SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
BRONCHITOL CAP	-	NC
PULMONARY FIBROSIS AGENTS		
nintedanib esylate cap (OFEV equiv) (QL= 2 caps/day)	LMSP-PA-QL	G
pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day)	LMSP-PA-QL	G
pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day)	LMSP-PA-QL	G
pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day)	LMSP-PA-QL	G
ESBRIET CAP	-	NC
ESBRIET TAB	-	NC
JASCAYD TAB	-	NC
OFEV CAP	-	NC
PIRFENIDONE TAB	-	NC
RESPIRATORY AGENTS - MISC.		
BRINSUPRI TAB (QL= 1 tab/day; Only available through Maxor Pharmacy 800-658-6046 or Amber Specialty Pharmacy 888-370-1724)	LD-PA-QL	B
SULFONAMIDES		
SULFONAMIDES		
sulfadiazine tab	-	G
TETRACYCLINES		
AMINOMETHYLCYCLINES		
NUZYRA TAB	-	NC
TETRACYCLINES		
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	G
doxycycline hyclate tab (VIBRATAB equiv)	-	G
doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv)	-	G
doxycycline monohydrate tab (ADOXA equiv)	-	G
doxycycline susp (VIBRAMYCIN equiv)	-	G
minocycline cap (MINOCIN equiv)	-	G
minocycline tab (DYNACIN equiv) (Step therapy requires trial of minocycline caps)	ST	G
tetracycline cap	-	G
ACTICLATE TAB 75MG, 150MG	-	NC
ADOXA CAP 150MG	-	NC
demeclocycline tab (DECLOMYCIN equiv)	-	NC
DORYX MPC TAB	-	NC
DOXYCYCLINE HYCLATE CAP	-	NC
doxycycline hyclate DR tab (DORYX equiv)	-	NC
doxycycline hyclate tab (TARGADOX equiv)	-	NC
doxycycline hyclate tab 75mg, 150mg	-	NC
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC
doxycycline monohydrate cap 150mg (MONODOX equiv)	-	NC
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC
doxycycline monohydrate tab 75mg (ADOXA equiv)	-	NC
MINOCYCLINE ER CAP	-	NC
minocycline ER tab (SOLODYN equiv)	-	NC
MINOLIRA TAB	-	NC
MONODOX CAP 75MG	-	NC
SEYSARA TAB	-	NC
TETRACYCLINE TAB	-	NC
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	G
propylthiouracil tab	-	G
SODIUM IODIDE I-131 SOLN	-	NC
THYROID HORMONE RECEPTOR AGONIST		
EMCITATE TAB	-	NC
THYROID HORMONES		
levothyroxine tab (SYNTHROID equiv)	-	G
liothyronine tab (CYTOMEL equiv)	-	G
ARMOUR THYROID TAB, NATURE THYROID TAB	-	NC
ERMEZA SOLN 150 MCG/5ML	-	NC
LEVOTHYROXINE INJ	-	NC
LEVOTHYROXINE INJ 100MCG/ML	-	NC
SYNTHROID TAB	-	NC
THYQUIDITY SOLN	-	NC
TIROSINT CAP	-	NC
TIROSINT-SOL	-	NC
TOXOIDS		
TOXOID COMBINATIONS		
ADACEL/BOOSTRIX INJ	VAC	$0
DAPTACEL INJ, INFANRIX INJ	VAC	$0
DIPTHERIA/TETANUS TOXOID (PEDIATRIC) INJ	VAC	$0
KINRIX INJ, QUADRACEL DTAP-IPV INJ	VAC	$0
KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE	VAC	$0
PEDIARIX INJ	VAC	$0
PENTACEL INJ	VAC	$0
TETANUS/DIPHTHERIA TOXOID INJ	VAC	$0
VAXELIS INJ	VAC	$0
ULCER DRUGS		
ANTISPASMODICS		
BELLADONNA ALKALOID/OPIUM SUPP	-	B
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	G
dicyclomine cap (BENTYL equiv)	-	G
dicyclomine soln (BENTYL equiv)	-	G
dicyclomine tab (BENTYL equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
glycopyrrolate tab (ROBINUL equiv)	-	G
hyoscyamine sulfate CR tab (LEVBID equiv)	-	G
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	G
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	G
hyoscyamine tab (LEVSIN equiv)	-	G
methscopolamine tab (PAMINE equiv)	-	G
b-donna tab (DONNATAL equiv)	-	NC
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC
H-2 ANTAGONISTS		
cimetidine soln (CIMETIDINE equiv)	-	G
cimetidine tab (TAGAMET equiv) (Rx Only)	-	G
famotidine susp (PEPCID equiv)	-	G
famotidine tab (PEPCID equiv) (Rx Only)	-	G
nizatidine cap (AXID equiv)	-	G
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	G
PROTON PUMP INHIBITORS		
FIRST OMEPRAZOLE SUSP	PA	B
LANSOPRAZOLE SUSP	PA	B
esomeprazole cap (NEXIUM equiv) (Rx Only)	PA	G
lansoprazole cap (PREVACID equiv) (Rx Only)	-	G
omeprazole DR cap (PRILOSEC equiv)	-	G
pantoprazole EC tab (PROTONIX equiv)	-	G
rabeprazole EC tab (ACIPHEX equiv)	PA	G
ACIPHEX SPRINKLE CAP	-	NC
ACIPHEX TAB	-	NC
PRILOSEC CAP	-	NC
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	G
ULCER THERAPY COMBINATIONS		
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC
ZEGERID POWDER PACK	-	NC
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS		
LEVBID ER TAB 0.375MG	-	B
LEVSIN SL TAB 0.125MG	-	B
LEVSIN TAB 0.125MG	-	B
CHLORDIAZEPOXIDE/CLIDINIUM CAP	-	G
glycopyrrolate oral soln (CUVPOSA equiv)	-	G
HYOSCYAMINE ELXIR	-	G
HYOSCYAMINE SULFATE ER TAB	-	G
HYOSCYAMINE SULFATE SL TAB	-	G
HYOSCYAMINE TAB	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont.		
DARTISLA ODT TAB	-	NC
DERMACINRX TAB	-	NC
DICYCLOMINE TAB	-	NC
DONNATAL ELIXIR, PB-BELLADONNA ELIXIR	-	NC
DONNATAL TAB	-	NC
GLYCATE TAB	-	NC
HYOSCYAMINE INJ	-	NC
H-2 ANTAGONISTS		
NIZATIDINE CAP	-	G
PEPCID SUSP	-	NC
RANITIDINE TAB	-	NC
MISC. ANTI-ULCER		
sucralfate susp (CARAFATE equiv)	PA	G
PROTON PUMP INHIBITORS		
omeprazole tab	OTC	EXC
esomeprazole DR granule pack (NEXIUM equiv) (Prior Authorization required for members age 9 years and older)	PA	G
DEXILANT DR CAP	-	NC
dexlansoprazole DR cap (DEXILANT equiv)	-	NC
FIRST PANTOPRAZOLE SUSP	-	NC
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC
pantoprazole sodium packet (PROTONIX equiv)	-	NC
PREVACID CAP	-	NC
VOQUEZNA TAB	-	NC
ULCER THERAPY COMBINATIONS		
bismuth/metro/tetra cap (PYLERA equiv)	-	NC
HELIDAC PACK	-	NC
KONVOMEP SUSP	-	NC
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	NC
LANSOPRAZOLE/AMOXICILLIN/CLARITHTHROMYCIN KIT	-	NC
PYLERA CAP	-	NC
TALICIA CAP	-	NC
VOQUEZNA DUAL PAK	-	NC
VOQUEZNA TRIP PAK	-	NC
URINARY ANTI-INFECTIVES		
URINARY ANTI-INFECTIVE COMBINATIONS		
PROSED DS TAB	-	NC
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)		
trospium chloride SR cap (SANCTURA XR equiv)	-	G
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
fesoterodine fumarate ER tab (TOVIAZ equiv)	-	G
oxybutynin ER tab (DITROPAN XL equiv)	-	G
oxybutynin syrup	-	G
oxybutynin tab (DITROPAN equiv)	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
URINARY ANTISPASMODICS Cont.		
solifenacin tab (VESICARE equiv)	-	G
tolterodine SR cap (DETROL LA equiv)	-	G
tolterodine tab (DETROL equiv)	-	G
trospium tab (SANCTURA equiv)	-	G
darifenacin SR tab (ENABLEX equiv)	-	NC
DETROL LA CAP	-	NC
oxybutynin tab 2.5mg	-	NC
TOVIAZ TAB	-	NC
VESICARE LS SUSP	-	NC
VESICARE TAB	-	NC
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB	-	NC
mirabegron granules for oral extended release susp (MYRBETRIQ equiv)	-	NC
mirabegron tab er (MYRBETRIQ equiv)	-	NC
MYRBETRIQ SUSP	-	NC
MYRBETRIQ TAB	-	NC
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol tab (URECHOLINE equiv)	-	G
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS (NEW)		
flavoxate tab (URISPAS equiv)	-	G
VACCINES		
BACTERIAL VACCINES		
ACTHIB INJ, HIBERIX INJ	VAC	$0
BEXSERO INJ	VAC	$0
CAPVAXIVE INJ	VAC	$0
MENACTRA INJ	VAC	$0
MENQUADFI INJ	VAC	$0
MENVEO INJ	VAC	$0
PEDVAXHIB INJ	VAC	$0
PENBRAYA INJ	VAC	$0
PENMENVY INJ	VAC	$0
PNEUMOVAX INJ	VAC	$0
PREVNAR 20 INJ	VAC	$0
TRUMENBA INJ	VAC	$0
VAXNEUVANCE INJ	VAC	$0
BCG INJ	VAC	EXC
TYPHIM VI INJ	VAC	EXC
VAXCHORA SUSP	VAC	EXC
VIVOTIF CAP	VAC	EXC
VIRAL VACCINES		
ABRYSVO INJ (QL= 1 dose/lifetime)	QL-VAC	$0
AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days)	QL-VAC	$0
AREXVY INJ (QL= 1 dose/lifetime)	QL-VAC	$0
COMIRNATY INJ (QL= 1 dose/17 days)	QL-VAC	$0
COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days)	QL-VAC	$0

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VACCINES Cont.		
COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	$0
COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days)	QL-VAC	$0
COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days)	QL-VAC	$0
DENGVAXIA SUSP	VAC	$0
ENGERIX-B INJ, RECOMBIVAX-HB INJ	VAC	$0
FLUAD INJ (QL= 1 inj/28 days)	QL-VAC	$0
FLUBLOK INJ (QL= 1 inj/28 days)	QL-VAC	$0
FLUCELVAX INJ (QL= 1 inj/28 days)	QL-VAC	$0
FLULAVAL INJ, FLUARIX INJ (QL= 1 inj/28 days)	QL-VAC	$0
FLUMIST NASAL (QL= 1 dose/28 days)	QL-VAC	$0
FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days)	QL-VAC	$0
GARDASIL 9 INJ	VAC	$0
HAVRIX INJ, VAQTA INJ	VAC	$0
HEPLISAV-B INJ	VAC	$0
IPOL INJ	VAC	$0
JYNNEOS INJ	VAC	$0
MFLUSIVA INJ (QL= 1 inj/28 days; Covered for members age 50 years and older)	QL-VAC	$0
M-M-R II INJ	VAC	$0
MNEXSPIKE INJ 10MCG/0.2ML (QL= 1 dose/24 days)	QL-VAC	$0
MRESVIA INJ (QL= 1 dose/lifetime)	QL-VAC	$0
NOVAVAX INJ (QL= 1 dose/24 days)	QL-VAC	$0
PREHEVBRIO SUSP	VAC	$0
PRIORIX INJ	VAC	$0
PROQUAD INJ	VAC	$0
ROTARIX SUSP	VAC	$0
ROTATEQ INJ	VAC	$0
SHINGRIX INJ (Covered for members age 19 years and older)	VAC	$0
SPIKEVAX INJ (QL= 1 dose/24 days)	QL-VAC	$0
SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days)	QL-VAC	$0
TWINRIX INJ	VAC	$0
VARIVAX INJ	VAC	$0
IMOVAX INJ	VAC	EXC
IXCHIQ INJ	-	EXC
IXIARO INJ	VAC	EXC
RABAVERT INJ	VAC	EXC
TICOVAC INJ	VAC	EXC
VIMKUNYA INJ	VAC	EXC
YF-VAX INJ	VAC	EXC
VAGINAL AND RELATED PRODUCTS		
VAGINAL ANTI-INFECTIVES		
CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill)	QL	B
XACIATO GEL (QL= 1 applicator/fill)	QL	B
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL (QL= 1 box/fill)	QL	$0
VAGINAL PROGESTINS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VAGINAL AND RELATED PRODUCTS Cont.		
ENDOMETRIN SUPP	-	NC
progesterone vaginal insert (ENDOMETRIN equiv)	-	NC
VAGINAL PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
FEM PH GEL	-	B
INTRAROSA SUPP	-	NC
SPERMICIDES		
CONTRACEPTIVE GEL	OTC	$0
CONTRACEPTIVE SUPP	OTC	$0
TODAY SPONGE	OTC	$0
VAGINAL ANTI-INFECTIVES		
clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill)	QL	G
metronidazole vaginal gel (METROGEL equiv)	-	G
terconazole cream (TERAZOL equiv)	-	G
TERCONAZOLE CREAM 0.8%	-	G
terconazole supp (TERAZOL equiv)	-	G
CLEOCIN VAGINAL SUPP	-	NC
VAGINAL ESTROGENS		
ESTRING (3 copays per Rx)	-	B
FEMRING (3 copays per Rx)	-	B
estradiol cream (ESTRACE equiv)	-	G
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill)	QL	G
ESTRACE VAGINAL CREAM	-	NC
IMVEXXY SUPP	-	NC
PREMARIN VAGINAL CREAM	-	NC
VAGINAL PROGESTINS		
CRINONE GEL	PA	B
PROGESTERONE SUPP	PA	B
ENDOMETRIN INSERT	-	NC
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
NEFFY SPRAY (QL= 2 doses/fill)	QL	B
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	G
ADRENACLICK INJ, EPINEPHRINE INJ	-	NC
AUVI-Q INJ	-	NC
EPIPEN (JR) INJ	-	NC
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
droxidopa cap (NORTHERA equiv)	-	NC
NORTHERA CAP	-	NC
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	G
VITAMINS		
OIL SOLUBLE VITAMINS		

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer
generic = small letters
BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

DrugName	Special Code	Tier
VITAMINS Cont.		
phytonadione tab (MEPHYTON equiv)	-	G
vitamin D cap (RX strength only)	-	G
ERGOCAL CAP	-	NC
vitamin D cap 1000unit	OTC	NC
vitamin D cap 400unit	OTC	NC
VITAMIN D TAB 2000IU	OTC	NC
VITAMIN D TAB 400UNIT	OTC	NC
WATER SOLUBLE VITAMINS		
pyridoxine inj	-	G

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

** OTC drugs are not a covered benefit.

NC = Not Covered
NC/3P = Not Covered, Third Party Reviewer

generic = small letters

BRANDS = CAPITAL LETTERS

INF	Infertility	LD	Limited Distribution	LMSP	Lumicera Mandatory Specialty Pharmacy Program
MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter	PA	Prior Authorization
QL	Quantity Limit	RDX	Restricted to Diagnosis	RS	Restricted to Specialist
SF	Limited to two 15 day fills per month for first 3 months	SMKG	Smoking Cessation	ST	Step Therapy
VAC	Vaccine Program	¢	RxCENTS		

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Prior Authorization Drug List
Last Updated* 11/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ACTEMRA IV INJ	B
ACTHAR GEL INJ	B
ACTIMMUNE INJ	B
ADAGEN INJ	B
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML	B
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT	B
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT	B
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT	B
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT	B
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT	B
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT	B
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	B
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML	B
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	B
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	B
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML	B
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML	B
adapalene gel 0.3%	G
ADBRY INJ	B
ADVATE, KOVALTRY INJ	B
AFSTYLA KIT	B
AIMOVIG INJ	B
AJOVY INJ	B
ALDURAZYME INJ	B
ALECENSA CAP	B
ALHEMO INJ	B
ALKINDI SPRINKLE CAP 0.5MG	B
ALKINDI SPRINKLE CAP 1MG	B
ALPHANATE, HUMATE-P INJ	B
ALPHANINE SD/MONONINE INJ	B
ALPROLIX INJ	B
ALTUVIIIO INJ	B
ALUNBRIG TAB 30MG	B
ALUNBRIG TAB 90MG, 180MG	B
ALYFTREK TAB	B
ALYFTREK TAB 4-20-50MG	B
ambrisentan tab	G
APRETUDE SUSP	$0
AQNEURSA PACKET FOR SUSPENSION	B
AQVESME TAB 100MG	B
ARALAST/PROLASTIN/ZEMAIRA INJ	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ARBLI SUSP	B
ARIKAYCE SUSP	B
armodafanil tab	G
ATORVALIQ SUSP	B
ATTRUBY PACK	B
AUGTYRO CAP	B
AUGTYRO CAP 160MG	B
AUSTEDO TAB	B
AUSTEDO XR TAB	B
AUSTEDO XR TAB TITRATION KIT	B
AUSTEDO XR TITRATION PACK	B
AVASTIN INJ	B
AVMAPKI FAKZYNJA CO-PACK	B
AVONEX INJ	B
AVSOLA INJ	B
AVTOZMA INJ	B
AYVAKIT TAB	B
baclofen oral soln 10mg/5ml	G
baclofen oral soln 5mg/5ml	G
baclofen susp	G
BALVERSA TAB 3MG	B
BALVERSA TAB 4MG	B
BALVERSA TAB 5MG	B
BARACLUDE SOLN	B
BENEFIX INJ	B
BENLYSTA AUTO-INJECTOR	B
BENLYSTA INJ	B
BERINERT INJ	B
BESREMI INJ	B
BESREMI PEN INJ	B
BETASERON INJ	B
bexarotene gel	G
BIMZELX INJ	B
BIMZELX INJ 320MG/2ML	B
BIMZELX SYRINGE	B
BIMZELX SYRINGE 320MG/2ML	B
bortezomib inj	B
bosentan tab	G
bosentan tab for oral susp	G
bosutinib tab	G
BOTOX INJ	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
BRAFTOVI CAP 75MG	B
BRINSUPRI TAB	B
BRUKINSA CAP	B
BRUKINSA TAB	B
budesonide ER tab	G
butalbital/acetaminophen tab 50-325mg	G
butalbital/acetaminophen/caffeine tab	G
butalbital/aspirin/caffeine cap	G
BYLVAY CAP 1200MCG	B
BYLVAY CAP 400MCG	B
BYLVAY SPRINKLE CAP 200MCG	B
BYLVAY SPRINKLE CAP 600MCG	B
CABLIVI INJ KIT	B
CABOMETYX TAB	B
CALQUENCE TAB	B
CAMZYOS CAP	B
CAPRELSA TAB	B
CAPRELSA TAB 300MG	B
carglumic acid tab	G
CARIMUNE INJ	B
CAYSTON INH SOLN	B
CERDELGA CAP	B
CEREZYME INJ	B
CHOLBAM CAP	B
CIBINQO TAB	B
CIMZIA INJ	B
CIMZIA INJ 200MG/ML	B
CINRYZE INJ	B
cladribine tab therapy pack	G
clobazam susp	G
clobazam tab	G
clobetasol foam	G
clobetasol lotion	G
COAGADEX INJ	B
COMETRIQ KIT	B
COPIKTRA CAP	B
CORIFACT KIT	B
CORLANOR SOLN	B
COTELLIC TAB	B
CRENESSITY CAP	B
CRENESSITY SOLN	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
CRINONE GEL	B
cyclosporine ophth emulsion	G
CYSTADANE POWDER	B
dasatinib tab	G
DAWNZERA INJ	B
DAYBUE SOLN	B
DAYBUE STIX POWDER	B
DAYBUE STIX POWDER 8000MG	B
deferiprone tab	G
DESCOVY TAB	$0
dextromethorphan hbr-quinidine sulfate cap	G
DIACOMIT CAP	B
DIACOMIT POWDER PACK	B
diclofenac gel	G
dihydroergotamine mesylate nasal spray	G
DOPTELET SPRINKLE CAP	B
DOPTELET TAB	B
dronabinol cap	G
DUPIXENT INJ	B
DUPIXENT PEN INJ	B
DUROLANE INJ	B
DYSPORT INJ	B
EBGLYSS INJ	B
EBGLYSS PEN INJ	B
EKTERLY TAB	B
ELAPRASE INJ	B
ELOCTATE INJ	B
eltrombopag olamine powder pack for susp	G
eltrombopag olamine tab	G
eltrombopag olamine tab 50MG	G
eltrombopag olamine tab 75MG	G
EMGALITY INJ	B
EMGALITY INJ 100MG/ML	B
EMPAVELI INJ	B
enalapril maleate oral soln	G
ENBREL INJ 25MG	B
ENBREL INJ 50MG	B
ENBREL MINI INJ	B
ENBREL SURECLICK INJ 50MG	B
ENSACOVE CAP	B
ENSACOVE CAP 100MG	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ENSPRYNG INJ	B
ENTYVIO SC INJ	B
EPIDIOLEX SOLN	B
ERIVEDGE CAP	B
ERLEADA TAB	B
ERLEADA TAB 240MG	B
erlotinib tab	G
erlotinib tab 25mg	G
esomeprazole cap	G
esomeprazole DR granule pack	G
ESPEROCT INJ	B
everolimus tab	G
everolimus tab (ZORTRESS equiv)	G
everolimus tab for oral susp	G
EVRYSDI SOLN	B
EVRYSDI TAB	B
EZALLOR SPRINKLE CAP	B
FABRAZYME INJ	B
FASENRA PEN INJ	B
FERRIPROX SOLN	B
FESILTY INJ	B
FIBRYGA INJ	B
FILSPARI TAB	B
FILSUVEZ GEL 10%	B
FINTEPLA SOLN	B
FIRDAPSE TAB	B
FIRST OMEPRAZOLE SUSP	B
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	B
FLOLIPID SUSP	B
FOTIVDA CAP	B
FRUZAQLA CAP 1MG	B
FRUZAQLA CAP 5MG	B
GALAFOLD CAP	B
GAMASTAN S/D INJ	B
GAMUNEX INJ	B
GAVRETO CAP	B
gefitinib tab	G
GENOTROPIN INJ	B
GENOTROPIN INJ 5MG	B
GENOTROPIN MINIQUICK INJ	B
GILENYA CAP 0.25MG	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
GILOTRIF TAB	B
GLASSIA INJ	B
glatiramer inj	G
GLOPERBA SOLN	B
GOMEKLI CAP	B
GOMEKLI CAP 1MG	B
GOMEKLI TAB FOR ORAL SUSP	B
HAEGARDA INJ	B
HELIXATE/KOGENATE INJ	B
HEMANGEOL ORAL SOLN	B
HEMANGEOL SOLN	B
HEMLIBRA INJ	B
HEMOFIL M, KOATE INJ	B
HERCEPTIN INJ	B
HERNEXEOS TAB	B
HIZENTRA INJ	B
HYCAMTIN CAP	B
HYFTOR GEL	B
HYQVIA INJ	B
HYRNUO TAB	B
IBTROZI CAP	B
icatibant inj	G
ICLUSIG TAB	B
IDHIFA TAB	B
IMBRUVICA CAP 140MG	B
IMBRUVICA CAP 70MG	B
IMBRUVICA SUSP	B
IMBRUVICA TAB 420MG	B
IMCIVREE INJ	B
INBRIJA INH POWDER	B
INGREZZA CAP	B
INGREZZA PACK 40-80MG	B
INGREZZA SPRINKLE CAP	B
INLURIYO TAB	B
INLYTA TAB	B
INLYTA TAB 1MG	B
INQOVI TAB	B
INZIRQO SUSP	B
IQIRVO TAB	B
ISTURISA TAB	B
itraconazole soln	G

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ivabradine hcl tab	G
IWILFIN TAB	B
JAKAFI TAB	B
JAKAFI XR TAB	B
JAYPIRCA TAB	B
JIVI INJ	B
JOENJA TAB	B
JYLAMVO SOLN, XATMEP SOLN	B
KALYDECO PAK	B
KALYDECO TAB	B
KATERZIA SUSP	B
KERENDIA TAB	B
KESIMPTA INJ	B
KEVZARA INJ	B
KHINDIVI SOLN	B
KINERET INJ	B
KISQALI PAK	B
KISQALI TAB	B
KOSELUGO CAP	B
KOSELUGO CAP 10MG	B
KOSELUGO SPRINKLE CAP	B
KOSELUGO SPRINKLE CAP 5MG	B
KRAZATI TAB	B
LANSOPRAZOLE SUSP	B
lapatinib ditosylate tab	G
LEDIPASVIR/SOFOSBUVIR TAB	B
LENVIMA CAP	B
LEQEMBI IQLIK INJ 250MG/1.25ML	B
LEQEMBI IQLK INJ	B
LEQSELVI TAB	B
l-glutamine powder packet	G
lidocaine patch 5%	G
LIKMEZ SUSP	B
LINZESS CAP	B
lisdexamfetamine dimesylate chew tab	G
LITFULO CAP	B
lithium oral solution	G
LIVDELZI CAP	B
LIVMARLI SOLN	B
LIVMARLI TAB	B
LIVMARLI TAB 30MG	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
LIVTENCITY TAB	B
lofexidine hcl tab	G
LOKELMA PAK	B
LONSURF TAB	B
LOPRESSOR SOLN	B
LORBRENA TAB 25MG	B
LUCEMYRA TAB	B
LUCENTIS INJ	B
LUMAKRAS TAB	B
LUMAKRAS TAB 240MG	B
LUMAKRAS TAB 320MG	B
LUMIZYME/MYOZYME INJ	B
LUPKYNIS CAP	B
LYNPARZA TAB	B
LYTGOBI THERAPY PACK	B
LYVISPAH GRANULE PACKET	B
macitentan tab	G
MAVYRET PAK	B
MAVYRET TAB	B
MAYZENT TAB	B
MAYZENT TAB STARTER PACK	B
MEKINIST SOLN	B
MEKINIST TAB 0.5MG	B
MEKINIST TAB 2MG	B
MEKTOVI TAB	B
mercaptopurine susp	G
mifepristone tab	G
miglustat cap	G
modafinil tab	G
MODEYSO CAP	B
MONOCLATE-P INJ	B
MOVANTIK TAB	B
MOZOBIL INJ	B
MYFEMBREE TAB	B
NAGLAZYME INJ	B
NEMLUVIO INJ	B
NERLYNX TAB	B
NEUPRO PATCH	B
nilotinib hcl cap	G
NINLARO CAP	B
nintedanib esylate cap	G

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
nitazoxanide tab	G
nitisinone cap	G
NORLIQVA ORAL SOLN	B
NOVOEIGHT INJ	B
NOVOSEVEN RT INJ	B
NPLATE INJ	B
NUBEQA TAB	B
NUCALA INJ	B
NUWIQ INJ	B
ODOMZO CAP	B
OGSIVEO TAB	B
OGSIVEO TAB 50MG	B
OHTUVAYRE SUSP	B
OJEMDA SUSP	B
OJEMDA TAB	B
OJJAARA TAB	B
OLUMIANT TAB	B
OMLYCLO SYRINGE	B
OMLYCLO SYRINGE 150MG/ML	B
OMLYCLO SYRINGE 300MG/2ML	B
OMNITROPE INJ	B
ONGENTYS CAP	B
OPZELURA CREAM	B
ORENCIA CLICK INJ	B
ORENCIA SC INJ 125MG/ML	B
ORENCIA SC INJ 50MG/0.4ML	B
ORENCIA SC INJ 87.5MG/0.7ML	B
ORGOVYX TAB	B
ORIAHNN CAP	B
ORILISSA TAB 150MG	B
ORILISSA TAB 200MG	B
ORKAMBI GRANULES PACKET	B
ORKAMBI TAB	B
ORLADEYO CAP	B
ORLADEYO PACK	B
ORSERDU TAB	B
ORSERDU TAB 345MG	B
OTEZLA STARTER PACK	B
OTEZLA TAB	B
OTEZLA XR TAB	B
OTEZLA/OTEZLA XR STARTER PACK	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
OXERVATE OPHTH SOLN	B
PALFORZIA POWDER PACK	B
PALFORZIA SPRINKLE CAP	B
PALSONIFY TAB	B
PALYNZIQ INJ	B
pazopanib tab	G
PEG-PREP KIT	B
PEMAZYRE TAB	B
PIQRAY TAB	B
pirfenidone cap	G
pirfenidone tab 267mg	G
pirfenidone tab 801mg	G
PLEGRIDY INJ	B
PLEGRIDY PEN INJ	B
plerixafor subcutaneous inj	B
pomalidomide cap	G
posaconazole DR tab	G
posaconazole susp	G
PREVYMIS PAK	B
PREVYMIS TAB	B
PROFILNINE INJ	B
PROGESTERONE SUPP	B
pyrimethamine tab	G
PYRUKYND TAB	B
PYRUKYND TAPER PACK	B
QBRELIS SOLN	B
QINLOCK TAB	B
rabeprazole EC tab	G
RADICAVA ORS STARTER KIT	B
RADICAVA ORS SUSP	B
ramelteon tab	G
REBIF INJ	B
RECOMBINATE INJ	B
REDEMPLO PFS INJ	B
REMODULIN SOLN 8MG/20ML	B
RENFLEXIS INJ	B
RETEVMO CAP	B
RETEVMO CAP 40MG	B
RETEVMO TAB	B
RETEVMO TAB 40MG	B
REVUFORJ TAB	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
REVUFORJ TAB 110MG	B
REVUFORJ TAB 25MG	B
REYVOW TAB	B
REZDIFFRA TAB	B
REZLIDHIA CAP	B
REZUROCK TAB	B
RINVOQ ER TAB	B
RINVOQ ORAL SOLN	B
riociguat tab	G
RITUXAN INJ	B
RIVFLOZA INJ	B
RIVFLOZA INJ 160MG	B
RIVFLOZA VIAL	B
RIXUBIS INJ	B
roflumilast tab	G
ROMVIMZA CAP	B
ROZLYTREK CAP	B
ROZLYTREK PAK	B
RUBRACA TAB	B
RUCONEST INJ	B
rufinamide susp	G
RYDAPT CAP	B
SAPHNELO INJ	B
SAPHNELO PEN INJ	B
sapropterin dihydrochloride powder packet	G
sapropterin dihydrochloride soluble tab	G
SCEMBLIX TAB	B
SCEMBLIX TAB 100 MG	B
SEPHIENCE POWDER	B
SEVENFACT INJ	B
SIGNIFOR INJ	B
sildenafil susp	G
sildenafil tab 20mg	G
SIMPONI AUTO-INJECTOR 100MG	B
SIMPONI INJ 100MG	B
SKYCLARYS CAP	B
SKYRIZI INJ 150MG/ML	B
SKYRIZI INJ 180 MG/1.2ML	B
SKYRIZI INJ 360MG/2.4ML	B
SKYRIZI INJ 55MG/0.37ML	B
SKYTROFA INJ	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
sodium oxybate oral soln	G
SODIUM OXYBATE SOLN	B
SOFOSBUVIR/VELPATASVIR TAB	B
SOHONOS CAP 1.5MG	B
SOHONOS CAP 10MG	B
SOHONOS CAP 1MG	B
SOHONOS CAP 2.5MG	B
SOHONOS CAP 5MG	B
sorafenib tosylate tab	G
SOTYLIZE SOLN 5MG/ML	B
SPEVIGO INJ	B
spironolactone susp	G
SPORANOX SOLN	B
SPRIX NASAL SPRAY	B
STEQEYMA INJ	B
STEQEYMA INJ 90MG	B
STIVARGA TAB	B
STRENSIQ INJ	B
SUBVENITE SUSP	B
sucralfate susp	G
sunitinib malate cap	G
SUNOSI TAB	B
SUPPRELIN LA INJ	B
SYMDEKO TAB	B
SYMLINPEN INJ	B
SYMPROIC TAB	B
TABRECTA TAB	B
tadalafil tab (PAH)	G
TADLIQ SUSP	B
TAFINLAR CAP	B
TAFINLAR TAB	B
TAGRISSO TAB	B
TAKHZYRO INJ	B
TAKHZYRO INJ 150MG/ML	B
TALTZ INJ	B
TALTZ INJ 20MG/0.25ML	B
TALTZ INJ 40 MG/0.5ML	B
TALZENNA CAP 0.25MG	B
TALZENNA CAP 0.5MG, 0.75MG, 1MG	B
TAVNEOS CAP	B
tazarotene cream 0.05%	G

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
tazarotene cream 0.1%	G
temsirolimus inj	B
TEPMETKO TAB	B
testosterone gel pump 1.62%	G
testosterone soln	G
TEZSPIRE INJ	B
TIBSOVO TAB	B
tiopronin tab	G
tiopronin tab delayed release	G
TOBI PODHALER	B
tolvaptan tab	G
tolvaptan tab therapy pack	G
TORISEL INJ	B
TREMFYA INDUCTION INJ 200MG/ML	B
TREMFYA INJ	B
TREMFYA INJ 200MG/2ML	B
treprostinil inj 10mg/ml	B
treprostinil inj 1mg/ml	B
treprostinil inj 2.5mg/ml	B
treprostinil inj 5mg/ml	B
tretinoin cream	G
tretinoin gel	G
trientine cap	G
TRIKAFTA TAB	B
TRIKAFTA THERAPY PACK	B
TRULANCE TAB	B
TRUQAP TAB	B
TRUQAP THERAPY PACK	B
TRYNGOLZA INJ	B
TUKYSA TAB	B
TURALIO CAP	B
TYENNE INJ	B
TYSABRI INJ	B
TYVASO DPI POWDER	B
TYVASO DPI POWDER 48-80MCG	B
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	B
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG	B
TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG	B
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	B
TYVASO INH SOLN 0.6 MG/ML	B
UBRELVY TAB	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
UPTRAVI TAB	B
UPTRAVI THERAPY PACK	B
USTEKINUMAB-AEKN 45MG/0.5ML	B
USTEKINUMAB-AEKN 90MG/ML	B
VALCHLOR GEL	B
VANFLYTA TAB	B
VANFLYTA TAB 26.5MG	B
VANRAFIA TAB	B
VELTASSA POWDER	B
VELTASSA POWDER 1GM	B
VEMLIDY TAB	B
VENCLEXTA STARTER PACK	B
VENCLEXTA TAB	B
VENTAVIS INH SOLN	B
VEOZAH TAB	B
VERZENIO TAB	B
vigabatrin powder pack	G
vigabatrin tab	G
vigadrone powder pack	G
VIJOICE GRANULES PACKET	B
VIJOICE TAB	B
VIJOICE TAB 250MG	B
VITRAKVI CAP 100MG	B
VITRAKVI CAP 25MG	B
VITRAKVI SOLN	B
VONJO CAP	B
VONVENDI INJ	B
VORANIGO TAB	B
VORANIGO TAB 10MG	B
VOSEVI TAB	B
VOWST CAP	B
VOXZOGO INJ	B
VOYDEYA TAB	B
VOYDEYA TAB THERAPY PACK	B
VPRIV INJ	B
VYJUVEK GEL	B
VYKAT XR TAB	B
VYKAT XR TAB 150MG	B
VYKAT XR TAB 75MG	B
VYNDAMAX CAP	B
VYNDAQEL CAP	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
VYVGART HYTRULO INJ	B
WAINUA INJ	B
WAKIX TAB	B
WELIREG TAB	B
WILATE INJ	B
WINREVAIR INJ	B
XADAGO TAB	B
XALKORI CAP	B
XALKORI SPRINKLE CAP	B
XDEMVY DROP	B
XEMBIFY INJ	B
XEOMIN INJ	B
XIAFLEX INJ	B
XIFAXAN TAB 200MG	B
XIFAXAN TAB 550MG	B
XOLAIR INJ	B
XOLAIR INJ 150MG/ML	B
XOLAIR INJ 300MG/2ML	B
XOLAIR SYRINGE	B
XOLAIR SYRINGE 150MG/ML	B
XOLAIR SYRINGE 300MG/2ML	B
XOLREMDI CAP	B
XOSPATA TAB	B
XPHOZAH TAB	B
XPOVIO PAK	B
XROMI SOLN	B
XYNTHA INJ	B
YESINTEK INJ	B
YESINTEK SYRINGE	B
YESINTEK SYRINGE 90MG	B
YEZTUGO INJ	$0
YEZTUGO TAB	$0
YORVIPATH INJ	B
YORVIPATH INJ 294MCG	B
YORVIPATH INJ 420MCG	B
YUTREPIA CAP	B
ZAVZPRET NASAL SPRAY	B
ZEJULA TAB	B
ZELBORAF TAB	B
ZELSUVMI GEL	B
ZEPOSIA CAP	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 11/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

Drug Name	Tier # for Drug Copay (if prior auth is approved)
ZEPOSIA STARTER PACK	B
ZILBRYSQ INJ	B
ZILBRYSQ INJ 23MG	B
ZILBRYSQ INJ 32.4MG	B
ZOKINVY CAP	B
ZOLINZA CAP	B
ZONISADE SUSP	B
ZORYVE CREAM	B
ZORYVE FOAM	B
ZTALMY SUSP	B
ZURZUVAE CAP 20MG, 25MG	B
ZURZUVAE CAP 30MG	B
ZYKADIA TAB	B

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Last Updated* 11/1/2026
RxCents (Cost Savings Enabled by Tablet Splitting)

Tablet splitting helps control prescription drug benefit costs and can provide significant savings for members. Participation in the program is voluntary. Through this program, members pay up to one-half of their usual copayment on a select group of prescription drugs. Drugs included in this program are based on the following criteria:

- The drug product is on the formulary.
- The drug product is recognized as an appropriate product to split by the Pharmacy & Therapeutics Committee.
- The drug is flat priced (i.e. various strengths of the medication must be comparably priced).
- The medication must have once-daily dosing.

An example of the savings that can be realized through this program is illustrated below:

	Product & Strength	Quantity	Member Copay	Member Annual Savings
Without Tablet Splitting	Drug A 40 mg tab	30	$15.00	
With Tablet Splitting	Drug A 80 mg tab	15	$7.50	$90

As the example illustrates, tablet splitting allows members to receive the same dose in a fewer number of tablets; thus, the overall

RxCents Program Medications

sitagliptin phosphate tab	TRINTELLIX TAB

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Last Updated* 11/1/2026
Over-the-Counter (OTC)

• The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHEK GUIDE CARE METER	ACCU-CHEK GUIDE ME KIT	ACCU-CHEK GUIDE TEST STRIP	AEROCHAMBER
aspirin chew tab 81mg	aspirin ec tab 81mg	B-D INSULIN SYRINGE	B-D PEN NEEDLE
CALIBRATION LIQUID	CLINISTIX TEST STRIP	CONTRACEPTIVE GEL	CONTRACEPTIVE SUPP
EMBECTA INSULIN SYRINGE	EMBECTA PEN NEEDLE	FEMALE CONDOMS	folic acid tab 400mcg
folic acid tab 800mcg	FREESTYLE FREEDOM LITE METER	FREESTYLE INSULINX TEST STRIP	FREESTYLE LITE METER
FREESTYLE LITE TEST STRIP	FREESTYLE PRECISION NEO METER	FREESTYLE PRECISION NEO TEST STRIP	FREESTYLE TEST STRIP
guaifenesin/codeine syrup	HUMULIN MIX INJ	HUMULIN MIX PEN INJ	HUMULIN N INJ
HUMULIN N PEN INJ	HUMULIN R INJ	KETO-DIASTIX TEST STRIF	KETOSTIX
LANCET KIT	LANCETS	levonorgestrel tab	MALE CONDOMS
naloxone hcl nasal spray	NARCAN NASAL SPRAY	nicotine gum	NICOTINE KIT
nicotine lozenge	nicotine patch	NOVOFINE PEN NEEDLE	olopatadine hcl ophth soln 0.2%
OPILL TAB	PEAK FLOW METER	PLAN B TAB	PRECISION XTRA METER
PRECISION XTRA TEST STRIP	RIVIVE, REXTOVY SPRAY	TODAY SPONGE	zinc gluconate tab

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

abiraterone tab 250mg	ACTEMRA IV INJ	ACTHAR GEL INJ	ACTIMMUNE INJ
ADAGEN INJ	ADALIMUMAB FKJP KIT INJ 20MG/0.4ML	ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT	ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT	ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT	ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT	ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML	ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA 80MG/0.8ML	ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA 40MG/0.4ML	ADBRY INJ	ADVATE, KOVALTRY INJ
AFSTYLA KIT	ALDURAZYME INJ	ALECENSA CAP	ALHEMO INJ
ALKINDI SPRINKLE CAP 0.5MG	ALKINDI SPRINKLE CAP 1MG	ALPHANATE, HUMATE-P INJ	ALPHANINE SD/MONONINE INJ
ALPROLIX INJ	ALTUVIIIO INJ	ALUNBRIG TAB 30MG	ALUNBRIG TAB 90MG, 180MG
ALYFTREK TAB	ALYFTREK TAB 4-20-50MG	ambrisentan tab	AQNEURSA PACKET FOR SUSPENSION
AQVESME TAB 100MG	ARALAST/PROLASTIN/ZEMAIRA INJ	ARIKAYCE SUSP	ATTRUBY PACK
AUGTYRO CAP	AUGTYRO CAP 160MG	AUSTEDO TAB	AUSTEDO XR TAB
AUSTEDO XR TAB TITRATION KIT	AUSTEDO XR TITRATION PACK	AVASTIN INJ	AVMAPKI FAKZYNJA CO-PACK
AVONEX INJ	AVSOLA INJ	AVTOZMA INJ	AYVAKIT TAB
azacitidine inj	BALVERSA TAB 3MG	BALVERSA TAB 4MG	BALVERSA TAB 5MG
BENEFIX INJ	BENLYSTA AUTO-INJECTOI	BENLYSTA INJ	BERINERT INJ
BESREMI INJ	BESREMI PEN INJ	BETASERON INJ	bexarotene cap
bexarotene gel	BIMZELX INJ	BIMZELX INJ 320MG/2ML	BIMZELX SYRINGE
BIMZELX SYRINGE 320MG/2ML	bortezomib inj	bosentan tab	bosentan tab for oral susp
bosutinib tab	BOTOX INJ	BRAFTOVI CAP 75MG	BRINSUPRI TAB
BRUKINSA CAP	BRUKINSA TAB	BYLVAY CAP 1200MCG	BYLVAY CAP 400MCG
BYLVAY SPRINKLE CAP 200MCG	BYLVAY SPRINKLE CAP 600MCG	CABENUVA IM SUSP	CABENUVA SUSP 600MG-900MG/3ML
CABLIVI INJ KIT	CABOMETYX TAB	CALCITRIOL INJ	CALQUENCE TAB

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

CAMZYOS CAP
capecitabine tab
CAPRELSA TAB
CAPRELSA TAB 300MG
carglumic acid tab
CARIMUNE INJ
CAYSTON INH SOLN
CERDELGA CAP
CEREZYME INJ
CHOLBAM CAP
CIBINQO TAB
CIMZIA INJ
CIMZIA INJ 200MG/ML
CINRYZE INJ
cladribine tab therapy pack
COAGADEX INJ
colistimethate inj
COMETRIQ KIT
COPIKTRA CAP
CORIFACT KIT
COTELLIC TAB
CRENESSITY CAP
CRENESSITY SOLN
CYSTADANE POWDER
CYSTADROPS SOLN
CYSTAGON CAP
CYSTARAN OPHTH SOLN
dalfampridine ER tab
dasatinib tab
DAWNZERA INJ
DAYBUE SOLN
DAYBUE STIX POWDER
DAYBUE STIX POWDER 8000MG
deferasirox granules packet
deferasirox tab
deferasirox tab for oral susp
deferiprone tab
DIACOMIT CAP
DIACOMIT POWDER PACK
dimethyl fumarate DR cap
dimethyl fumarate DR starter pack
DOPTELET SPRINKLE CAP
DOPTELET TAB
DUPIXENT INJ
DUPIXENT PEN INJ
DUROLANE INJ
DYSPORT INJ
EBGLYSS INJ
EBGLYSS PEN INJ
EKTERLY TAB
ELAPRASE INJ
ELOCTATE INJ
eltrombopag olamine powder pack for susp
eltrombopag olamine tab
eltrombopag olamine tab 50MG
eltrombopag olamine tab 75MG
EMPAVELI INJ
ENBREL INJ 25MG
ENBREL INJ 50MG
ENBREL MINI INJ
ENBREL SURECLICK INJ 50MG
ENBUMYST SOLN 0.5MG/0.1ML
ENSACOVE CAP
ENSACOVE CAP 100MG
ENSPRYNG INJ
ENTYVIO SC INJ
EPIDIOLEX SOLN
ERIVEDGE CAP
ERLEADA TAB
ERLEADA TAB 240MG
erlotinib tab
erlotinib tab 25mg
ESPEROCT INJ
etoposide cap
everolimus tab
everolimus tab for oral susp
EVRYSDI SOLN
EVRYSDI TAB
FABRAZYME INJ
FASENRA PEN INJ
FERRIPROX SOLN
FESILTY INJ
FIBRYGA INJ
FILSPARI TAB
FILSUVEZ GEL 10%
fingolimod hcl cap 0.5mg
FINTEPLA SOLN
FIRDAPSE TAB
FIRMAGON INJ
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ
FOTIVDA CAP
FRUZAQLA CAP 1MG
FRUZAQLA CAP 5MG
FULPHILA INJ
GALAFOLD CAP
GAMASTAN S/D INJ
GAMUNEX INJ
GANCICLOVIR INJ
GAVRETO CAP
gefitinib tab
GENOTROPIN INJ
GENOTROPIN INJ 5MG
GENOTROPIN MINIQUICK INJ
GILENYA CAP 0.25MG
GILOTRIF TAB
GLASSIA INJ
glatiramer inj
GOMEKLI CAP
GOMEKLI CAP 1MG
GOMEKLI TAB FOR ORAL SUSP
HAEGARDA INJ
HELIXATE/KOGENATE INJ
HEMANGEOL ORAL SOLN
HEMANGEOL SOLN
HEMLIBRA INJ
HEMOFIL M, KOATE INJ
HERCEPTIN INJ
HERNEXEOS TAB
HIZENTRA INJ
HYCAMTIN CAP
HYFTOR GEL
HYQVIA INJ
HYRNUO TAB
IBTROZI CAP
icatibant inj
ICLUSIG TAB
IDHIFA TAB
imatinib tab
IMBRUVICA CAP 140MG
IMBRUVICA CAP 70MG
IMBRUVICA SUSP
IMBRUVICA TAB 420MG
IMCIVREE INJ
INBRIJA INH POWDER
INCRELEX INJ
INGREZZA CAP
INGREZZA PACK 40-80MG
INGREZZA SPRINKLE CAP
INLURIYO TAB
INLYTA TAB
INLYTA TAB 1MG
INQOVI TAB
IQIRVO TAB
ISTURISA TAB
IWILFIN TAB
JAKAFI TAB
JAKAFI XR TAB
JAYPIRCA TAB
JIVI INJ
JOENJA TAB
KALYDECO PAK
KALYDECO TAB
KESIMPTA INJ
KEVZARA INJ
KHINDIVI SOLN
KINERET INJ
KISQALI PAK
KISQALI TAB
KOSELUGO CAP
KOSELUGO CAP 10MG
KOSELUGO SPRINKLE CAP
KOSELUGO SPRINKLE CAP 5MG
KRAZATI TAB
lapatinib ditosylate tab

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

LEDIPASVIR/SOFOSBUVIR TAB	lenalidomide cap	LENVIMA CAP	LEQEMBI IQLIK INJ 250MG/1.25ML
LEQEMBI IQLK INJ	LEQSELVI TAB	l-glutamine powder packet	LITFULO CAP
LIVDELZI CAP	LIVMARLI SOLN	LIVMARLI TAB	LIVMARLI TAB 30MG
LIVTENCITY TAB	LONSURF TAB	LORBRENA TAB 25MG	LUCENTIS INJ
LUMAKRAS TAB	LUMAKRAS TAB 240MG	LUMAKRAS TAB 320MG	LUMIZYME/MYOZYME INJ
LUPKYNIS CAP	LUPRON DEPOT PED INJ	LUPRON DEPOT-PED INJ	LYNPARZA TAB
LYSODREN TAB	LYTGOBI THERAPY PACK	macitentan tab	MATULANE CAP
MAVYRET PAK	MAVYRET TAB	MAYZENT TAB	MAYZENT TAB STARTER PACK
MEKINIST SOLN	MEKINIST TAB 0.5MG	MEKINIST TAB 2MG	MEKTOVI TAB
mesna tab	mifepristone tab	miglustat cap	MODEYSO CAP
MONOCLATE-P INJ	MOZOBIL INJ	MYLERAN TAB	NAGLAZYME INJ
NEMLUVIO INJ	NERLYNX TAB	nilotinib hcl cap	nilutamide tab
NINLARO CAP	nintedanib esylate cap	nitisinone cap	NIVESTYM INJ
NOVOEIGHT INJ	NOVOSEVEN RT INJ	NPLATE INJ	NUBEQA TAB
NUCALA INJ	NUWIQ INJ	NYVEPRIA INJ	octreotide inj
OCTREOTIDE INJ 100MCG	ODOMZO CAP	OGSIVEO TAB	OGSIVEO TAB 50MG
OHTUVAYRE SUSP	OJEMDA SUSP	OJEMDA TAB	OJJAARA TAB
OLUMIANT TAB	OMLYCLO SYRINGE	OMLYCLO SYRINGE 150MG/ML	OMLYCLO SYRINGE 300MG/2ML
OMNITROPE INJ	ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML
ORENCIA SC INJ 87.5MG/0.7ML	ORGOVYX TAB	ORKAMBI GRANULES PACKET	ORKAMBI TAB
ORLADEYO CAP	ORLADEYO PACK	ORSERDU TAB	ORSERDU TAB 345MG
OTEZLA STARTER PACK	OTEZLA TAB	OTEZLA XR TAB	OTEZLA/OTEZLA XR STARTER PACK
OXERVATE OPHTH SOLN	PALFORZIA POWDER PACK	PALFORZIA SPRINKLE CAP	PALSONIFY TAB
PALYNZIQ INJ	pazopanib tab	PEGASYS INJ	PEMAZYRE TAB
PHEBURANE ORAL PELLETS	PIQRAY TAB	pirfenidone cap	pirfenidone tab 267mg
pirfenidone tab 801mg	PLEGRIDY INJ	PLEGRIDY PEN INJ	plerixafor subcutaneous inj
pomalidomide cap	PREVYMIS PAK	PREVYMIS TAB	PROFILNINE INJ
PROLIA INJ	PULMOZYME INH SOLN	pyrimethamine tab	PYRUKYND TAB
PYRUKYND TAPER PACK	QINLOCK TAB	RADICAVA ORS STARTER KIT	RADICAVA ORS SUSP
REBIF INJ	RECOMBINATE INJ	REDEMPLO PFS INJ	REMODULIN SOLN 8MG/20ML
RENFLEXIS INJ	RETACRIT INJ	RETEVMO CAP	RETEVMO CAP 40MG
RETEVMO TAB	RETEVMO TAB 40MG	REVUFORJ TAB	REVUFORJ TAB 110MG
REVUFORJ TAB 25MG	REZDIFFRA TAB	REZLIDHIA CAP	REZUROCK TAB
ribavirin cap	RIBAVIRIN TAB	RINVOQ ER TAB	RINVOQ ORAL SOLN
riociguat tab	RITUXAN INJ	RIVFLOZA INJ	RIVFLOZA INJ 160MG
RIVFLOZA VIAL	RIXUBIS INJ	ROMVIMZA CAP	ROZLYTREK CAP
ROZLYTREK PAK	RUBRACA TAB	RUCONEST INJ	RYDAPT CAP
SAPHNELO INJ	SAPHNELO PEN INJ	sapropterin dihydrochloride powder packet	sapropterin dihydrochloride soluble tab
SCEMBLIX TAB	SCEMBLIX TAB 100 MG	SEPHIENCE POWDER	SEVENFACT INJ

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SIGNIFOR INJ	SIMPONI AUTO-INJECTOR 100MG	SIMPONI INJ 100MG	SKYCLARYS CAP
SKYRIZI INJ 150MG/ML	SKYRIZI INJ 180 MG/1.2ML	SKYRIZI INJ 360MG/2.4ML	SKYRIZI INJ 55MG/0.37ML
SKYTROFA INJ	sodium oxybate oral soln	SODIUM OXYBATE SOLN	SOFOSBUVIR/VELPATASVIR TAB
SOHONOS CAP 1.5MG	SOHONOS CAP 10MG	SOHONOS CAP 1MG	SOHONOS CAP 2.5MG
SOHONOS CAP 5MG	sorafenib tosylate tab	SPEVIGO INJ	STEQEYMA INJ
STEQEYMA INJ 90MG	STIVARGA TAB	STRENSIQ INJ	SUBLOCADE SOLN, BRIXADI SOLN
sunitinib malate cap	SUPPRELIN LA INJ	SYMDEKO TAB	TABRECTA TAB
TAFINLAR CAP	TAFINLAR TAB	TAGRISSO TAB	TAKHZYRO INJ
TAKHZYRO INJ 150MG/ML	TALTZ INJ	TALTZ INJ 20MG/0.25ML	TALTZ INJ 40 MG/0.5ML
TALZENNA CAP 0.25MG	TALZENNA CAP 0.5MG, 0.75MG, 1MG	TAVNEOS CAP	temozolomide cap
temsirolimus inj	TEPMETKO TAB	teriflunomide tab	teriparatide (recombinant) soln pen-inj
tetrabenazine tab	TEZSPIRE INJ	THALOMID CAP	TIBSOVO TAB
tiopronin tab	tiopronin tab delayed release	TOBI PODHALER	tobramycin neb soln
tofacitinib citrate ER tab	tofacitinib citrate oral soln	tofacitinib citrate tab	tolvaptan tab
tolvaptan tab therapy pack	TORISEL INJ	TREMFYA INDUCTION INJ 200MG/ML	TREMFYA INJ
TREMFYA INJ 200MG/2ML	treprostinil inj 10mg/ml	treprostinil inj 1mg/ml	treprostinil inj 2.5mg/ml
treprostinil inj 5mg/ml	tretinoin cap	trientine cap	TRIKAFTA TAB
TRIKAFTA THERAPY PACK	TRUQAP TAB	TRUQAP THERAPY PACK	TRYNGOLZA INJ
TUKYSA TAB	TURALIO CAP	TYENNE INJ	TYMLOS INJ
TYSABRI INJ	TYVASO DPI POWDER	TYVASO DPI POWDER 48-80MCG	TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG	TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG	TYVASO DPI POWDER TITRATION KIT 16-32-48MC	TYVASO INH SOLN 0.6 MG/ML
UPTRAVI TAB	UPTRAVI THERAPY PACK	USTEKINUMAB-AEKN 45MG/0.5ML	USTEKINUMAB-AEKN 90MG/ML
VALCHLOR GEL	VANFLYTA TAB	VANFLYTA TAB 26.5MG	VANRAFIA TAB
VENCLEXTA STARTER PACK	VENCLEXTA TAB	VENTAVIS INH SOLN	VEPESID CAP
VERZENIO TAB	vigabatrin powder pack	vigabatrin tab	vigadrone powder pack
VIJOICE GRANULES PACKET	VIJOICE TAB	VIJOICE TAB 250MG	VITRAKVI CAP 100MG
VITRAKVI CAP 25MG	VITRAKVI SOLN	VIVITROL INJ	VONJO CAP
VONVENDI INJ	VORANIGO TAB	VORANIGO TAB 10MG	VOSEVI TAB
VOWST CAP	VOXZOGO INJ	VOYDEYA TAB	VOYDEYA TAB THERAPY PACK
VPRIV INJ	VYJUVEK GEL	VYKAT XR TAB	VYKAT XR TAB 150MG
VYKAT XR TAB 75MG	VYNDAMAX CAP	VYNDAQEL CAP	VYVGART HYTRULO INJ
WAINUA INJ	WAKIX TAB	WELIREG TAB	WILATE INJ
WINREVAIR INJ	XALKORI CAP	XALKORI SPRINKLE CAP	XDEMVY DROP
XEMBIFY INJ	XEOMIN INJ	XGEVA INJ	XIAFLEX INJ
XOLAIR INJ	XOLAIR INJ 150MG/ML	XOLAIR INJ 300MG/2ML	XOLAIR SYRINGE

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

XOLAIR SYRINGE 150MG/ML
XOLAIR SYRINGE 300MG/2ML
XOLREMDI CAP
XOSPATA TAB
XPHOZAH TAB
XPOVIO PAK
XYNTHA INJ
YESINTEK INJ
YESINTEK SYRINGE
YESINTEK SYRINGE 90MG
YEZTUGO INJ
YEZTUGO TAB
YORVIPATH INJ
YORVIPATH INJ 294MCG
YORVIPATH INJ 420MCG
YUTREPIA CAP
ZARXIO INJ
ZEJULA TAB
ZELBORAF TAB
ZEPOSIA CAP
ZEPOSIA STARTER PACK
ZILBRYSQ INJ
ZILBRYSQ INJ 23MG
ZILBRYSQ INJ 32.4MG
ZOKINVY CAP
ZOLADEX INJ
ZOLINZA CAP
ZTALMY SUSP
ZURZUVAE CAP 20MG, 25MG
ZURZUVAE CAP 30MG
ZYKADIA TAB

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
arformoterol tartrate neb soln	Step Therapy requires trial of PERFOROMIST
asenapine maleate SL tab	QL= 2 tabs/day; Step Therapy requires trial of aripiprazole or quetiapine ER
ASTEPRO NASAL SPRAY	Step therapy requires trial of azelastine nasal spray 0.1%
AURYXIA TAB	Step Therapy requires trial of RENVELA and FOSRENOL
azelastine nasal spray 0.15%	Step therapy requires trial of azelastine nasal spray 0.1%
buprenorphine patch	QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
CAVERJECT INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
CEQUA OPHTH SOLN	Restricted to Ophthalmology or Optometry Specialist; Step Therapy requires trial of cyclosporine ophth emulsion
ciclopirox shampoo	Step Therapy requires trial of ketoconazole shampoo
CIPRO HC OTIC SUSP	Step Therapy requires trial of CIPRODEX
ciprofloxacin-hydrocortisone otic susp	Step Therapy requires trial of CIPRODEX
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not curren utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not curren utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR (15-DAY)	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DIFICID SUSP	QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
DISKETS TAB	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
EDEX INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
ERYTHROMYCIN CAP DR	Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg
erythromycin DR cap	Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg
ERYTHROMYCIN EC CAP	Step Therapy requires trial of azithromycin, clarithromycin, or doycycline hyclate 100mg
erythromycin ethylsuccinate susp	Step Therapy requires trial of azithromycin or clarithromycin
erythromycin tab	Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg
febuxostat tab	Step Therapy requires trial of allopurinol
fentanyl patch	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
ferric citrate tab	Step Therapy requires trial of RENVELA and FOSRENOL
fidaxomicin tab	QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
fluvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not curren utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 READER	QL= 1 receiver/year; Prior authorization (exception) required if member is not curren utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not curren utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
HYDROCODONE BITARTRATE ER CAP	QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioic ER Dependency)
hydrocodone bitartrate er tab	QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid I Dependency)
LEVALBUTEROL INHALER, XOPENEX HF INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of an albuterol HFA product (6.7 or 8.5gm)
MECLOFENAMATE CAP	Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen
methadone soln	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
methadone tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
METHADOSE CONC	
methadose tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
metronidazole gel 1%	Step Therapy requires trial of metronidazole gel 0.75%
minocycline tab	Step therapy requires trial of minocycline caps
morphine sulfate ER tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
MS CONTIN TAB	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
nevirapine ER tab	Step Therapy requires trial of nevirapine
NEXLETOL TAB	QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
NUCYNTA ER TAB	QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
paliperidone ER tab	Step Therapy requires trial of aripiprazole or quetiapine ER
REPATHA INJ	QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL
tramadol ER tab	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
TRAMADOL HCL ER TAB	Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency
travoprost ophth soln	QL= 5ml/30 days; Step Therapy requires trial of latanoprost
TRINTELLIX TAB	QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine
TYRVAYA NASAL SPRAY	QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist; Step Therapy Requires trial of cyclosporine opth emulsion
XTAMPZA ER CAP	QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
zolmitriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days; Step Therapy Requires trial of the following sumatriptan, naratriptan, rizatriptan and zolmitriptan
ZOLMITRIPTAN SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
ZOMIG SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Smoking Cessation Agents
Last Updated* 11/1/2026

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	$0
CHANTIX STARTER PACK	NC
nicotine gum(Limited to 180 days/plan year)	$0
NICOTINE KIT	$0
nicotine lozenge(Limited to 180 days/plan year)	$0
nicotine patch(Limited to 180 days/plan year)	$0
NICOTROL INHALER(Limited to 180 days/plan year)	$0
NICOTROL NASAL SPRAY(Limited to 180 days/plan year)	$0
VARENICLINE TAB(Limited to 180 days/plan year)	$0
varenicline tartrate tab(Limited to 180 days/plan year)	$0
varenicline tartrate tab starter pack(Limited to 180 days/plan year)	$0

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

SISC - Book of Business Drug List
Infertility Drug List
Last Updated* 11/1/2026

Drug Name	Tier # for Drug Copay
cetrorelix acetate for inj kit	EXC
CETROTIDE KIT	EXC
clomiphene citrate tab	EXC
CLOMIPHENE TAB	EXC
OVIDREL INJ	EXC

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
abiraterone tab 250mg	QL= 4 tabs/day
ABRYSVO INJ	QL= 1 dose/lifetime
ACTHAR GEL INJ	QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
ADALIMUMAB FKJP KIT INJ 20MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT	QL= 2 inj/28 days
ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT	QL= 1 kit/fill; 1 fill/plan year
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	QL= 2 inj/28 days
ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML	QL= 2 inj/28 days
ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML	QL= 2 inj/28 days
ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML	QL= 2 inj/28 days; Only available through Lumicera 855-847-3553
ADALIMUMAB-RYVK AUTO-INJECTOR KI (TEVA) 40MG/0.4ML	QL= 2 inj/28 days; Only available through Lumicera 855-847-3553
ADBRY INJ	QL= 2 inj/28 days
AFLURIA INJ, FLUZONE INJ	QL= 1 inj/28 days
AIMOVIG INJ	QL= 1 pack/28 days
AJOVY INJ	QL= 1 pack/28 days
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
albuterol HFA (6.7gm, 8.5gm) inhaler	QL= 2 inhalers/30 days
ALECENSA CAP	QL= 8 caps/day
ALKINDI SPRINKLE CAP 0.5MG	QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older
ALKINDI SPRINKLE CAP 1MG	QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older
ALUNBRIG TAB 30MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
ALYFTREK TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
ALYFTREK TAB 4-20-50MG	QL= 3 tabs/day; Only available through Walgreens 888-347-3416
ambrisentan tab	QL= 1 tab/day; Only available through Lumicera 855-847-3553
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill
aprepitant pak	QL= 3 caps/fill
APRETUDE SUSP	QL= 7 inj/year
AQNEURSA PACKET FOR SUSPENSION	QL= 4 packets/day; Only available through CurantHealth 866-437-8040
AQVESME TAB 100MG	QL= 2 tabs/day; Only available through Biologics 800-850-4306
ARBLI SUSP	QL= 330mL/30 days; Prior Authorization required for members age 9 years and older
AREXVY INJ	QL= 1 dose/lifetime
ARIKAYCE SUSP	QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046
armodafanil tab	QL= 1 tab/day
asenapine maleate SL tab	QL= 2 tabs/day; Step Therapy requires trial of aripiprazole or quetiapine ER
ATTRUBY PACK	QL= 4 tabs/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-84
AUGTYRO CAP	QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
AUGTYRO CAP 160MG	QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
AUSTEDO TAB	QL= 4 tabs/day
AUSTEDO XR TAB	QL= 1 tab/day
AUSTEDO XR TAB TITRATION KIT	QL= 1 pack/28 days
AUSTEDO XR TITRATION PACK	QL= 1 pack/28 days
AVMAPKI FAKZYNJA CO-PACK	QL= 1 pack/28 days; Only available through Biologics 800-850-4306
AVTOZMA INJ	QL= 2 inj/28 days
AYVAKIT TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
BALVERSA TAB 3MG	QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767
BALVERSA TAB 4MG	QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767
BALVERSA TAB 5MG	QL= 1 tab/day; Only available through CVS Specialty 800-237-2767
BAQSIMI NASAL POWDER	QL= 2 inhalations/fill
BAXDELA TAB	QL= 2 tabs/day; Restricted to Infectious Disease Specialist
BENLYSTA AUTO-INJECTOR	QL= 4 inj/28 day
BENLYSTA INJ	QL= 4 inj/28 day
BESREMI INJ	QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
BESREMI PEN INJ	QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
bexarotene cap	QL= 10 caps/day
bexarotene gel	QL= 60 grams/30 days

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
BIMZELX INJ	QL= 1 mL/28 days
BIMZELX INJ 320MG/2ML	QL= 2 mL/56 days
BIMZELX SYRINGE	QL= 1 mL/28 days
BIMZELX SYRINGE 320MG/2ML	QL= 2 mL/56 days
bosentan tab	QL= 2 tabs/day; Only available through Lumicera 855-847-3553
bosentan tab for oral susp	QL= 4 tabs/day; Only available through Accredo 800-803-2523
BRAFTOVI CAP 75MG	QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118
BRINSUPRI TAB	QL= 1 tab/day; Only available through Maxor Pharmacy 800-658-6046 or Amber Specialty Pharmacy 888-370-1724
BRUKINSA CAP	QL= 4 caps/day; Only available through Lumicera 855-847-3553
BRUKINSA TAB	QL= 2 tabs/day; Only available through Lumicera 855-847-3553
budesonide ER tab	QL=1 tab/day
buprenorphine patch	QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
bupropion SR tab	Limited to 180 days/plan year
butalbital/acetaminophen tab 50-325mg	QL= 60 tabs/30 days
butalbital/acetaminophen/caffeine tab	QL= 60 tabs/30 days
butalbital/aspirin/caffeine cap	QL= 60 tabs/30 days
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYLVAY CAP 1200MCG	QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY CAP 400MCG	QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 200MCG	QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479
BYLVAY SPRINKLE CAP 600MCG	QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479
CABENUVA IM SUSP	QL= 1 kit/30 days
CABENUVA SUSP 600MG-900MG/3ML	QL= 1 kit/30 days
CABLIVI INJ KIT	QL= 1 vial/day; Only available through Biologics 800-850-4306
CABOMETYX TAB	QL= 1 tab/day
CALQUENCE TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
CAMZYOS CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
CAPRELSA TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
CAPRELSA TAB 300MG	QL= 1 tab/day; Only available through Biologics 800-850-4306
carisoprodol tab	QL= 90 tabs/90 days
CAVERJECT INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
CEQUA OPHTH SOLN	Restricted to Ophthalmology or Optometry Specialist; Step Therapy requires trial of cyclosporine ophth emulsion
CERDELGA CAP	QL= 2 caps/day
CIBINQO TAB	QL= 1 tab/day
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA INJ 200MG/ML	QL= 2 inj/28 days
CINRYZE INJ	QL= 16 vials/28 days; Only available through Accredo 800-803-2523

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
clindamycin vaginal cream	QL=1 tube/fill
CLINDESSE VAGINAL CREAM	QL= 1 applicator/fill
COMIRNATY INJ	QL= 1 dose/17 days
COMIRNATY INJ 30MCG/0.3ML	QL= 1 dose/17 days
COPIKTRA CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
COTELLIC TAB	QL= 3 tabs/day
COVID-19 VACCINE INJ 5-11Y (PFIZER)	QL= 1 dose/17 days
COVID-19 VACCINE INJ 6M-11Y (MODERNA)	QL= 1 dose/24 days
COVID-19 VACCINE INJ 6M-4Y (PFIZER)	QL= 1 dose/17 days
CRENESSITY CAP	QL= 2 caps/day; Only available through PantheRx 855-726-8479
CRENESSITY SOLN	QL= 2ml/day; Only available through PantheRx 855-726-8479
cyclosporine ophth emulsion	QL= 60 vials/30 days
CYSTADROPS SOLN	QL= 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007
CYSTARAN OPHTH SOLN	QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416
dalfampridine ER tab	QL= 2 tabs/day; Restricted to Neurology Specialist
dapagliflozin tab	QL= 1 tab/day
dapagliflozin-metformin er tab	QL= 1 tab/day
dapagliflozin-metformin er tab 5-1000MG	QL= 2 tabs/day
DAWNZERA INJ	QL= 1 inj/28 days; Only available through Orsini 800-410-8575
DAYBUE SOLN	QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007
DAYBUE STIX POWDER	QL= 4 packets/day; Only available through AnovoRx 844-288-5007
DAYBUE STIX POWDER 8000MG	QL= 2 packets/day; Only available through AnovoRx 844-288-5007
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 SENSOR	QL= 3 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR	QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
DEXCOM G7 SENSOR (15-DAY)	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
dextromethorphan hbr-quinidine sulfate cap	QL= 2 caps/day
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	QL= 4 doses/fill
diazepam rectal gel	QL= 4 doses/fill

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
diclofenac gel	QL= 300gm/30 days
DIFICID SUSP	QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
dihydroergotamine mesylate nasal spray	QL= 8 sprays/fill, 2 fills/30 days
donepezil ODT	QL= 1 tab/day
donepezil tab	QL= 2 tabs/day
donepezil tab 23mg	QL= 1 tab/day
DOPTELET SPRINKLE CAP	QL= 2 caps/day; Only available through Accredo 800-803-2523
DOPTELET TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
DUPIXENT INJ	QL= 2 inj/28 days
DUPIXENT PEN INJ	QL= 2 inj/28 days
EBGLYSS INJ	QL= 1 inj/28 days
EBGLYSS PEN INJ	QL= 1 inj/28 days
econazole cream	QL= 30gm/30 days
EDEX INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
EKTERLY TAB	QL= 8 tabs/fill; Only available through Accredo 800-803-2523 or Optum 877-445-6874
eltrombopag olamine powder pack for susp	QL= 1 packet/day
eltrombopag olamine tab	QL= 1 tab/day
eltrombopag olamine tab 50MG	QL= 2 tabs/day
eltrombopag olamine tab 75MG	QL= 2 tabs/day
EMGALITY INJ	QL= 1 inj/28 days
EMGALITY INJ 100MG/ML	QL= 3 inj/fill, 6 fills/year
EMPAVELI INJ	QL= 160ml/28 days; Only available through PantheRx 855-726-8479
ENBREL INJ 25MG	QL= 8 inj/28 days
ENBREL INJ 50MG	QL= 4 inj/28 days
ENBREL MINI INJ	QL= 4 inj/28 days
ENBREL SURECLICK INJ 50MG	QL= 4 inj/28 days
ENBUMYST SOLN 0.5MG/0.1ML	QL= 12 devices/fill; Only available through Carepoint Pharmacy 855-237-9112
ENSACOVE CAP	QL= 1 cap/day; Only available through Biologics 800-850-4306
ENSACOVE CAP 100MG	QL= 2 caps/day; Only available through Biologics 800-850-4306
ENSPRYNG INJ	QL= 1 inj/28 days
entecavir tab	QL= 1 tab/day
ENTYVIO SC INJ	QL= 2 inj/28 days
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
ERIVEDGE CAP	QL= 1 cap/day
ERLEADA TAB	QL= 4 tabs/day
ERLEADA TAB 240MG	QL= 1 tab/day
erlotinib tab	QL= 1 tab/day
erlotinib tab 25mg	QL= 3 tabs/day
estradiol td gel	QL= 1 packet/day
estradiol td gel 1.25mg	QL= 1 packet/day
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days, 18 tabs on first fill
estradiol valerate inj	QL= 5ml/fill

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day
everolimus tab for oral susp	QL= 1 tab/day
EVRYSDI SOLN	QL= 6.67ml/day; Only available through Accredo 800-803-2523
EVRYSDI TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
FASENRA PEN INJ	QL= 1 inj/56 days
FEMALE CONDOMS	QL= 12 condoms/fill
fidaxomicin tab	QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution
FILSPARI TAB	QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CV Specialty 800-378-0695
fingolimod hcl cap 0.5mg	QL= 1 cap/day
FINTEPLA SOLN	QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007
FLUAD INJ	QL= 1 inj/28 days
FLUBLOK INJ	QL= 1 inj/28 days
FLUCELVAX INJ	QL= 1 inj/28 days
FLULAVAL INJ, FLUARIX INJ	QL= 1 inj/28 days
FLUMIST NASAL	QL= 1 dose/28 days
flunisolide nasal soln	QL= 2 bottles/fill
FLUZONE HIGH DOSE PF INJ	QL= 1 inj/28 days
FOTIVDA CAP	QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 2-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 READER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3 SENSOR	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE 3-PLUS SENSOR	QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin
FRUZAQLA CAP 1MG	QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
FRUZAQLA CAP 5MG	QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
gabapentin cap 100mg	QL= 9 caps/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
gabapentin cap 300mg	QL= 6 caps/day
gabapentin cap 400mg	QL= 4 caps/day
gabapentin soln	QL= 72 mls/day
gabapentin tab 600mg	QL= 6 tabs/day
gabapentin tab 800mg	QL= 4.5 tabs/day
GALAFOLD CAP	QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
GAVILYTE-C SOLN	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay
GAVRETO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
gefitinib tab	QL= 1 tab/day; Only available through Lumicera 855-847-3553
GILENYA CAP 0.25MG	QL= 1 cap/day
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
glucagon (rdna) for inj kit	QL= 2 inj/fill
GLUCAGON EMR INJ	QL= 2 inj/fill
GLUCAGON INJ KIT	QL= 2 inj/fill
GOLYTELY SOLN	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at preferred brand copay
GOMEKLI CAP	QL= 84 caps/28 days; Only available through Biologics 800-850-4306
GOMEKLI CAP 1MG	QL= 168 caps/28 days; Only available through Biologics 800-850-4306
GOMEKLI TAB FOR ORAL SUSP	QL= 168 tabs/28 days; Only available through Biologics 800-850-4306
granisetron tab	QL= 9 tabs/fill
guaifenesin/codeine syrup	QL= 240ml/fill
GVOKE INJ	QL= 2 inj/fill
GVOKE INJ KIT	QL= 2 inj/fill
GVOKE PFS INJ	QL= 2 inj/fill
HEMANGEOL ORAL SOLN	QL= 9.6mL/day; 1750mL/365 days; Only available through AnovoRx 844-288-5007
HEMANGEOL SOLN	QL= 9.6mL/day; 1750mL/365 days; Only available through AnovoRx 844-288-5007
HERNEXEOS TAB	QL= 3 tabs/day; Only available through Accredo 800-803-2523 or Onco360 877-662-6633
HYD POL/CPM SUSP	QL= 120ml/fill; 2 fills/30 days
HYDROCODONE BITARTRATE ER CAP	QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
HYDROCODONE BITARTRATE ER TAB	QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid E Dependency)
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
hydrocortisone succinate inj 100mg	QL= 2 vials/fill
HYFTOR GEL	QL= 10 grams/30 days; Only available through Walgreens 888-347-3416
HYRNUO TAB	QL= 4 tabs/day; Only available through Onco360 877-662-6633
ibandronate tab 150mg	QL= 1 tab/30 days
IBTROZI CAP	QL= 3 caps/day; Only available through Biologics 800-850-4306

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ICLUSIG TAB	QL= 1 tab/day; Only available through AcariaHealth 800-511-5144
icosapent ethyl cap	QL= 4 caps/day
IDHIFA TAB	QL= 1 tab/day
IMBRUVICA CAP 140MG	QL= 4 caps/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA CAP 70MG	QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA SUSP	QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118
IMBRUVICA TAB 420MG	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
IMCIVREE INJ	QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479
INBRIJA INH POWDER	QL= 10 caps/day; Only available through Sterling 888-618-4126 or Walgreens 888-347-3416
INGREZZA CAP	QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479
INGREZZA PACK 40-80MG	QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479
INGREZZA SPRINKLE CAP	QL= 1 cap/day; Only available through PantheRx 855-726-8479
INLURIYO TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Orsini 800-410-857
INLYTA TAB	QL=4 tabs/day
INLYTA TAB 1MG	QL= 8 tabs/day
INQOVI TAB	QL= 5 tabs/28 days
IQIRVO TAB	QL= 1 tab/day; Only available through Caremark/CVS Specialty 800-378-0695 or Walgreens 888-347-3416
ISTURISA TAB	QL= 12 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007
IWILFIN TAB	QL= 8 tabs/day; Only available through CurantHealth 866-437-8040
JAKAFI TAB	QL= 2 tabs/day
JAKAFI XR TAB	QL= 1 tab/day
JAYPIRCA TAB	QL= 2 tabs/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
JOENJA TAB	QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479
KALYDECO PAK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
KALYDECO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KERENDIA TAB	QL= 1 tab/day
ketorolac inj 15mg/ml	QL= 20ml/5 days
ketorolac inj 30mg/ml	QL= 20ml/5 days
ketorolac inj 60mg/2ml	QL= 20ml/5 days
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KHINDIVI SOLN	QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older
KINERET INJ	QL= 1 inj/day; Only available through Biologics 800-850-4306
KISQALI PAK	QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828
KISQALI TAB	QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828
KOSELUGO CAP	QL= 4 caps/day; Only available through Onco360 877-662-6633
KOSELUGO CAP 10MG	QL= 8 caps/day; Only available through Onco360 877-662-6633

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
KOSELUGO SPRINKLE CAP	QL= 12 caps/day; Only available through Onco360 877-662-6633
KOSELUGO SPRINKLE CAP 5MG	QL= 20 caps/day; Only available through Onco360 877-662-6633
KRAZATI TAB	QL= 6 tabs/day; Only available through Biologics 800-850-4306
LAGEVRIO CAP (EUA)	QL= 40 caps/fill
LAGEVRIO CAP 200MG	QL= 40 caps/fill
LASIX ONYU INJ 80MG/2.67ML	QL= 6 cartridges/fill
LASIX ONYU REUSABLE UNIT	QL= 1 device/year
latanoprost ophth soln	QL= 2.5ml/30 days
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/day
lenalidomide cap	QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416
LENVIMA CAP	QL= 3 caps/day; Only available through Optum 877-445-6874
LEQEMBI IQLIK INJ 250MG/1.25ML	QL= 8 inj/28 days; Only available through Caremed 877-227-3405 or Walgreens 888-347-3416
LEQEMBI IQLK INJ	QL= 4 inj/28 days; Only available through CareMed 877-227-3405 or Walgreens 888-347-3416
LEQSELVI TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523 or Optum 877-445-687
LEVALBUTEROL INHALER, XOPENEX HF INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of an albuterol HFA product (6.7 or 8.5gm)
l-glutamine powder packet	QL= 6 packets/day
LIDOCAINE OINT	QL= 36gm/fill
lidocaine patch 5%	QL= 3 patches/day
LINZESS CAP	QL= 1 cap/day
liraglutide soln pen-injector	QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11)
lisdexamfetamine dimesylate cap	QL= 1 cap/day
lisdexamfetamine dimesylate chew tab	QL= 1 tab/day; Members age 9 or older require Prior Authorization
LITFULO CAP	QL= 1 cap/day; Only available through Caremark/CVS Specialty 800-378-0695
LIVDELZI CAP	QL= 1 cap/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-847
LIVMARLI SOLN	QL= 90ml/30 days; Only available through Eversana 866-849-4481
LIVMARLI TAB	QL= 2 tabs/day; Only available through Eversana 866-849-4481
LIVMARLI TAB 30MG	QL= 1 tab/day; Only available through Eversana 866-849-4481
LIVTENCITY TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
lofexidine hcl tab	QL= 96 tabs/7 days
LOKELMA PAK	QL= 1 packet/day
LOPRESSOR SOLN	QL= 45ml/day; Prior Authorization required for members age 9 years and older
LORBRENA TAB 25MG	QL= 3 tabs/day
lubiprostone cap	QL= 2 caps/day
LUCEMYRA TAB	QL= 96 tabs/7 days
LUMAKRAS TAB	QL= 8 tabs/day; Only available through Biologics 800-850-4306
LUMAKRAS TAB 240MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306
LUMAKRAS TAB 320MG	QL= 3 tabs/day; Only available through Biologics 800-850-4306

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
LUPKYNIS CAP	QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479
LYNPARZA TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
LYTGOBI THERAPY PACK	QL= 5 tabs/day; Only available through Onco360 877-662-6633
macitentan tab	QL= 1 tab/day
malathion lotion	QL= 2 bottles/fill
MALE CONDOMS	QL= 12 condoms/fill
MAVYRET PAK	QL= 5 packs/day
MAVYRET TAB	QL= 3 tabs/day
medroxyprogesterone inj	QL= 1 inj/90 days
MEKINIST TAB 0.5MG	QL= 3 tabs/day
MEKINIST TAB 2MG	QL= 1 tab/day
MEKTOVI TAB	QL= 6 tabs/day
methylergonovine tab	QL= 28 tabs/fill, 1 fill/365 days
MFLUSIVA INJ	QL= 1 inj/28 days; Covered for members age 50 years and older
MIDAZOLAM INJ	QL= 1 inj/fill
mifepristone tab	QL= 4 tabs/day
miglustat cap	QL= 3 caps/day; Only available through Accredo 800-803-2523
milnacipran hcl tab	QL= 2 tabs/day
MNEXSPIKE INJ 10MCG/0.2ML	QL= 1 dose/24 days
modafinil tab	QL= 2 tabs/day
MODEYSO CAP	QL= 20 caps/28 days; Only available through Onco360 877-662-6633
mometasone nasal spray	QL= 2 bottles/fill
MOUNJARO INJ	QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
MOVANTIK TAB	QL= 1 tab/day
MRESVIA INJ	QL= 1 dose/lifetime
MYFEMBREE TAB	QL= 1 tab/day
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NATACYN OPHTH SUSP	QL= 15ml/fill
NATROBA SUSP	QL= 1 bottle/fill
NATROBA SUSP 0.90%	QL= 1 bottle/fill
NAYZILAM SPRAY	QL= 4 doses/fill
NEFFY SPRAY	QL= 2 doses/fill
NEMLUVIO INJ	QL= 1 inj/56 days
NERLYNX TAB	QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
NEXLETOL TAB	QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
nicotine gum	Limited to 180 days/plan year
NICOTINE KIT	
nicotine lozenge	Limited to 180 days/plan year
nicotine patch	Limited to 180 days/plan year

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
nintedanib esylate cap	QL= 2 caps/day
nitazoxanide tab	QL= 6 tabs/3 days
NOVAVAX INJ	QL= 1 dose/24 days
NUBEQA TAB	QL= 4 tabs/day
NUCALA INJ	QL= 1 inj/28 days
NUCYNTA ER TAB	QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid E Dependency)
ODOMZO CAP	QL= 1 cap/day
OGSIVEO TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
OGSIVEO TAB 50MG	QL= 6 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
OHTUVAYRE SUSP	QL= 60 ampules/30 days; Only available through CVS Specialty 800-238-7828 or AcariaHealth 800-511-5144
OJEMDA SUSP	QL= 96ml/28 days; Only available through Onco360 877-662-6633
OJEMDA TAB	QL= 24 tabs/28 days; Only available through Onco360 877-662-6633
OJJAARA TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
olopatadine hcl ophth soln 0.2%	QL= 2.5ml/30 days
OLUMIANT TAB	QL= 1 tab/day
OMLYCLO SYRINGE	QL= 2 inj/28 days
OMLYCLO SYRINGE 150MG/ML	QL= 2 inj/28 days
OMLYCLO SYRINGE 300MG/2ML	QL= 1 inj/28 days
OMNIPOD 5 DEX G7G6 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 DEX G7G6 PODS	QL= 10 pods/month
OMNIPOD 5 G7 KIT INTRO	QL= 1 kit/year
OMNIPOD 5 G7 MIS PODS	QL= 10 pods/30 days
OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT	QL= 1 kit/year
OMNIPOD 5 LIBRE2 PLUS G6 PODS	QL= 10 pods/30 days
OMNIPOD 5 PACK PODS	QL= 10 pods/month
OMNIPOD DASH INTRO KIT	QL= 1 kit/year
OMNIPOD DASH PODS	QL= 10 pods/month
OMNIPOD GO KIT	QL= 10 pods/month
OMNIPOD STARTER KIT	QL= 1 kit/year
ONGENTYS CAP	QL= 1 tab/day, 30 tabs per fill
OPZELURA CREAM	QL= 4 tubes/30 days for the first two months; then QL= 12 tubes/year thereafter
ORENCIA CLICK INJ	QL= 4 inj/28 days
ORENCIA SC INJ 125MG/ML	QL= 4 inj/28 days
ORENCIA SC INJ 50MG/0.4ML	QL= 4 inj/28 days
ORENCIA SC INJ 87.5MG/0.7ML	QL= 4 inj/28 days

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ORGOVYX TAB	QL= 30 tabs/28 days; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
ORIAHNN CAP	QL= 2 caps/day
ORILISSA TAB 150MG	QL= 1 tab/day
ORILISSA TAB 200MG	QL= 2 tabs/day
ORKAMBI GRANULES PACKET	QL= 2 packets/day; Only available through Walgreens 888-347-3416
ORKAMBI TAB	QL= 4 tabs/day; Only available through Walgreens 888-347-3416
ORLADEYO CAP	QL= 1 cap/day; Only available through CareMed 877-227-3405 or Onco360 877-662-6633
ORLADEYO PACK	QL= 1 packet/day; Only available through CareMed 877-227-3405 or Onco360 877-662-6633
ORSERDU TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
ORSERDU TAB 345MG	QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
oseltamivir cap	QL= 10 caps/fill, 1 fill/calendar year
oseltamivir cap 30mg	QL= 20 caps/fill, 1 fill/calendar year
oseltamivir susp	QL= 250ml/fill, 1 fill per calendar year
OTEZLA STARTER PACK	QL= 1 pack/28 days
OTEZLA TAB	QL= 2 tabs/day
OTEZLA XR TAB	QL= 1 tab/day
OTEZLA/OTEZLA XR STARTER PACK	QL= 1 pack/28 days
OXERVATE OPHTH SOLN	QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523
OZEMPIC INJ	QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
OZEMPIC TAB, RYBELSUS TAB	QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11)
PALSONIFY TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Orsini 800-410-857
PALYNZIQ INJ	QL= 1 inj/day; Only available through Accredo 800-803-2523
PAXLOVID PAK	QL= 11 tabs/90 days
PAXLOVID TAB 150-100MG	QL= 20 tabs/90 days
PAXLOVID TAB 300-100MG	QL= 30 tabs/90 days
pazopanib tab	QL= 4 tabs/day
peg 3350 soln (100 gram Moviprep equiv)	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay
peg 3350/electrolytes soln	QL= 2 fills/365 days; $0 copay for members age 45-75 years; All other members covered at generic copay
PEMAZYRE TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
PHEXXI GEL	QL= 1 box/fill
pirfenidone cap	QL= 9 caps/day
pirfenidone tab 267mg	QL= 9 tabs/day
pirfenidone tab 801mg	QL= 3 tabs/day
pomalidomide cap	QL= 21 caps/28 days
posaconazole DR tab	QL= 93 tabs/30 days

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
posaconazole susp	QL= 525ml/26 days
pregabalin cap	QL= 3 caps/day
pregabalin cap 225mg	QL= 2 caps/day
pregabalin cap 300mg	QL= 2 caps/day
pregabalin soln	QL= 30ml/day
PRETOMANID TAB	QL= 1 tab/day; Restricted to Infectious Disease Specialist
PREVYMIS PAK	QL= 4 packets/day; Limit 800 packets/365 days
PREVYMIS TAB	QL= 1 tab/day; Limit 200 tabs/365 days
PROLIA INJ	QL= 1 fill/6 months
prucalopride succinate tab	QL= 1 tab/day
pyrimethamine tab	QL= 3 tabs/day; Only available through Walgreens 888-347-3416
PYRUKYND TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
PYRUKYND TAPER PACK	QL= 1 tab/day; Only available through Biologics 800-850-4306
QINLOCK TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
RADICAVA ORS STARTER KIT	QL= 70ml/365 days; Only available through Accredo 800-803-2523
RADICAVA ORS SUSP	QL= 50mL/28 days; Only available through Accredo 800-803-2523
ramelteon tab	QL= 1 tab/day
REDEMPLO PFS INJ	QL= 1 inj/84 days; Only available through Vanscoy Rare Pharmacy 855-826-7269
RELENZA DISKHALER	QL= 1 inhaler/calendar year
REPATHA INJ	QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin
RETEVMO CAP	QL= 2 caps/day
RETEVMO CAP 40MG	QL= 3 caps/day
RETEVMO TAB	QL= 2 tabs/day
RETEVMO TAB 40MG	QL= 3 tabs/day
REVUFORJ TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
REVUFORJ TAB 110MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
REVUFORJ TAB 25MG	QL= 8 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
REYVOW TAB	QL= 8 tabs/30 days, 6 fills/year
REZDIFFRA TAB	QL= 1 tab/day; Only available through Optum 877-445-6874
REZLIDHIA CAP	QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
REZUROCK TAB	QL= 1 tab/day; Only available through Lumicera 855-847-3553
RINVOQ ER TAB	QL= 1 tab/day
RINVOQ ORAL SOLN	QL= 12ml/day
riociguat tab	QL= 3 tabs/day; Only available through Accredo 800-803-2523
RIVFLOZA INJ	QL= 1 inj/30 days; Only available through Orsini 800-410-8575
RIVFLOZA INJ 160MG	QL= 1 inj/30 days; Only available through Orsini 800-410-8575

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
RIVFLOZA VIAL	QL= 2 vials/30 days; Only available through Orsini 800-410-8575
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
ROMVIMZA CAP	QL= 8 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
ROZLYTREK CAP	QL= 3 caps/day
ROZLYTREK PAK	QL= 6 packs/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Optum 877-445-6874
RYDAPT CAP	QL= 56 caps/28 days
sacubitril-valsartan tab	QL= 2 tabs/day
SANCUSO PATCH	QL= 4 patches/fill
SANTYL OINT	QL= 90gm/30 days
SAPHNELO INJ	QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767
SAPHNELO PEN INJ	QL= 4 inj/28 days; Only available through CVS Specialty 800-237-2767
SAVELLA TAB	QL= 2 tabs/day
SCEMBLIX TAB	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
SCEMBLIX TAB 100 MG	QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
SIGNIFOR INJ	QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007
sildenafil tab	QL=6 tabs/30 days
SIMPONI AUTO-INJECTOR 100MG	QL=1 inj/28 days
SIMPONI INJ 100MG	QL=1 inj/28 days
sitagliptin phosphate tab	QL= 1 tab/day
sitagliptin phosphate-metformin hcl er tab	QL= 2 tabs/day
sitagliptin phosphate-metformin hcl tab	QL= 2 tabs/day
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKYCLARYS CAP	QL= 3 caps/day; Only available through Biologics 800-850-4306
SKYRIZI INJ 150MG/ML	QL= 1 inj/84 days
SKYRIZI INJ 180 MG/1.2ML	QL= 1 inj/56 days
SKYRIZI INJ 360MG/2.4ML	QL= 1 inj/56 days
SKYRIZI INJ 55MG/0.37ML	QL= 1 inj/84 days
sodium oxybate oral soln	QL= 540ml/30 days
SODIUM OXYBATE SOLN	QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-368
sodium/magnesium/potassium soln	$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year
SOFOSBUVIR/VELPATASVIR TAB	QL= 1 tab/day
SOHONOS CAP 1.5MG	QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 10MG	QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 1MG	QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 2.5MG	QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828
SOHONOS CAP 5MG	QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
SOLIQUA INJ	QL= 15ml/25 days
SOLU-CORTEF INJ	QL= 1 vial/fill
SOLU-CORTEF INJ 100MG	QL= 2 vials/fill
SPEVIGO INJ	QL= 2ml/28 days; Only available through Accredo 800-803-2523
SPIKEVAX INJ	QL= 1 dose/24 days
SPIKEVAX INJ 50MCG/0.5ML	QL= 1 dose/24 days
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL)
STEQEYMA INJ	QL= 1 inj/84 days
STEQEYMA INJ 90MG	QL= 1 inj/84 days
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
SUFLAVE SOLN	QL= 2 fills/365 days
sumatriptan inj	QL= 6 inj/fill, 3 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 3 fills/30 days
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 10 vials/fill, 2 fills/30 days
sunitinib malate cap	QL= 1 cap/day
SUNOSI TAB	QL= 1 tab/day
SYMDEKO TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
SYMPROIC TAB	QL= 1 tab/day
TABRECTA TAB	QL= 4 tabs/day
tadalafil tab 2.5mg, 5mg	QL= 1 tab/day
TAGRISSO TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
TAKHZYRO INJ	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TAKHZYRO INJ 150MG/ML	QL= 2 inj/28 days; Only available through Accredo 800-803-2523
TALTZ INJ	QL= 1 inj/28 days
TALTZ INJ 20MG/0.25ML	QL= 1 inj/28 days
TALTZ INJ 40 MG/0.5ML	QL= 1 inj/28 days
TALZENNA CAP 0.25MG	QL= 3 caps/day
TALZENNA CAP 0.5MG, 0.75MG, 1MG	QL= 1 cap/day
TAVNEOS CAP	QL= 6 caps/day; Only available through PantheRx 855-726-8479
TEMPO SMART BUTTON	QL= 1 button/8 months
TEPMETKO TAB	QL= 2 tabs/day; Only available through Biologics 800-850-4306
TESTOSTERONE ENANTHATE INJ 200MG/ML	QL= 5ml/fill
testosterone gel pump 1.62%	QL= 2 bottles/30 days
testosterone soln	QL= 2 bottles/30 days
TEZSPIRE INJ	QL= 1 pen/28 days

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TIBSOVO TAB	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
tofacitinib citrate ER tab	QL= 1 tab/day
tofacitinib citrate oral soln	QL= 10ml/day
tofacitinib citrate tab	QL= 2 tabs/day
tolvaptan tab	QL= 2 tabs/day
tolvaptan tab therapy pack	QL= 2 tabs/day
TRADJENTA TAB	QL= 1 tab/day
travoprost ophth soln	QL= 5ml/30 days; Step Therapy requires trial of latanoprost
TREMFYA INDUCTION INJ 200MG/ML	QL= 2 inj/28 days; 6 inj/year
TREMFYA INJ	QL= 1 inj/56 days
TREMFYA INJ 200MG/2ML	QL= 1 inj/28 days
tretinoin cream	QL= 20gm/fill; Acne Only - Prior Authorization required for members age 35 years and older
tretinoin gel	QL= 15gm/fill; Acne Only - Prior Authorization required for members age 35 years and older
TRIKAFTA TAB	QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416
TRIKAFTA THERAPY PACK	QL= 2 packets/day; Only available through Walgreens 888-347-3416
TRINTELLIX TAB	QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine
TRULANCE TAB	QL= 1 tab/day
TRULICITY INJ	QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)
TRUQAP TAB	QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
TRUQAP THERAPY PACK	QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
TRYNGOLZA INJ	QL= 1 inj/28 days; Only available through Accredo 800-803-2523
TUKYSA TAB	QL= 4 tabs/day; Only available through Biologics 800-850-4306
TURALIO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
TWIIST REFILL KIT	QL= 1 kit/month
TWIIST STARTER KIT	QL= 1 kit/month
TYENNE INJ	QL= 2 inj/28 days
TYRVAYA NASAL SPRAY	QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist; Step Therapy Requires trial of cyclosporine opth emulsion
TYVASO DPI POWDER	QL= 4 cartridges/day; Only available through Accredo 800-803-2523
TYVASO DPI POWDER 48-80MCG	QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG	QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG	QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG	QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO DPI POWDER TITRATION KIT 16-32-48MCG	QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523
TYVASO INH SOLN 0.6 MG/ML	QL= 1 ampule/day; Only available through Accredo 800-803-2523
UBRELVY TAB	QL= 10 tabs/30 days, 6 fills/year
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
UPTRAVI THERAPY PACK	QL= 1 pack/year; Only available through Accredo 800-803-2523
USTEKINUMAB-AEKN 45MG/0.5ML	QL= 1 inj/84 days; Only available through Lumicera 855-847-3553
USTEKINUMAB-AEKN 90MG/ML	QL= 1 inj/84 days; Only available through Lumicera 855-847-3553
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Accredo 800-803-2523
VALTOCO NASAL SPRAY	QL= 5 doses/fill
vancomycin cap	QL= 56 caps/fill
VANFLYTA TAB	QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
VANFLYTA TAB 26.5MG	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
VANRAFIA TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306 or CareMed 877-227-3405
VARENICLINE TAB	Limited to 180 days/plan year
varenicline tartrate tab	Limited to 180 days/plan year
varenicline tartrate tab starter pack	Limited to 180 days/plan year
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VELTASSA POWDER	QL= 1 packet/day
VELTASSA POWDER 1GM	QL= 4 packets/day
VENTAVIS INH SOLN	QL= 9 ampules/day; Only available through Accredo 800-803-2523
VEOZAH TAB	QL= 1 tab/day
VERQUVO TAB	QL= 1 tab/day; Restricted to Cardiology Specialist
VERZENIO TAB	QL= 2 tabs/day
VIJOICE GRANULES PACKET	QL= 1 packet/day; Only available through Biologics 800-850-4306
VIJOICE TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
VIJOICE TAB 250MG	QL= 2 tabs/day; Only available through Biologics 800-850-4306
VITRAKVI CAP 100MG	QL= 2 caps/day; Only available through Accredo 800-803-2523
VITRAKVI CAP 25MG	QL= 6 caps/day; Only available through Accredo 800-803-2523
VITRAKVI SOLN	QL= 10ml/day; Only available through Accredo 800-803-2523
VONJO CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
VORANIGO TAB	QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
VORANIGO TAB 10MG	QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306
VOSEVI TAB	QL= 1 tab/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
VOWST CAP	QL= 12 caps/fill; Only available through Orsini 800-410-8575
VOXZOGO INJ	QL= 1 vial/day; Only available through Accredo 888-773-7376
VOYDEYA TAB	QL= 6 tabs/day; Only available through Onco360 877-662-6633
VOYDEYA TAB THERAPY PACK	QL= 6 tabs/day; Only available through Onco360 877-662-6633
VYJUVEK GEL	QL= 4 vials/28 days; Only available through CVS Specialty 800-237-2767
VYKAT XR TAB	QL= 4 tabs/day; Only available through PantherRx 855-726-8479
VYKAT XR TAB 150MG	QL= 3 tabs/day; Only available through PantherRx 855-726-8479
VYKAT XR TAB 75MG	QL= 7 tabs/day; Only available through PantherRx 855-726-8479
VYNDAMAX CAP	QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
VYNDAQEL CAP	QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416
VYVGART HYTRULO INJ	QL= 4 inj/28 days; Only available through Accredo 800-803-2523
WAINUA INJ	QL= 1 inj/28 days; Only available through Orsini 800-410-8575
WAKIX TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
WELIREG TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633
XACIATO GEL	QL= 1 applicator/fill
XADAGO TAB	QL= 1 tab/day
XALKORI CAP	QL= 2 caps/day
XALKORI SPRINKLE CAP	QL= 4 caps/day
XCOPRI PAK 100-150MG	QL= 2 tabs/day
XCOPRI PAK 150-200MG	QL= 2 tabs/day
XCOPRI TAB 150MG, 200MG	QL= 2 tabs/day
XCOPRI TAB 25MG	QL= 1 tab/day
XCOPRI TAB 50MG, 100MG	QL= 1 tab/day
XCOPRI TITRATION PAK 12.5-25MG	QL= 1 tab/day
XCOPRI TITRATION PAK 150-200MG	QL= 1 tab/day
XCOPRI TITRATION PAK 50-100MG	QL= 1 tab/day
XDEMVY DROP	QL= 1 bottle/42 days; Only available through CVS Specialty 800-238-7828 or Walgreens 888-347-3416
XENLETA TAB	QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist
XIFAXAN TAB 200MG	QL= 9 tabs/3 days
XIFAXAN TAB 550MG	QL= 2 tabs/day
XIGDUO XR TAB 2.5-1000	QL= 2 tabs/day
XOLAIR INJ	QL= 2 inj/28 days
XOLAIR INJ 150MG/ML	QL= 2 inj/28 days
XOLAIR INJ 300MG/2ML	QL= 1 inj/28 days
XOLAIR SYRINGE	QL= 2 inj/28 days
XOLAIR SYRINGE 150MG/ML	QL= 2 inj/28 days
XOLAIR SYRINGE 300MG/2ML	QL= 1 inj/28 days
XOLREMDI CAP	QL= 4 caps/day; Only available through PantherRx Pharmacy 855-726-8479

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XOSPATA TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
XPHOZAH TAB	QL= 2 tabs/day
XPOVIO PAK	QL= 32 tabs/28 days; Only available through Onco360 877-662-6633
XTAMPZA ER CAP	QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)
XULTOPHY INJ	QL= 15ml/30 days
YESINTEK INJ	QL= 1 inj/84 days
YESINTEK SYRINGE	QL= 1 inj/84 days
YESINTEK SYRINGE 90MG	QL= 1 inj/84 days
YEZTUGO INJ	QL= 2 inj/180 days; Only available through Walgreens 888-347-3416
YEZTUGO TAB	QL= 4 tabs/28 days; Only available through Walgreens 888-347-3416
YORVIPATH INJ	QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-847
YORVIPATH INJ 294MCG	QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-847
YORVIPATH INJ 420MCG	QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-847
YUTREPIA CAP	QL= 112 caps/28 days; Only available through CVS Specialty 800-237-2767
zaleplon cap	QL= 1 cap/day
ZAVZPRET NASAL SPRAY	QL= 6 units/fill; 60 units/365 days
ZEGALOGUE INJ	QL= 2 inj/fill
ZEJULA TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
ZELBORAF TAB	QL= 8 tabs/day
ZELSUVMI GEL	QL= 1 carton/fill, 2 fills/365 days
ZEPOSIA CAP	QL= 1 cap/day
ZEPOSIA STARTER PACK	QL= 1 cap/day
ZILBRYSQ INJ	QL= 1 inj/day; Only available through PantheRx 855-726-8479
ZILBRYSQ INJ 23MG	QL= 1 inj/day; Only available through PantheRx 855-726-8479
ZILBRYSQ INJ 32.4MG	QL= 1 inj/day; Only available through PantheRx 855-726-8479
ZOKINVY CAP	QL= 4 caps/day; Only available through CVS Specialty 800-237-2767
zolmitriptan nasal spray	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days; Step Therapy Requires trial of the following sumatriptan naratriptan, rizatriptan and zolmitriptan
ZOLMITRIPTAN SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
zolmitriptan tab	QL= 9 tabs/fill, 2 fills/30 days
zolpidem tab	QL= 1 tab/day
ZOMIG SPRAY	QL= 6 sprays/fill, 2 fills/30 days; Step Therapy requires trial of sumatriptan nasal spray
ZORYVE CREAM	QL= 60 grams/30 days
ZORYVE FOAM	QL= 60 grams/30 days
ZTALMY SUSP	QL= 1100ml/30 days; Only available through Orsini 800-410-8575
ZURZUVAE CAP 20MG, 25MG	QL= 28 caps/365 days; Only available through Caremark/CVS Specialty 800-378-069
ZURZUVAE CAP 30MG	QL= 14 caps/365 days; Only available through Caremark/CVS Specialty 800-378-069
ZYKADIA TAB	QL= 3 tabs/day

** OTC drugs are not a covered benefit.

Coverage of medications, including those not otherwise identified by qualifiers such as QL/PA/ST, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.