

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 2/1/2021**

Drug Name	Special Code	Tier	Category
8-MOP CAP	-	B	DERMATOLOGICALS
abacavir soln (ZIAGEN equiv)	-	G	ANTIVIRALS
abacavir tab (ZIAGEN equiv)	-	G	ANTIVIRALS
abacavir/lamivudine tab (EPZICOM equiv)	-	G	ANTIVIRALS
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	G	ANTIVIRALS
ABILIFY DISCMELT (QL= 2 tabs/day)	QL	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ABILIFY MYCITE TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ABILIFY SOLN	-	B	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	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ABSORICA CAP	-	NC	DERMATOLOGICALS
ABSORICA LD CAP	-	NC	DERMATOLOGICALS
ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	B	ANALGESICS - OPIOID
acamprosate calcium DR tab (CAMPRAL equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
acarbose tab (PRECOSE equiv)	-	G	ANTIDIABETICS
ACCU-CHEK AVIVA PLUS METER	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCU-CHEK GUIDE CARE METER	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE ME KIT	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK GUIDE TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCU-CHEK NANO METER	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
ACCU-CHEK SMARTVIEW TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
ACCU-CHEK TEST STRIP	OTC-PA	B	DIAGNOSTIC PRODUCTS
acebutolol cap (SECTRAL equiv)	-	G	BETA BLOCKERS
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC	ANALGESICS - OPIOID
acetaminophen/codeine soln	-	G	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
ACETASOL HC OTIC SOLN	-	B	OTIC AGENTS
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	G	DIURETICS
acetazolamide tab	-	G	DIURETICS
acetic acid otic soln (VOSOL equiv)	-	G	OTIC AGENTS
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	G	OTIC AGENTS
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	G	OTIC AGENTS
acetylcysteine soln (MUCOMYST equiv)	-	G	COUGH/COLD/ALLERGY
ACIDIC VAGINAL JELLY	-	B	VAGINAL PRODUCTS
ACIPHEX SPRINKLE CAP	-	NC	ULCER DRUGS
ACIPHEX SPRINKLE CAP 10MG, RABEPRAZOLE SPRINKLE CAP 10MG	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS
acitretin cap (SORIATANE equiv)	-	G	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
ACTEMRA ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA IV INJ	MSP-PA	B	ANALGESICS - ANTI-INFLAMMATORY
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
ACTICLATE TAB 75MG, 150MG	-	NC	TETRACYCLINES
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTINEOPLASTICS
ACTIVE OB	-	NC	MULTIVITAMINS
ACTOPLUS MET TAB	-	NC	ANTIDIABETICS
ACTOPLUS MET XR TAB	-	NC	ANTIDIABETICS
ACUVAIL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
acyclovir cap (ZOVIRAX equiv)	-	G	ANTIVIRALS
acyclovir cream (ZOVIRAX equiv)	PA	G	DERMATOLOGICALS
acyclovir oint (ZOVIRAX OINT equiv)	-	NC	DERMATOLOGICALS
acyclovir susp (ZOVIRAX equiv)	-	G	ANTIVIRALS
acyclovir tab (ZOVIRAX equiv)	-	G	ANTIVIRALS
ACZONE GEL, DAPSONE GEL 7.5%	-	NC	DERMATOLOGICALS
ADACEL/BOOSTRIX INJ	VAC	\$0	TOXOIDS
ADAGEN INJ	MSP-PA	B	BIOLOGICALS MISC
adapalene cream (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
adapalene gel (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
ADAPALENE LOTION (DIFFERIN equiv)	-	NC	DERMATOLOGICALS
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	NC	DERMATOLOGICALS
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC	DERMATOLOGICALS
ADASUVE INHALER	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ADAZIN CREAM	-	NC	DERMATOLOGICALS
ADCIRCA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
ADDERALL XR CAP	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ADDYI TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
adefovir dipivoxil tab (HEPSERA equiv)	-	G	ANTIVIRALS
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
ADLYXIN INJ	-	NC	ANTIDIABETICS
ADMELOG INJ, INSULIN LISPRO INJ	PA	B	ANTIDIABETICS
ADMELOG SOLOSTAR INJ, INSULIN LISPRO KWIKPEN INJ (JUNIOR)	PA	B	ANTIDIABETICS
ADOXA CAP 150MG	-	NC	TETRACYCLINES
ADOXA TAB 150MG	-	NC	TETRACYCLINES
ADOXA TAB 75MG	-	NC	TETRACYCLINES
ADRENACLICK INJ, EPINEPHRINE INJ	-	NC	VASOPRESSORS
ADVAIR DISKUS INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVAIR HFA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ADVATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ADZENYS ER SUSP, AMPHETAMINE ER SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ADZENYS XR TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
AEMCOLO TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
AEROCHAMBER	OTC	B	MEDICAL DEVICES AND SUPPLIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
AFINITOR DISPERZ (QL= 1 tab/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB 10MG (QL= 1 tab/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFINITOR TAB 2.5MG, 5MG, 7.5MG	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AFLURIA INJ	VAC	\$0	VACCINES
AFLURIA INJ, FLUZONE INJ	VAC	\$0	VACCINES
AFSTYLA KIT	-	NC	HEMATOLOGICAL AGENTS - MISC.
AGGRENOX CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
AIMOVIQ 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
AJOVY INJ	-	NC	MIGRAINE PRODUCTS
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
ALAMAST OPTH SOLN	-	B	OPHTHALMIC AGENTS
ALBUTEROL HFA INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol HFA inhaler (PROAIR equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol HFA inhaler (PROVENTIL equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol neb soln	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate syrup	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol sulfate tab	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ALBUTEROL TAB ER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
albuterol/ipratropium neb soln (DUONEB equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
alclometasone cream (ACLOVATE equiv)	-	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.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
ALENDRONATE TAB 40MG	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ALEVICYN SOLN DERMAL	-	NC	DERMATOLOGICALS
ALFERON-N INJ	LMSF	B	ANTINEOPLASTICS
alfuzosin SR tab (UROXATRAL equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	B	ANTI-INFECTIVE AGENTS - MISC.
aliskiren tab (TEKTURNA equiv) (Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan)	ST-¢	G	ANTIHYPERTENSIVES
ALKINDI SPRINKLE CAP	-	NC	CORTICOSTEROIDS
allopurinol tab (ZYLOPRIM equiv)	-	G	GOUT AGENTS
ALLZITAL TAB	-	NC	ANALGESICS - NONNARCOTIC
almotriptan tab (AXERT equiv)	-	NC	MIGRAINE PRODUCTS
ALOCRILOPHTH SOLN	-	B	OPHTHALMIC AGENTS
ALOGLIPTIN TAB, NESINA TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC	ANTIDIABETICS
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC	ANTIDIABETICS
ALOMIDE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
ALOQUIN GEL	-	NC	DERMATOLOGICALS
ALORA PATCH	-	NC	ESTROGENS
alosetron tab (LOTRONEX equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
ALPHAGAN P OPHTH SOLN 0.1%	-	B	OPHTHALMIC AGENTS
ALPHAGAN P OPHTH SOLN 0.15%	-	NC	OPHTHALMIC AGENTS
ALPHANATE/HEMOFIL/KOATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ALPHANINE SD/MONONINE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
alprazolam ER tab (XANAX XR equiv)	-	G	ANTI-ANXIETY AGENTS
alprazolam ODT (NIRAVAM equiv)	-	G	ANTI-ANXIETY AGENTS
alprazolam tab (XANAX equiv)	-	G	ANTI-ANXIETY AGENTS
ALREX OPHTH SUSP	-	B	OPHTHALMIC AGENTS
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC	MIGRAINE PRODUCTS
ALTABAX OINT	-	NC	DERMATOLOGICALS
ALTOPREV TAB	-	NC	ANTIHYPERLIPIDEMICS
ALTRENO LOTION	-	NC	DERMATOLOGICALS
aluminum chloride soln (DRYSOL equiv)	-	G	DERMATOLOGICALS
ALUNBRIG PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ALVESCO INHALER	-	NC	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
alvimopan cap (ENTEREG equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
ALZAIR NASAL SPRAY	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
amantadine cap (SYMMETREL equiv)	-	G	ANTIPARKINSON AGENTS
amantadine syrup (SYMMETREL equiv)	-	G	ANTIPARKINSON AGENTS
amantadine tab	-	G	ANTIPARKINSON AGENTS
AMBIEN CR TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSF	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Lumicera 855-847-3553 or Walgreens 888-347-3416)	LD-QL-RS	B	CARDIOVASCULAR AGENTS - MISC.
AMCINONIDE CREAM 0.1%	-	NC	DERMATOLOGICALS
AMCINONIDE LOTION	-	NC	DERMATOLOGICALS
AMCINONIDE OINT	-	NC	DERMATOLOGICALS
AMERGE TAB	-	NC	MIGRAINE PRODUCTS
amethyst tab (LYBREL equiv)	-	\$0	CONTRACEPTIVES
AMICAR SYRUP	-	B	HEMOSTATICS
amiloride tab (MIDAMOR equiv)	-	G	DIURETICS
amiloride/hydrochlorothiazide tab (MODURETIC equiv)	-	G	DIURETICS
aminocaproic acid soln (AMICAR equiv)	-	G	HEMOSTATICS
aminocaproic acid syrup (AMICAR equiv)	-	G	HEMOSTATICS
aminocaproic acid tab (AMICAR equiv)	-	G	HEMOSTATICS
aminophylline tab	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
amiodarone tab (CORDARONE equiv)	-	G	ANTIARRHYTHMICS
AMITIZA CAP, LUBIPROSTONE CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
amitriptyline tab (ELAVIL equiv)	-	G	ANTIDEPRESSANTS
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)	-	G	DERMATOLOGICALS
ammonium lactate lotion (LAC-HYDRIN equiv)	-	G	DERMATOLOGICALS
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (AC CUTANE equiv)	-	G	DERMATOLOGICALS
AMOXAPINE TAB	-	G	ANTIDEPRESSANTS
amoxicillin cap (TRIMOX equiv)	-	G	PENICILLINS
AMOXICILLIN CHEW TAB	-	G	PENICILLINS
amoxicillin susp (TRIMOX equiv)	-	G	PENICILLINS
amoxicillin tab (AMOXIL equiv)	-	G	PENICILLINS
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	G	PENICILLINS
AMOXICILLIN/CLAVULANATE ER TAB	-	B	PENICILLINS
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	G	PENICILLINS
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	G	PENICILLINS
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	G	PENICILLINS
amphetamine tab (EVEKEO equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ampicillin cap (PRINCIPEN equiv)	-	G	PENICILLINS
ampicillin susp (PRINCIPEN equiv)	-	G	PENICILLINS
AMTURNIDE TAB (Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan)	ST	B	ANTIHYPERTENSIVES
AMZEEQ FOAM	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
anagrelide cap (AGRYLIN equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
ANALPRAM-E KIT	-	B	ANORECTAL AGENTS
ANASTIA LOTION	-	NC	DERMATOLOGICALS
anastrozole tab (ARIMIDEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	B	ANDROGENS-ANABOLIC
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
ANDROGEL PUMP 1%	-	NC	ANDROGENS-ANABOLIC
ANDROXY TAB	-	B	ANDROGENS-ANABOLIC
ANGELIQ TAB	-	NC	ESTROGENS
ANNOVERA RING	-	NC	CONTRACEPTIVES
ANORO ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ANTARA CAP, LOFIBRA CAP	-	NC	ANTIHYPERLIPIDEMICS
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC	OTIC AGENTS
anusol-HC supp	-	NC	ANORECTAL AGENTS
ANZEMET TAB (QL= 9 tabs/fill)	QL	B	ANTIEMETICS
APADAZ TAB	-	NC	ANALGESICS - OPIOID
APEXICON E CREAM (PSORCON E equiv)	-	NC	DERMATOLOGICALS
APHTHASOL PASTE	-	B	MOUTH/THROAT/DENTAL AGENTS
APIDRA INJ	PA	B	ANTIDIABETICS
APIDRA SOLOSTAR INJ	PA	B	ANTIDIABETICS
APLENZIN TAB	-	NC	ANTIDEPRESSANTS
APOKYN INJ	-	NC	ANTIPARKINSON 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
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
APTIVUS SOLN	-	B	ANTIVIRALS
ARAKODA TAB	-	NC	ANTIMALARIALS
ARALAST/PROLASTIN/ZEMAIRA INJ	MSP-PA	B	RESPIRATORY AGENTS - MISC.
ARANESP INJ	-	NC	HEMATOPOIETIC AGENTS
ARAZLO LOTION	-	NC	DERMATOLOGICALS
ARCALYST INJ	MSP-PA	B	ANALGESICS - ANTI-INFLAMMATORY
ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046)	LD-PA-QL	B	AMINOGLYCOSIDES
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	QL	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole soln (ABILIFY equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
aripiprazole tab (ABILIFY equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ARIXTRA INJ	-	NC	ANTICOAGULANTS
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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
ARMONAIR RESPICLICK	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARMOUR THYROID TAB, NATURE THROID TAB	-	G	THYROID AGENTS
ARNUITY ELLIPTA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ARTHROTEC TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ARYMO ER TAB	-	NC	ANALGESICS - OPIOID
ARZERRA INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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 ABILIFY 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 males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0	ANALGESICS - NONNARCOTIC
aspirin/codeine tab	-	G	ANALGESICS - OPIOID
aspirin/dipyridamole cap (AGGRENOX equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
ASPIRIN/OMEPRAZOLE ER TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
ASTAGRAF XL CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSE
ASTAMED MYO CAP	-	NC	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
atenolol tab (TENORMIN equiv)	-	G	BETA BLOCKERS
atenolol/chlorthalidone tab (TENORETIC equiv)	-	G	ANTIHYPERTENSIVES
atomoxetine cap (STRATTERA CAP equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
atorvastatin tab 10mg (LIPITOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
atorvastatin tab 20mg (LIPITOR equiv)	-	\$0	ANTIHYPERLIPIDEMICS
atorvastatin tab 40mg (LIPITOR equiv)	-	G	ANTIHYPERLIPIDEMICS
atorvastatin tab 80mg (LIPITOR equiv)	-	G	ANTIHYPERLIPIDEMICS
atovaquone susp (MEPRON equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
atovaquone/proguanil tab (MALARONE equiv)	-	G	ANTIMALARIALS
ATRALIN GEL	-	NC	DERMATOLOGICALS
ATRIPLA TAB	-	NC	ANTIVIRALS
atropine ophth oint	-	G	OPHTHALMIC AGENTS
atropine ophth soln (ISOPTO ATROPINE equiv)	-	G	OPHTHALMIC AGENTS
ATROVENT HFA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
AUBAGIO TAB	LMS-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AURYXIA TAB (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B	GASTROINTESTINAL AGENTS - MISC.
AUSTEDO TAB (QL= 4 tabs/day)	LMS-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AUVI-Q INJ	-	NC	VASOPRESSORS
AVANDAMET TAB	-	B	ANTIDIABETICS
AVANDARYL TAB	-	B	ANTIDIABETICS
AVANDIA TAB	-	B	ANTIDIABETICS
AVAR AEROSOL FOAM	-	NC	DERMATOLOGICALS
AVAR GEL	-	NC	DERMATOLOGICALS
AVAR PAD	-	NC	DERMATOLOGICALS
AVASTIN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AVC VAGINAL CREAM	-	B	VAGINAL PRODUCTS
AVONEX INJ	LMS-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
AXERT TAB	-	NC	MIGRAINE PRODUCTS
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
azacitidine inj (VIDAZA equiv)	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
AZASAN TAB	-	NC	ASSORTED CLASSES
AZASITE SOLN	-	B	OPHTHALMIC AGENTS
azathioprine tab (IMURAN equiv)	-	G	ASSORTED 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
azithromycin susp (ZITHROMAX equiv)	-	G	MACROLIDES
azithromycin tab (ZITHROMAX equiv)	-	G	MACROLIDES
AZOPT OPHTH SUSP	-	B	OPHTHALMIC AGENTS
AZOR TAB	-	NC	ANTIHYPERTENSIVES
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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMS-PA	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN equiv)	-	G	OPHTHALMIC AGENTS
BACLOFEN CREAM COMPOUND KIT	-	B	DERMATOLOGICALS
baclufen tab (BACLOFEN equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
BACLOFEN TAB 5MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
BACTROBAN CREAM	-	NC	DERMATOLOGICALS
BACTROBAN NASAL OINT (QL= 10 tubes/fill)	QL	B	NASAL AGENTS - SYSTEMIC AND TOPICAL
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 US Bioservices 888-518-7246)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BANZEL SUSP	PA	B	ANTICONVULSANTS
BANZEL TAB	PA	B	ANTICONVULSANTS
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	B	ANTIDIABETICS
BARACLUDGE SOLN	-	NC	ANTIVIRALS
BASAGLAR INJ	-	NC	ANTIDIABETICS
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	B	FLUOROQUINOLONES
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
BEBULIN/PROFILNINE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
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
BENEFIX INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
BENEFIX/RIXUBIS INJ	MSP-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
BENLYSTA INJ (QL= 4 inj/28 day)	LMSP-PA-QL	B	MISCELLANEOUS THERAPEUTIC CLASSES
BENZAC WASH	-	NC	DERMATOLOGICALS
BENZNIDAZOLE TAB	PA	B	ANTHELMINTICS
benzonatate cap (TESSALON equiv)	-	G	COUGH/COLD/ALLERGY
benzonatate cap 150mg (ZONATUSS equiv)	-	NC	COUGH/COLD/ALLERGY
BENZOYL PEROXIDE CREAM	OTC	NC	DERMATOLOGICALS
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC	DERMATOLOGICALS
benzoyl peroxide/hydrocortisone lotion (VANOXIDE-HC equiv)	-	NC	DERMATOLOGICALS
BENZPHETAMINE TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
benztropine tab	-	G	ANTIPARKINSON AGENTS
BEPREVE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
BERINERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
BESER KIT 0.05%	-	NC	DERMATOLOGICALS
BESIVANCE OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	G	DERMATOLOGICALS
BETAMETHASONE AUGMENTED GEL	-	B	DERMATOLOGICALS
betamethasone augmented gel	-	G	DERMATOLOGICALS
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	G	DERMATOLOGICALS
betamethasone augmented oint (DIPROLENE OINT equiv)	-	G	DERMATOLOGICALS
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	G	DERMATOLOGICALS
betamethasone dipropionate lotion	-	G	DERMATOLOGICALS
betamethasone dipropionate 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	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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	-	B	OPHTHALMIC AGENTS
BETOPTIC-S OPHTH SOLN	-	B	OPHTHALMIC AGENTS
BEVESPI AEROSPHERE INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
BEVYXXA CAP	-	NC	ANTICOAGULANTS
bexarotene cap (TARGRETIN equiv)	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BEXSERO INJ	VAC	\$0	VACCINES
BEYAZ TAB	-	NC	CONTRACEPTIVES
BIAFINE EMULSION	-	NC	DERMATOLOGICALS
BIAXIN XL TAB	-	NC	MACROLIDES
bicalutamide tab (CASODEX equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BIFERARX TAB	-	NC	HEMATOPOIETIC AGENTS
BIJUVA CAP	-	NC	ESTROGENS
BIKTARVY TAB	-	B	ANTIVIRALS
BILTRICIDE TAB	-	B	ANTHELMINTICS
bimatoprost ophth soln	-	NC	OPHTHALMIC AGENTS
bimatoprost topical soln (LATISSE equiv)	-	NC	DERMATOLOGICALS
BINOSTO TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
bisoprolol tab (ZEBETA equiv)	-	G	BETA BLOCKERS
bisoprolol/hydrochlorothiazide tab (ZIAC equiv)	-	G	ANTIHYPERTENSIVES
BLEPHAMIDE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
BLEPHAMIDE S.O.P. OPHTH OINT	-	B	OPHTHALMIC AGENTS
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B	CARDIOVASCULAR AGENTS - MISC.
BOSULIF TAB	MSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BOTOX INJ	MSP-PA	B	NEUROMUSCULAR AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BREO ELLIPTA INHALER	-	B	ASTHMA AND BRONCHODILATOR AGENTS
BREZTRI AEROSPHERE INHALER	-	B	ASTHMA AND BRONCHODILATOR AGENTS
BRILINTA TAB	-	B	HEMATOLOGICAL AGENTS - MISC.
brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv)	-	G	OPHTHALMIC AGENTS
brimonidine ophth soln 0.2%	-	G	OPHTHALMIC AGENTS
BRISDELLE CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
BRIVIACT INJ 50MG/5ML	-	NC	ANTICONSULTANTS
BRIVIACT SOLN 10MG/ML	-	NC	ANTICONSULTANTS
BRIVIACT TAB	-	NC	ANTICONSULTANTS
bromfenac ophth soln (BROMDAY equiv)	-	G	OPHTHALMIC AGENTS
bromocriptine cap (PARLODEL equiv)	-	G	ANTIPARKINSON AGENTS
bromocriptine tab (PARLODEL equiv)	-	G	ANTIPARKINSON AGENTS
BROMSITE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
BROVANA NEB SOLN (Step Therapy requires trial of PERFOROMIST)	ST	B	ASTHMA AND BRONCHODILATOR AGENTS
BRUKINSA CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
BRYHALI LOTION	-	NC	DERMATOLOGICALS
B-SERENE PAD	-	NC	HEMATOPOIETIC AGENTS
budesonide ER tab (UCERIS equiv) (QL=1 tab/day)	PA-QL	G	CORTICOSTEROIDS
budesonide inh susp (PULMICORT equiv)	-	G	ASTHMA AND BRONCHODILATOR AGENTS
budesonide nasal spray (RHINOCORT AQUA equiv)	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
budesonide SR cap (ENTOCORT EC equiv)	-	G	CORTICOSTEROIDS
BUDESONIDE/FORMOTEROL INHALER, SYMBICORT INHALER	-	NC	ASTHMA AND BRONCHODILATOR AGENTS
bumetanide tab (BUMEX equiv)	-	G	DIURETICS
BUNAVAIL FILM	-	NC	ANALGESICS - OPIOID
bupap tab	-	NC	ANALGESICS - NONNARCOTIC
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days)	QL	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
bupirone tab (BUSPAR equiv)	-	G	ANTI-ANXIETY AGENTS
bupirone tab 30mg (BUSPAR equiv)	-	NC	ANTI-ANXIETY AGENTS
butalbital/acetaminophen cap	-	G	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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSPP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
bupropion/paroxetine cap (WELLBUTRIN XL/OLYMPIA XL equiv) (QL= 60 tabs/30 days)	PA-QL	G	ANALGESICS - NONNARCOTIC
BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC	ANALGESICS - NONNARCOTIC
BUTISOL ELIXIR	-	B	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
BUTISOL TAB	-	B	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days)	QL	G	ANALGESICS - OPIOID
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	B	ANTIDIABETICS
BYDUREON INJ (QL= 4 inj/28 days)	QL	B	ANTIDIABETICS
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	B	ANTIDIABETICS
BYETTA INJ (Step Therapy requires trial of VICTOZA or BYDUREON)	ST	B	ANTIDIABETICS
BYNFEZIA PEN INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
BYSTOLIC TAB	¢	B	BETA BLOCKERS
BYVALSON TAB	-	NC	ANTIHYPERTENSIVES
cabergoline tab (DOSTINEX equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
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// NOREXIANTS
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
calcipotriene cream (DOVONEX CREAM equiv)	-	G	DERMATOLOGICALS
CALCIPOTRIENE FOAM, SORILUX FOAM	-	B	DERMATOLOGICALS
calcipotriene oint	-	G	DERMATOLOGICALS
calcipotriene soln (DOVONEX SOLN equiv)	-	G	DERMATOLOGICALS
calcipotriene/betamethasone dipropionate susp (TACLONEX equiv)	-	NC	DERMATOLOGICALS
calcipotriene/betamethasone oint (TACLONEX equiv)	-	NC	DERMATOLOGICALS
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
CALOMIST NASAL SPRAY	-	NC	HEMATOPOIETIC AGENTS
CALQUENCE CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
CAMBIA POWDER PACKET	-	NC	MIGRAINE PRODUCTS
candesartan tab (ATACAND equiv)	-	NC	ANTIHYPERTENSIVES
candesartan/hydrochlorothiazide tab (ATACAND HCT equiv)	-	NC	ANTIHYPERTENSIVES
CANTIL TAB	-	B	ULCER DRUGS
capecitabine tab (XELODA equiv)	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
CAPEX SHAMPOO	-	NC	DERMATOLOGICALS
CAPITAL/CODEINE SUSP	-	B	ANALGESICS - OPIOID
CAPLYTA CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
capsaicin/menthol topical patch (SINELEE equiv)	-	NC	DERMATOLOGICALS
captopril tab (CAPOTEN equiv)	-	G	ANTIHYPERTENSIVES
CARAC CREAM	-	NC	DERMATOLOGICALS
CARBAGLU TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
carbamazepine chew tab (TEGRETOL equiv)	-	G	ANTICONSULTANTS
carbamazepine ER cap (CARBATROL equiv)	-	G	ANTICONSULTANTS
carbamazepine ER tab (TEGRETOL XR equiv)	-	G	ANTICONSULTANTS
carbamazepine susp (TEGRETOL equiv)	-	G	ANTICONSULTANTS
carbamazepine tab (TEGRETOL equiv)	-	G	ANTICONSULTANTS
carbidopa tab (LODOSYN equiv)	-	G	ANTIPARKINSON 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
CARBINOXAMINE SOLN	-	G	ANTIHISTAMINES
carbinoxamine soln (PALGIC equiv)	-	G	ANTIHISTAMINES
CARBINOXAMINE TAB	-	G	ANTIHISTAMINES
carbinoxamine tab (PALGIC equiv)	-	G	ANTIHISTAMINES
CARDENE SR CAP	-	B	CALCIUM CHANNEL BLOCKERS
CARDURA XL TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
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
CAROSPIR SUSP	-	NC	DIURETICS
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.
CAYSTON INH SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTI-INFECTIVE AGENTS - MISC.
CEDAX CAP	-	B	CEPHALOSPORINS
CEDAX SUSP	-	B	CEPHALOSPORINS
CEFACTOR CAP	-	G	CEPHALOSPORINS
cefaclor cap (CECLOR equiv)	-	G	CEPHALOSPORINS
CEFACTOR ER TAB	-	B	CEPHALOSPORINS
CEFACTOR SUSP	-	B	CEPHALOSPORINS
cefadroxil cap (DURICEF equiv)	-	G	CEPHALOSPORINS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
cefadroxil susp (DURICEF equiv)	-	G	CEPHALOSPORINS
CEFADROXIL TAB	-	G	CEPHALOSPORINS
cefadroxil tab (DURICEF equiv)	-	G	CEPHALOSPORINS
cefdinir cap (OMNICEF equiv)	-	G	CEPHALOSPORINS
cefdinir susp (OMNICEF equiv)	-	G	CEPHALOSPORINS
CEFDITOREN TAB	-	B	CEPHALOSPORINS
cefixime cap (SUPRAX equiv)	-	G	CEPHALOSPORINS
cefixime susp (SUPRAX equiv)	-	G	CEPHALOSPORINS
cefpodoxime proxetil susp (VANTIN equiv)	-	G	CEPHALOSPORINS
cefpodoxime proxetil tab (VANTIN equiv)	-	G	CEPHALOSPORINS
cefprozil susp (CEFZIL equiv)	-	G	CEPHALOSPORINS
cefprozil tab (CEFZIL equiv)	-	G	CEPHALOSPORINS
cefuroxime susp (CEFTIN equiv)	-	G	CEPHALOSPORINS
cefuroxime tab (CEFTIN equiv)	-	G	CEPHALOSPORINS
CELEBREX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	G	ANALGESICS - ANTI-INFLAMMATORY
CELONTIN CAP	-	B	ANTICONVULSANTS
CENESTIN TAB	-	B	ESTROGENS
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 (PF) OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
CERDELGA CAP	-	NC	HEMATOPOIETIC AGENTS
CEREZYME INJ	MSP-PA	B	HEMATOPOIETIC AGENTS
CERVARIX INJ	VAC	\$0	VACCINES
CERVICAL CAP	-	\$0	MEDICAL DEVICES AND SUPPLIES
CESAMET CAP	-	B	ANTIEMETICS
CETYLEV TAB	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
cevimeline cap (EVOXAC equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHANTIX TAB (Limited to 180 days/plan year)	QL-SMKG	\$0	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
CHEMET CAP	-	B	ANTIDOTES
chlordiazepoxide cap (LIBRIUM equiv)	-	G	ANTIANKXIETY AGENTS
CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	G	ULCER DRUGS
chlorhexidine gluconate soln (PERIDEX equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
chloroquine tab (ARALEN equiv)	-	G	ANTIMALARIALS
CHLOROTHIAZIDE TAB	-	G	DIURETICS
chlorothiazide tab (DIURIL equiv)	-	G	DIURETICS
chlorpheniramine ER cap	-	G	ANTIHISTAMINES
chlorpromazine tab (THORAZINE equiv)	-	G	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
chlorpropamide tab (DIABINESE equiv)	-	G	ANTIDIABETICS
CHLORTHALIDONE TAB	-	G	DIURETICS
chlorzoxazone tab	-	NC	MUSCULOSKELETAL THERAPY AGENTS
CHLORZOXAZONE TAB 250MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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
CHOLINE MAGNESIUM TRISALICYLATE TAB	-	G	ANALGESICS - NONNARCOTIC
choline magnesium trisalicylate tab (TRILISATE equiv)	-	G	ANALGESICS - NONNARCOTIC
cicatrace kit (REXASIL equiv)	-	NC	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	-	G	ULCER DRUGS
cimetidine tab (TAGAMET equiv)	-	G	ULCER DRUGS
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	GASTROINTESTINAL AGENTS - MISC.
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	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 CVS Specialty 800-237-2767)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
CIPRO HC OTIC SUSP (Step Therapy requires trial of CIPRODEX)	ST	B	OTIC AGENTS
CIPRO SUSP 5%	-	B	FLUOROQUINOLONES
CIPROFLOXACIN 100MG TAB	-	B	FLUOROQUINOLONES
CIPROFLOXACIN ER TAB	-	B	FLUOROQUINOLONES
ciprofloxacin ophth soln (CILOXAN equiv)	-	G	OPHTHALMIC AGENTS
CIPROFLOXACIN OTIC SOLN	-	B	OTIC AGENTS
ciprofloxacin susp (CIPRO equiv)	-	G	FLUOROQUINOLONES
ciprofloxacin tab (CIPRO equiv)	-	G	FLUOROQUINOLONES
ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv)	-	G	OTIC AGENTS
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
CLARINEX REDITAB	-	EXC	ANTIHISTAMINES
CLARINEX SYRUP	-	EXC	ANTIHISTAMINES
CLARINEX TAB	-	EXC	ANTIHISTAMINES
CLARINEX-D TAB	-	EXC	COUGH/COLD/ALLERGY
CLARITHROMYC SUSP	-	B	MACROLIDES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
clarithromycin ER tab (BIAXIN XL equiv)	-	NC	MACROLIDES
clarithromycin susp (BIAXIN equiv)	-	G	MACROLIDES
clarithromycin tab (BIAXIN equiv)	-	G	MACROLIDES
CLARITIN CAP	OTC	EXC	ANTIHISTAMINES
CLENPIQ SOLN	-	B	LAXATIVES
CLEOCIN VAGINAL SUPP	-	B	VAGINAL PRODUCTS
CLIMARA PATCH	-	NC	ESTROGENS
CLIMARA PRO PATCH	-	NC	ESTROGENS
CLINDACIN KIT	-	NC	DERMATOLOGICALS
CLINDAGEL	-	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 lotion (CLEOCIN- T equiv)	-	G	DERMATOLOGICALS
clindamycin pad (CLEOCIN-T equiv)	-	G	DERMATOLOGICALS
clindamycin soln (CLEOCIN equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
clindamycin topical soln (CLEOCIN-T equiv)	-	G	DERMATOLOGICALS
clindamycin vaginal cream (CLEOCIN equiv)	-	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
CLINDESSE VAGINAL CREAM	-	B	VAGINAL PRODUCTS
CLINISTIX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
clobazam susp (ONFI equiv)	-	NC	ANTICONSULTANTS
clobazam tab (ONFI equiv)	PA	G	ANTICONSULTANTS
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 emollient cream (TEMOVATE E equiv)	-	G	DERMATOLOGICALS
clobetasol propionate gel (TEMOVATE GEL equiv)	-	G	DERMATOLOGICALS
clobetasol propionate oint (TEMOVATE equiv)	-	G	DERMATOLOGICALS
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	INF	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
clomipramine cap (ANAFRANIL equiv)	-	G	ANTIDEPRESSANTS
clonazepam ODT (KLONOPIN equiv)	-	G	ANTICONSULTANTS
clonazepam tab (KLONOPIN equiv)	-	G	ANTICONSULTANTS
clonidine ER tab (KAPVAY equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
clonidine patch (CATAPRES-TTS equiv)	-	G	ANTIHYPERTENSIVES
clonidine tab (CATAPRES equiv)	-	G	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
clopidogrel tab 75mg (PLAVIX equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
CLOPIDOGREL THERAPY PACK	-	NC	HEMATOLOGICAL AGENTS - MISC.
clorazepate tab (TRANXENE-T equiv)	-	G	ANTIANKXIETY AGENTS
clotrimazole cream (LOTRIMIN AF CREAM equiv) (Rx Only)	-	G	DERMATOLOGICALS
clotrimazole troches (MYCELEX TROCHES equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
clotrimazole/betamethasone cream (LOTRISONE equiv)	-	NC	DERMATOLOGICALS
clotrimazole/betamethasone lotion (LOTRISONE equiv)	-	NC	DERMATOLOGICALS
CLOZAPINE ODT	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CLOZAPINE ODT 12.5MG	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
clozapine ODT 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CLOZAPINE ODT, FAZACLO ODT	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
clozapine tab (CLOZARIL equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
CODEINE SULFATE SOLN	-	B	ANALGESICS - OPIOID
CODEINE SULFATE TAB	-	G	ANALGESICS - OPIOID
COLCHICINE CAP	-	NC	GOUT AGENTS
colchicine tab (COLCRYS equiv)	-	NC	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
colistimethate inj (COLY-MYCIN M equiv)	LMSP	B	ANTI-INFECTIVE AGENTS - MISC.
COLY-MYCIN S OTIC SUSP	-	B	OTIC AGENTS
COLYTE SOLN	-	NC	LAXATIVES
COMBIGAN OPHTH SOLN	-	B	OPHTHALMIC AGENTS
COMBIPATCH	-	NC	ESTROGENS
COMBIVENT INHALER	-	B	ASTHMA AND BRONCHODILATOR AGENTS
COMBIVENT RESPIMAT INHALER	-	B	ASTHMA AND BRONCHODILATOR AGENTS
COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COMPLERA TAB	-	B	ANTIVIRALS
COMPLETE NATAL DHA	-	G	MULTIVITAMINS
CONCEPT DHA CAP	-	G	MULTIVITAMINS
CONDYLOX GEL	-	B	DERMATOLOGICALS
CONJUPRI TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONSENSI TAB	-	NC	CALCIUM CHANNEL BLOCKERS
CONTRACEPTIVE FOAM	OTC	\$0	VAGINAL PRODUCTS
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 TAPE	-	NC	DERMATOLOGICALS
CORLANOR SOLN	PA	B	CARDIOVASCULAR AGENTS - MISC.
CORLANOR TAB	PA	B	CARDIOVASCULAR AGENTS - MISC.
CORTANE-B AQUEOUS OTIC SOLN	-	NC	OTIC AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
CORTANE-B OTIC SOLN	-	NC	OTIC AGENTS
CORTEF TAB	-	NC	CORTICOSTEROIDS
CORTIFOAM	-	B	ANORECTAL AGENTS
CORTISONE ACETATE TAB	-	B	CORTICOSTEROIDS
CORTISPORIN CREAM	-	B	DERMATOLOGICALS
CORTISPORIN OINT	-	B	DERMATOLOGICALS
CORVITE 150 TAB	-	NC	HEMATOPOIETIC AGENTS
CORZIDE TAB 80-5MG	-	B	ANTIHYPERTENSIVES
COSENTYX INJ (1-PACK)	-	NC	DERMATOLOGICALS
COSENTYX INJ (2-PACK)	-	NC	DERMATOLOGICALS
COTELLIC TAB (QL= 3 tabs/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
COTEMPLA XR ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
COVERA-HS TAB	-	B	CALCIUM CHANNEL BLOCKERS
COVID-19 VACCINE INJ (MODERNA) (QL= 1 dose/24 days; limit 2 fills/12 months)	QL	\$0	VACCINES
COVID-19 VACCINE INJ (PFIZER) (QL= 1 dose/17 days; limit 2 fills/12 months)	QL	\$0	VACCINES
CREON CAP	-	B	DIGESTIVE AIDS
CRESEMBA CAP	-	NC	ANTIFUNGALS
CRESTOR TAB	-	NC	ANTIHYPERLIPIDEMICS
CRESTOR TAB 20MG	-	NC	ANTIHYPERLIPIDEMICS
CRINONE GEL	PA	B	VAGINAL PRODUCTS
CRIVAN CAP	-	B	ANTIVIRALS
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
CROTAN LOTION	-	B	DERMATOLOGICALS
cryselle tab	-	\$0	CONTRACEPTIVES
CUTAQUIG INJ	-	NC	PASSIVE IMMUNIZING AND TREATMENT AGENTS
CUTIVATE LOTION	-	NC	DERMATOLOGICALS
CUVITRU INJ	-	NC	PASSIVE IMMUNIZING AGENTS
CUVPOSA SOLN	-	B	ULCER DRUGS
cyanocobalamin inj	-	G	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
CYCLOMYDRIL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
cyclopentolate ophth soln (CYCLOGYL equiv)	-	G	OPHTHALMIC AGENTS
cyclophosphamide cap	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
cyclophosphamide tab (CYTOXAN equiv)	-	G	ANTINEOPLASTICS
CYCLOSERINE CAP	-	NC	ANTIMYCOBACTERIAL AGENTS
cycloserine cap (CYCLOSERINE CAP equiv)	-	NC	ANTIMYCOBACTERIAL AGENTS
CYCLOSET TAB	-	B	ANTIDIABETICS
cyclosporine cap (SANDIMMUNE equiv)	-	G	ASSORTED CLASSES
cyclosporine modified cap (NEORAL equiv)	-	G	ASSORTED CLASSES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
cyclosporine modified soln (NEORAL equiv)	-	G	ASSORTED CLASSES
CYFOLEX CAP	-	NC	HEMATOPOIETIC AGENTS
cyproheptadine syrup	-	G	ANTIHISTAMINES
cyproheptadine tab	-	G	ANTIHISTAMINES
CYSTADANE POWDER	MSP-PA	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
DAKLINZA TAB	-	NC	ANTIVIRALS
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day)	LMSP-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DALIRESP TAB	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
danazol cap (DANOCRINE equiv)	-	G	ANDROGENS-ANABOLIC
dantrolene cap (DANTRIUM equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
dapsone gel (ACZONE equiv)	-	NC	DERMATOLOGICALS
dapsone tab	-	G	ANTI-INFECTIVE AGENTS - MISC.
darifenacin SR tab (ENABLEX equiv)	-	NC	URINARY ANTISPASMODICS
DAURISMO TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
DAXBIA CAP	-	NC	CEPHALOSPORINS
DAYTRANA PATCH	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
DAYVIGO TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
DDAVP NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
DECON-A LIQUID	OTC	EXC	COUGH/COLD/ALLERGY
deferasirox granules packet (JADENU equiv)	LMSP	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab (EXJADE equiv)	LMSP	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 180mg (JADENU equiv)	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferasirox tab 90mg, 360mg (JADENU equiv)	LMSP	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
deferiprone tab (FERRIPROX equiv) (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
DELSTRIGO TAB	-	B	ANTIVIRALS
DELZICOL CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
demeclocycline tab (DECLOMYCIN equiv)	-	NC	TETRACYCLINES
DEMSEER CAP	-	NC	ANTIHYPERTENSIVES
DENAVIR CREAM	-	NC	DERMATOLOGICALS
DEPACON INJ	-	NC	ANTICONVULSANTS
DEPLIN CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
DEPO-ESTRADIOL INJ	-	G	ESTROGENS
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
DERMASORB XM KIT	-	B	DERMATOLOGICALS
DESCOVY TAB	PA	B	ANTIVIRALS
desipramine tab (NORPRAMIN equiv)	-	G	ANTIDEPRESSANTS
DESLORATADINE ODT	-	EXC	ANTIHISTAMINES
desloratadine tab (CLARINEX equiv)	-	EXC	ANTIHISTAMINES
desmopressin acetate inj (DDAVP equiv)	-	G	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.
desmopressin nasal soln (DDAVP equiv)	-	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 (TOPICORT equiv)	-	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 ophth soln	-	G	OPHTHALMIC AGENTS
dexamethasone pak (DEXPAK equiv)	-	NC	CORTICOSTEROIDS
DEXAMETHASONE SOLN	-	G	CORTICOSTEROIDS
dexamethasone tab (DECADRON equiv)	-	G	CORTICOSTEROIDS
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 SENSOR (QL= 3 sensors/28 days)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
DEXILANT CAP	-	NC	ULCER DRUGS
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
dexamethylphenidate tab (FOCALIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DEXPAK TAB	-	NC	CORTICOSTEROIDS
DEXTENZA OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
dextroamphetamine ER cap (DEXEDRINE equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine soln (PROCENTRA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
dextroamphetamine tab (DEXEDRINE equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DIABETIC METER (all other diabetic meters)	OTC-PA	B	MEDICAL DEVICES AND SUPPLIES
DIACOMIT CAP (Only available through US Bioservices 888-518-7246)	LD-PA	B	ANTICONVULSANTS
DIACOMIT POWDER PACK (Only available through US Bioservices 888-518-7246)	LD-PA	B	ANTICONVULSANTS
DIALYVITE TAB	-	G	MULTIVITAMINS
dialyvite tab (NEPHRO-VITE equiv)	-	G	MULTIVITAMINS
DIALYVITE/ZINC TAB	-	G	MULTIVITAMINS
DIAPHRAGM	-	\$0	MEDICAL DEVICES AND SUPPLIES
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 2 packs/fill)	QL	B	ANTICONVULSANTS
diazepam conc (VALIUM equiv)	-	G	ANTIAXIETY AGENTS
DIAZEPAM SOLN	-	G	ANTIAXIETY AGENTS
diazepam tab (VALIUM equiv)	-	G	ANTIAXIETY AGENTS
diazoxide susp (PROGLYCEM equiv)	-	G	ANTIDIABETICS
diclofenac gel (SOLARAZE equiv)	-	NC	DERMATOLOGICALS
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	G	DERMATOLOGICALS
DICLOFENAC PATCH, FLECTOR PATCH (QL= 30 patches/fill; Step Therapy requires trial of celecoxib)	QL-ST	B	DERMATOLOGICALS
diclofenac potassium tab (CATAFLAM equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium EC tab (VOLTAREN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac sodium ophth soln (VOLTAREN equiv)	-	G	OPHTHALMIC AGENTS
diclofenac sodium XR tab (VOLTAREN XR equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
diclofenac soln 1.5% (PENNSAID equiv)	-	NC	DERMATOLOGICALS
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
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
didanosine DR cap (VIDEX EC equiv)	-	G	ANTIVIRALS
DIDANOSINE DR CAP, VIDEX EC CAP	-	G	ANTIVIRALS
DIETHYLPROPION ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
diethylpropion tab	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
DIFFERIN OTC GEL 0.1%	OTC	EXC	DERMATOLOGICALS
DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN)	QL-ST	B	MACROLIDES
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN)	QL-ST	B	MACROLIDES
DIFLORASONE CREAM	-	NC	DERMATOLOGICALS
diflorasone oint	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
diflunisal tab (DOLOBID equiv)	-	G	ANALGESICS - NONNARCOTIC
DIGOXIN SOLN	-	G	CARDIOTONICS
digoxin soln (LANOXIN equiv)	-	G	CARDIOTONICS
digoxin tab (LANOXIN equiv)	-	G	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 tab (CARDIZEM LA equiv)	-	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	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
DIOVAN TAB	-	NC	ANTIHYPERTENSIVES
DIPENTUM CAP	-	B	GASTROINTESTINAL AGENTS - MISC.
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	G	ANTIHISTAMINES
DIPHENOXYLATE/ATROPINE LIQUID	-	G	ANTIDIARRHEAL/PROBIOTIC AGENTS
diphenoxylate/atropine tab (LOMOTIL equiv)	-	G	ANTIDIARRHEALS
dipyridamole tab (PERSANTINE equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
disopyramide cap (NORPACE equiv)	-	G	ANTIARRHYTHMICS
disopyramide ER cap (NORPACE CR equiv)	-	G	ANTIARRHYTHMICS
DISULFIRAM TAB	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
disulfiram tab (ANTABUSE equiv)	-	G	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, ELESTRIN GEL	-	NC	ESTROGENS
dofetilide cap (TIKOSYN equiv)	-	G	ANTIARRHYTHMICS
DOJOLVI ORAL LIQUID	-	NC	NUTRIENTS
DOLGIC PLUS 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 EXTENTABS	-	NC	ULCER DRUGS
DONNATAL TAB	-	NC	ULCER DRUGS
DOPTelet TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
DORAL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
DORYX MPC TAB	-	NC	TETRACYCLINES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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
DOXEPIIN CAP	-	G	ANTIDEPRESSANTS
doxepin cap (SINEQUAN equiv)	-	G	ANTIDEPRESSANTS
doxepin conc (SINEQUAN equiv)	-	G	ANTIDEPRESSANTS
DOXEPIIN CREAM, PRUDOXIN CREAM, ZONALON 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 CAP, ORACEA CAP	-	NC	DERMATOLOGICALS
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	G	TETRACYCLINES
doxycycline hyclate DR tab (DORYX equiv)	PA	G	TETRACYCLINES
doxycycline hyclate tab (VIBRATAB equiv)	-	G	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg	-	NC	TETRACYCLINES
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC	TETRACYCLINES
doxycycline monohydrate cap (MONODOX equiv)	-	G	TETRACYCLINES
doxycycline monohydrate cap 150mg (ADOXA equiv)	-	NC	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
D-PENAMINE TAB	-	B	ASSORTED CLASSES
DRIZALMA DR CAP	-	NC	ANTIDEPRESSANTS
dronabinol cap (MARINOL equiv)	PA	G	ANTIEMETICS
drosiprenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	NC	CONTRACEPTIVES
drosiprenone/ethinyl estradiol/levomefolate tab (SAFYRAL equiv)	-	NC	CONTRACEPTIVES
DROXIA CAP	-	B	HEMATOPOIETIC AGENTS
DRYSOL SOLN	-	G	DERMATOLOGICALS
DST PLUS PAK KIT	-	NC	DERMATOLOGICALS
DSUVIA SL TAB	-	NC	ANALGESICS - OPIOID
DUAKLIR INHALER	-	NC	ASTHMA AND BRONCHODILATOR AGENTS
DUAVEE TAB	-	B	ESTROGENS
DUET	-	NC	MULTIVITAMINS
DUET DHA 400, DUET DHA BALANCED	-	NC	MULTIVITAMINS
DUETACT TAB	-	NC	ANTIDIABETICS
DUEXIS TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
DULERA INHALER	-	B	ASTHMA AND BRONCHODILATOR AGENTS
duloxetine cap 40mg (IRENKA equiv)	-	NC	ANTIDEPRESSANTS
duloxetine EC cap (CYMBALTA equiv)	-	G	ANTIDEPRESSANTS
DUOBRII LOTION	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSPP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
DUOPA ENTERAL SUSP	-	NC	ANTIPARKINSON AGENTS
DUPIXENT INJ (QL= 2 inj/ 28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
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
DURAVENT PE TAB	-	NC	COUGH/COLD/ALLERGY
DUREZOL OPHTH EMULSION	-	B	OPHTHALMIC AGENTS
DUROLANE INJ	MSP-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
DUZALLO TAB	-	NC	GOUT AGENTS
DXEVO 11-DAY PAK	-	NC	CORTICOSTEROIDS
DYANAVEL XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
DYNACIRC CR TAB	-	B	CALCIUM CHANNEL BLOCKERS
DYRENIUM CAP	-	B	DIURETICS
DYSPORT INJ	MSP-PA	B	NEUROMUSCULAR AGENTS
ECONASIL KIT	-	NC	DERMATOLOGICALS
econazole cream (SPECTAZOLE equiv) (QL= 30gm/30 days)	QL	G	DERMATOLOGICALS
ECOZA FOAM	-	NC	DERMATOLOGICALS
EDARBI TAB	-	NC	ANTIHYPERTENSIVES
EDARBYCLOR TAB	-	NC	ANTIHYPERTENSIVES
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 TAB	-	B	ANTIVIRALS
efavirenz cap (SUSTIVA equiv)	-	G	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
EFFEXOR XR CAP	-	NC	ANTIDEPRESSANTS
EGATEN TAB	-	NC	ANTHELMINTICS
EGRIFTA INJ	-	EXC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ELAPRASE INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
eletriptan tab (RELPAX equiv)	-	NC	MIGRAINE PRODUCTS
ELIGEN B12 TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
ELIQUIS TAB, ELIQUIS STARTER PACK	-	B	ANTICOAGULANTS
ELIXOPHYLLIN ELIXIR	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ELLA TAB	-	\$0	CONTRACEPTIVES
ELMIRON CAP	-	B	GENITOURINARY AGENTS - MISCELLANEOUS
eluryng vaginal ring (NUVARING equiv)	-	NC	CONTRACEPTIVES
EMADINE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
EMBEDA CAP	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
EMCYT CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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
EMSAM PATCH	-	B	ANTIDEPRESSANTS
emtricitabine cap (EMTRIVA equiv)	-	G	ANTIVIRALS
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	\$0	ANTIVIRALS
EMTRIVA CAP	-	B	ANTIVIRALS
EMTRIVA SOLN	-	B	ANTIVIRALS
EMVERM TAB	-	NC	ANTHELMINTICS
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
ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	B	HEMATOPOIETIC AGENTS
ENDOMETRIN INSERT	PA	B	VAGINAL PRODUCTS
ENGERIX-B INJ	VAC	\$0	VACCINES
ENGERIX-B/RECOMBIVAX-HB INJ	VAC	\$0	VACCINES
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	G	ANTICOAGULANTS
enpresse tab (TRI-LEVELLEN equiv)	-	\$0	CONTRACEPTIVES
ENSPRYNG INJ	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ENSTILAR FOAM	-	NC	DERMATOLOGICALS
entacapone tab (COMTAN equiv)	-	G	ANTIPARKINSON AGENTS
entecavir tab (BARACLUDE equiv) (QL= 1 tab/day)	QL	G	ANTIVIRALS
ENTEREG CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
ENVARUSUS XR TAB	-	NC	ASSORTED CLASSES
EPANED PREMIXED SOLN	PA	B	ANTIHYPERTENSIVES
EPANED SOLN	PA	B	ANTIHYPERTENSIVES
EPCLUSA TAB	-	NC	ANTIVIRALS
EPIDIOLEX SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTICONVULSANTS
EPIDUO FORTE GEL	PA	B	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
EPIVIR HBV SOLN	-	B	ANTIVIRALS
eplerenone tab (INSPIRA equiv)	¢	G	ANTIHYPERTENSIVES
EPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
EPROSARTAN TAB	-	NC	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
EQUETRO CAP	-	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
ERGOAL CAP	-	NC	VITAMINS
ERGOLOID MESYLATES TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ergoloid mesylates tab (HYDERGINE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ergotamine/caffeine tab (CAFERGOT equiv) (QL= 40 tabs/30 days)	QL	G	MIGRAINE PRODUCTS
ERIVEDGE CAP	MSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERLEADA TAB (QL= 4 tabs/day)	LMSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
erlotinib tab (TARCEVA equiv)	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ERTACZO CREAM	-	NC	DERMATOLOGICALS
ERY PAD	-	G	DERMATOLOGICALS
ERYPED SUSP	-	NC	MACROLIDES
erythromycin DR cap (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G	MACROLIDES
ERYTHROMYCIN EC CAP (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	B	MACROLIDES
erythromycin ethylsuccinate susp (ERYPED equiv) (Step Therapy requires trial of azithromycin or clarithromycin)	ST	G	MACROLIDES
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	NC	MACROLIDES
erythromycin gel	-	G	DERMATOLOGICALS
erythromycin ophth oint	-	G	OPHTHALMIC AGENTS
erythromycin pad	-	G	DERMATOLOGICALS
erythromycin soln	-	G	DERMATOLOGICALS
erythromycin stearate tab (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G	MACROLIDES
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 doxycycline hyclate 100mg)	ST	G	MACROLIDES
erythromycin/benzoyl peroxide gel	-	G	DERMATOLOGICALS
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
ESBRIET CAP (QL= 9 caps/day)	LMSP-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 267MG (QL= 9 tabs/day)	LMSP-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
ESBRIET TAB 801MG (QL= 3 tabs/day)	LMSP-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
escitalopram soln (LEXAPRO equiv)	-	G	ANTIDEPRESSANTS
escitalopram tab (LEXAPRO equiv)	-	G	ANTIDEPRESSANTS
ESKATA SOLN	-	NC	DERMATOLOGICALS
esomeprazole cap	PA	G	ULCER DRUGS
esomeprazole DR granule pack (NEXIUM equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
ESOMEPRAZOLE STRONTIUM CAP	-	NC	ULCER DRUGS
estazolam tab (PROSOM equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	G	ESTROGENS
ESTRACE VAGINAL CREAM	-	NC	VAGINAL PRODUCTS
estradiol cream (ESTRACE equiv)	-	NC	VAGINAL PRODUCTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
estradiol patch (CLIMARA equiv)	-	G	ESTROGENS
estradiol patch (VIVELLE-DOT equiv)	-	G	ESTROGENS
estradiol tab (ESTRACE equiv)	-	G	ESTROGENS
estradiol vaginal tab, yuvaferm vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill)	QL	G	VAGINAL PRODUCTS
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	G	ESTROGENS
ESTRING (3 copays per Rx)	-	B	VAGINAL PRODUCTS
ESTROPIPATE TAB	-	G	ESTROGENS
estropipate tab (OGEN equiv)	-	G	ESTROGENS
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	G	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ethacrynic tab (EDECIN equiv)	-	G	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	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EUCRISA OINT	-	NC	DERMATOLOGICALS
EUFLEXXA/SUPARTZ INJ	MSP-PA	B	MUSCULOSKELETAL THERAPY AGENTS
EURAX CREAM	-	B	DERMATOLOGICALS
EVAMIST SPRAY	-	NC	ESTROGENS
EVEKEO ODT	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
everolimus tab 0.25mg, 0.5mg, 0.75mg (ZORTRESS equiv)	PA	G	MISCELLANEOUS THERAPEUTIC CLASSES
EVIVO LIQUID	-	NC	ANTI-DIARRHEALS
EVOCLIN FOAM	-	NC	DERMATOLOGICALS
EVOTAZ TAB	-	B	ANTIVIRALS
EVRYSDI SOLN	-	NC	NEUROMUSCULAR AGENTS
EVZIO INJ	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
EVZIO INJ	-	NC	ANTIDOTES
EXALGO TAB	-	NC	ANALGESICS - OPIOID
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC	DERMATOLOGICALS
EXELDERM SOLN	-	NC	DERMATOLOGICALS
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC	DERMATOLOGICALS
exemestane tab (AROMASIN equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
EXTAVIA INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
EYSUVIS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
EZALLOR SPRINKLE CAP	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe tab (ZETIA equiv)	-	G	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC	ANTIHYPERLIPIDEMICS
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage)	-	NC	ANTIHYPERLIPIDEMICS
FABIOR AEROSOL FOAM	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
FABRAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
FACTIVE TAB	-	NC	FLUOROQUINOLONES
FALESSA KIT	-	NC	CONTRACEPTIVES
FALESSA TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
famciclovir tab (FAMVIR equiv)	-	G	ANTIVIRALS
famotidine susp (PEPCID equiv)	-	G	ULCER DRUGS
famotidine tab (PEPCID equiv)	-	G	ULCER DRUGS
FANAPT TAB (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANAPT TITRATION PACK (QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
FANSIDAR TAB	-	B	ANTIMALARIALS
FARXIGA TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FASENRA PEN INJ (QL= 1 inj/56 days)	MSP-PA-QL	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST-¢	G	GOUT AGENTS
FEIBA INJ	MSP-PA	B	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	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
FEMHRT TAB	-	NC	ESTROGENS
FEMRING (3 copays per Rx)	-	B	VAGINAL PRODUCTS
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC	ANTIHYPERTENSIVES
fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv)	-	G	ANTIHYPERTENSIVES
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC	ANTIHYPERTENSIVES
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC	ANTIHYPERTENSIVES
fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv)	-	G	ANTIHYPERTENSIVES
fenofibric acid DR cap (TRILIPIX equiv)	-	G	ANTIHYPERTENSIVES
FENOFIBRIC TAB, FIBRICOR TAB	-	B	ANTIHYPERTENSIVES
fenopropfen calcium tab	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENOPROFEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
FENSOLVI INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
fantanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	G	ANALGESICS - OPIOID
fantanyl patch (DURAGESIC equiv)	-	G	ANALGESICS - OPIOID
fantanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC	ANALGESICS - OPIOID
FENTORA TAB, FENTANYL BUCCAL TAB (QL= 120 tabs/30 days)	PA-QL	B	ANALGESICS - OPIOID
FEONYX TAB	-	NC	HEMATOPOIETIC AGENTS
ferrex 150 forte cap	-	G	HEMATOPOIETIC AGENTS
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	G	HEMATOPOIETIC AGENTS
FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B	ANTIDOTES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B	ANTIDOTES
ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
ferrous sulfate syrup (FERROUS SULFATE equiv) (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
FETZIMA CAP	-	NC	ANTIDEPRESSANTS
FETZIMA TITRATION PACK	-	NC	ANTIDEPRESSANTS
FIASP FLEXTOUCH INJ	-	B	ANTIDIABETICS
FIASP INJ	-	B	ANTIDIABETICS
FIASP PENFILL INJ	-	B	ANTIDIABETICS
FIBRIK CAP	-	NC	MULTIVITAMINS
FINACEA FOAM	-	B	DERMATOLOGICALS
FINACEA PLUS KIT	-	B	DERMATOLOGICALS
finasteride tab (PROPECIA equiv)	-	EXC	DERMATOLOGICALS
finasteride tab (PROSCAR equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
FINTEPLA SOLN	-	NC	ANTICONVULSANTS
FIRAZYR INJ	-	NC	HEMATOLOGICAL AGENTS - MISC.
FIRDAPSE TAB	-	NC	ANTIMYASTHENIC/CHOLINERGIC AGENTS
FIRMAGON INJ	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
FIRST ATENOLOL SOLN	-	B	BETA BLOCKERS
FIRST BACLOFEN SUSP KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
FIRST METOPROLOL ORAL SOLN	-	B	BETA BLOCKERS
FIRST METRONIDAZOLE SUSP	-	B	ANTI-INFECTIVE AGENTS - MISC.
FIRST MOUTHWASH BLM	-	B	MOUTH/THROAT/DENTAL AGENTS
FIRST OMEPRAZOLE SUSP	PA	B	ULCER DRUGS
FIRST-VANCOMYCIN SOLN	-	G	ANTI-INFECTIVE AGENTS - MISC.
FIRVANQ SOLN	-	G	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
FLAGYL ER TAB	-	B	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	-	NC	ANTIHYPERLIPIDEMICS
FLO-PRED SUSP	-	NC	CORTICOSTEROIDS
FLORIVA CHEW TAB	-	NC	MULTIVITAMINS
FLORIVA PLUS DROPS	-	B	MULTIVITAMINS
FLOVENT DISKUS INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLOVENT HFA INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
FLUAD INJ	VAC	\$0	VACCINES
FLUAD QUAD INJ	VAC	\$0	VACCINES
FLUBLOK INJ	VAC	\$0	VACCINES
FLUBLOK QUAD PF INJ	VAC	\$0	VACCINES
FLUCELVAX INJ	VAC	\$0	VACCINES
FLUCELVAX QUAD INJ	VAC	\$0	VACCINES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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 QUAD INJ, FLUZONE QUAD INJ	VAC	\$0	VACCINES
FLUMIST QUADRIVALENT NASAL SUSP	VAC	\$0	VACCINES
FLUNISOLIDE NASAL SPRAY (NASAREL equiv)	-	EXC	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% (VANOS CREAM equiv)	-	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 (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MINERALS & ELECTROLYTES
FLUORAC CREAM	-	NC	DERMATOLOGICALS
FLUOR-A-DAY CHEW TAB	-	G	MINERALS & ELECTROLYTES
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	G	OPHTHALMIC AGENTS
FLUOROPLEX CREAM	-	NC	DERMATOLOGICALS
fluorouracil cream (EFUDEX CREAM equiv)	-	G	DERMATOLOGICALS
FLUOROURACIL CREAM 0.5%	-	NC	DERMATOLOGICALS
FLUOROURACIL SOLN	-	B	DERMATOLOGICALS
FLUOVIX PAK	-	NC	DERMATOLOGICALS
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
flurandrenolide cream (CORDRAN equiv)	-	NC	DERMATOLOGICALS
flurandrenolide lotion (CORDRAN equiv)	-	NC	DERMATOLOGICALS
flurandrenolide oint (CORDRAN equiv)	-	NC	DERMATOLOGICALS
FLURAZEPAM CAP	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
FLURBIPROFEN OPHTH SOLN	-	G	OPHTHALMIC AGENTS
flurbiprofen ophth soln (OCUFEN equiv)	-	G	OPHTHALMIC AGENTS
FLURBIPROFEN TAB	-	G	ANALGESICS - ANTI-INFLAMMATORY
flurbiprofen tab (ANSAID equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
flutamide cap (EULEXIN equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
fluticasone nasal spray (FLONASE equiv)	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
fluticasone propionate cream (CUTIVATE equiv)	-	G	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
fluticasone propionate lotion (CUTIVATE equiv)	-	NC	DERMATOLOGICALS
fluticasone propionate oint (CUTIVATE equiv)	-	G	DERMATOLOGICALS
FLUTICASONE/SALMETEROL INHALER	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
fluvastatin cap (LESCOL equiv)	-	NC	ANTIHYPERLIPIDEMICS
fluvastatin ER tab (LESCOL XL equiv)	-	NC	ANTIHYPERLIPIDEMICS
FLUVIRIN INJ	VAC	\$0	VACCINES
FLUVIRIN PF INJ	VAC	\$0	VACCINES
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 HD PF INJ	VAC	\$0	VACCINES
FLUZONE HIGH DOSE PF INJ	VAC	\$0	VACCINES
FLUZONE INTRADERMAL INJ	VAC	\$0	VACCINES
FLUZONE QUADRIVALENT INJ	VAC	\$0	VACCINES
FLUZONE/FLUARIX QUAD INJ	VAC	\$0	VACCINES
FML FORTE OPHTH SUSP	-	B	OPHTHALMIC AGENTS
FML S.O.P. OPHTH OINT	-	B	OPHTHALMIC AGENTS
FOCALIN XR CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
FOLBEE PLUS CZ TAB	-	G	MULTIVITAMINS
folbee tab	-	G	HEMATOPOIETIC AGENTS
FOLET ONE	-	NC	MULTIVITAMINS
folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0	HEMATOPOIETIC AGENTS
folic acid tab 400mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
folic acid tab 800mcg (Covered for females only)	OTC	\$0	HEMATOPOIETIC AGENTS
FOLIKA-V TAB	-	NC	MULTIVITAMINS
FOLITE TAB	-	NC	HEMATOPOIETIC AGENTS
folvite-d tab (GENICIN VITA-D equiv)	-	NC	HEMATOPOIETIC AGENTS
FOLVITE-FE TAB	-	NC	HEMATOPOIETIC AGENTS
fondaparinux inj (ARIXTRA equiv)	-	G	ANTICOAGULANTS
FORFIVO XL TAB	-	NC	ANTIDEPRESSANTS
FORTAMET TAB	-	NC	ANTIDIABETICS
FORTEO INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
FORTICAL NASAL SPRAY	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
FOSAMAX+D TAB (Step Therapy requires trial of ACTONEL)	ST	B	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.
FRAGMIN INJ	-	B	ANTICOAGULANTS
FREESTYLE FREEDOM LITE METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
FREESTYLE INSULINX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	G	MEDICAL DEVICES AND SUPPLIES
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	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
FULPHILA INJ	LMSP	B	HEMATOPOIETIC AGENTS
FUROSEMIDE SOLN	-	G	DIURETICS
furosemide soln (LASIX equiv)	-	G	DIURETICS
furosemide tab (LASIX equiv)	-	G	DIURETICS
FUZEON INJ	LMSP	B	ANTIVIRALS
FYCOMPA TAB	-	B	ANTICONVULSANTS
FYCOMPA SUSP	-	B	ANTICONVULSANTS
gabapentin cap (NEURONTIN equiv)	-	G	ANTICONVULSANTS
gabapentin soln (NEURONTIN equiv)	-	G	ANTICONVULSANTS
gabapentin tab (NEURONTIN equiv)	-	G	ANTICONVULSANTS
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
GALAFOLD CAP (QL= 15 caps/30 days; Only available through 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	-	B	MINERALS & ELECTROLYTES
GAMASTAN S/D INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
GAMUNEX INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
GANCICLOVIR CAP	-	B	ANTIVIRALS
GANCICLOVIR INJ	MSP	B	ANTIVIRALS
ganciclovir inj (CYTOVENE equiv)	MSP	B	ANTIVIRALS
ganirelix ac inj (GANIRELIX equiv)	INF-MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GARDASIL 9 INJ	VAC	\$0	VACCINES
GARDASIL INJ	VAC	\$0	VACCINES
gatifloxacin ophth soln (ZYMAXID equiv)	-	G	OPHTHALMIC AGENTS
GATTEX KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
GAVILYTE-C SOLN (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
gavilyte-h kit	-	NC	LAXATIVES
GAVRETO CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
GAZYVA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
GELCLAIR GEL	-	B	MOUTH/THROAT/DENTAL AGENTS
GELNIQUE	-	NC	URINARY ANTISPASMODICS
GELSYN-3 INJ	MSP-PA	B	MUSCULOSKELETAL THERAPY AGENTS
gemfibrozil tab (LOPID equiv)	-	G	ANTHYPERLIPIDEMICS
GEMTESA TAB	-	NC	URINARY ANTISPASMODICS
GEN7T LOTION	-	NC	DERMATOLOGICALS
GEN7T PLUS LOTION	-	NC	DERMATOLOGICALS
GEN7T PLUS PAD	-	NC	DERMATOLOGICALS
GENOTROPIN INJ	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
GENTAK OPHTH OINT	-	G	OPHTHALMIC AGENTS
gentamicin ophth oint (GARAMYCIN equiv)	-	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	LMSP-PA	B	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	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
GLEOSTINE/LOMUSTINE CAP	-	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
glimepiride tab (AMARYL equiv)	-	G	ANTIDIABETICS
glipizide ER tab (GLUCOTROL XL equiv)	-	G	ANTIDIABETICS
glipizide tab (GLUCOTROL equiv)	-	G	ANTIDIABETICS
glipizide/metformin tab (METAGLIP equiv)	-	G	ANTIDIABETICS
GLOPERBA SOLN	-	NC	GOUT AGENTS
GLUCAGEN HYPOKIT INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUCAGEN INJ	-	B	DIAGNOSTIC PRODUCTS
glucagon (rdna) for inj kit (GLUCAGON equiv) (QL= 2 inj/fill)	QL	G	ANTIDIABETICS
GLUCAGON DIAGNOSTIC INJ	-	NC	DIAGNOSTIC PRODUCTS
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUCAGON KIT (QL= 2 inj/fill)	QL	B	ANTIDIABETICS
GLUMETZA TAB 1000MG	-	NC	ANTIDIABETICS
GLUMETZA TAB 500MG	-	NC	ANTIDIABETICS
glyburide micronized tab (GLYNASE equiv)	-	G	ANTIDIABETICS
glyburide tab (MICRONASE equiv)	-	G	ANTIDIABETICS
glyburide/metformin tab (GLUCOVANCE equiv)	-	G	ANTIDIABETICS
GLYCATE TAB	-	NC	ULCER DRUGS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
glycopyrrolate tab (ROBINUL equiv)	-	G	ULCER DRUGS
GLYGEST PAK	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
GLYXAMBI TAB (QL= 1 tab/day)	QL	B	ANTI-DIABETICS
GOCOVRI CAP	-	NC	ANTI-PARKINSON AGENTS
GOLYTELY PACKET	PA	G	LAXATIVES
GOLYTELY SOLN	-	NC	LAXATIVES
GONITRO POWDER	-	NC	ANTI-ANGINAL AGENTS
GOPRELTO SOLN	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
GRALISE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	G	ANTIEMETICS
GRANISOL SOLN (QL= 60ml/fill)	QL	B	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
GUAIFENESIN SYRUP	-	NC	COUGH/COLD/ALLERGY
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	G	COUGH/COLD/ALLERGY
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	G	COUGH/COLD/ALLERGY
GUANABENZ TAB	-	B	ANTI-HYPERTENSIVES
guanfacine ER tab (INTUNIV equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
guanfacine IR tab (TENEX equiv)	-	G	ANTI-HYPERTENSIVES
GVOKE INJ (QL= 2 inj/fill)	QL	B	ANTI-DIABETICS
GVOKE PFS INJ (QL= 2 inj/fill)	QL	B	ANTI-DIABETICS
HAEGARDA INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
halcinonide cream (HALOG equiv)	-	NC	DERMATOLOGICALS
HALFLYTELY BOWEL PREP KIT	PA	B	LAXATIVES
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	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
haloperidol tab (HALDOL equiv)	-	G	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
HARVONI PELLETT PAK	-	NC	ANTIVIRALS
HARVONI TAB	-	NC	ANTIVIRALS
HAVRIX INJ, VAQTA INJ	VAC	\$0	VACCINES
HC BUTYRATE SOLN	-	NC	DERMATOLOGICALS
HC-LIDOCAINE CREAM	-	NC	DERMATOLOGICALS
HDC DM SYRUP	-	NC	COUGH/COLD/ALLERGY
HELIDAC PACK	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
HELIXATE/KOGENATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEMADY TAB	-	NC	CORTICOSTEROIDS
HEMANGEOL SOLN	-	NC	BETA BLOCKERS
HEMLIBRA INJ	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HEPLISAV-B INJ	VAC	\$0	VACCINES
HERCEPTIN HYLECTA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HERCEPTIN INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
HETLIOZ CAP	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
HEXALEN CAP	-	B	ANTINEOPLASTICS
HIZENTRA INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
HOMATROPINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	G	OPHTHALMIC AGENTS
HORIZANT TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
HUMALOG INJ	PA	B	ANTIDIABETICS
HUMALOG KWIKPEN INJ	PA	B	ANTIDIABETICS
HUMALOG MIX INJ	PA	B	ANTIDIABETICS
HUMALOG MIX KWIKPEN INJ, INSULIN LISPRO PROTAMINE INJ	PA	B	ANTIDIABETICS
HUMALOG PEN INJ	-	NC	ANTIDIABETICS
HUMATE-P/WILATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
HUMATROPE INJ, ZOMACTON INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, fill/plan year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/pla year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/pla year)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
HUMULIN MIX INJ	OTC-PA	B	ANTIDIABETICS
HUMULIN MIX PEN INJ	OTC-PA	B	ANTIDIABETICS
HUMULIN N INJ	OTC-PA	B	ANTIDIABETICS
HUMULIN N PEN INJ	OTC-PA	B	ANTIDIABETICS
HUMULIN R INJ	OTC-PA	B	ANTIDIABETICS
HUMULIN R INJ U-500	-	B	ANTIDIABETICS
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
HYCOFENIX SOLN	-	NC	COUGH/COLD/ALLERGY
hydralazine tab (APRESOLINE equiv)	-	G	ANTIHYPERTENSIVES
hydrochlorothiazide cap (MICROZIDE equiv)	-	G	DIURETICS
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	G	DIURETICS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
hydrocodone bitartrate ER cap (ZOHYDRO equiv)	-	NC	ANALGESICS - OPIOID
hydrocodone/acetaminophen cap (LORCET equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	G	ANALGESICS - OPIOID
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	G	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/CHLORPHENIRAMINE/PSEUDOEPHEDRINE LIQUID (QL= 120ml/fill, 2 fills/month)	QL	B	COUGH/COLD/ALLERGY
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	QL	G	COUGH/COLD/ALLERGY
hydrocodone/homatropine syrup (HYCODAN equiv)	-	G	COUGH/COLD/ALLERGY
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	G	ANALGESICS - OPIOID
hydrocortisone butyrate cream (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate oint (LOCOID equiv)	-	NC	DERMATOLOGICALS
hydrocortisone butyrate soln (LOCOID equiv)	-	NC	DERMATOLOGICALS
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 oint	-	G	DERMATOLOGICALS
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	G	DERMATOLOGICALS
hydrocortisone supp (ANUSOL HC equiv)	-	G	ANORECTAL AGENTS
hydrocortisone tab (CORTEF equiv)	-	G	CORTICOSTEROIDS
hydrocortisone valerate cream (WESTCORT equiv)	-	NC	DERMATOLOGICALS
hydrocortisone valerate oint (WESTCORT equiv)	-	NC	DERMATOLOGICALS
hydromorphone ER tab (EXALGO TAB equiv)	-	NC	ANALGESICS - OPIOID
HYDROMORPHONE SUPP	-	G	ANALGESICS - OPIOID
hydromorphone tab (DILAUDID equiv)	-	G	ANALGESICS - OPIOID
hydroquinone cream (LUSTRA equiv)	-	EXC	DERMATOLOGICALS
hydroquinone cream/sunscreen (LUSTRA ULTRA equiv)	-	NC	DERMATOLOGICALS
hydroquinone micro cream (EPIQUIN MICRO equiv)	-	NC	DERMATOLOGICALS
hydroxychloroquine tab (PLAQUENIL equiv)	-	G	ANTIMALARIALS
HYDROXYPROGESTERONE CAPROATE INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
hydroxyurea cap (HYDREA equiv)	-	G	ANTINEOPLASTICS
hydroxyzine pamoate cap (VISTARIL equiv)	-	G	ANTI-ANXIETY AGENTS
hydroxyzine syrup (ATARAX equiv)	-	G	ANTI-ANXIETY AGENTS
hydroxyzine tab (ATARAX equiv)	-	G	ANTI-ANXIETY AGENTS
HYLAMEND GEL FIRST AID	-	NC	ANTISEPTICS & DISINFECTANTS
HYLINATE LOTION	-	NC	DERMATOLOGICALS
HYMOVIS INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
HYOPHEN TAB	-	B	ANTI-INFECTIVE AGENTS - MISC.
hyophen tab (PROSED DS equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
hyoscyamine inj (LEVSIN equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
hyoscyamine sulfate CR tab (LEVBID equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate elixir (LEVSIN equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate soln (LEVSIN equiv)	-	G	ULCER DRUGS
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	G	ULCER DRUGS
hyoscyamine tab (LEVSIN equiv)	-	G	ULCER DRUGS
HYQVIA INJ	MSP-PA	B	PASSIVE IMMUNIZING AGENTS
HYSINGLA ER TAB (QL= 1 tab/day)	QL	B	ANALGESICS - OPIOID
ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days)	QL	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IBRANCE TAB (QL= 21 caps/28 days)	MSP-PA-QL	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
icatibant inj (FIRAZYR equiv)	LMSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
ICLUSIG TAB (Only available through AcariaHealth 800-511-5144)	LD-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
icosapent ethyl cap 1gm (VASCEPA equiv)	-	NC	ANTIHYPERLIPIDEMICS
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ILEVRO OPHTH SUSP	-	B	OPHTHALMIC AGENTS
imatinib tab (GLEEVEC equiv)	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMBRUVICA CAP 140MG (QL= 3 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 TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
IMCIVREE INJ	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
imipramine pamoate cap (TOFRANIL PM equiv)	-	G	ANTIDEPRESSANTS
imipramine tab (TOFRANIL equiv)	-	G	ANTIDEPRESSANTS
imiquimod cream (ALDARA equiv)	-	G	DERMATOLOGICALS
IMITREX NASAL SPRAY, SUMATRIPTAN NASAL SPRAY	-	NC	MIGRAINE PRODUCTS
IMITREX TAB	-	NC	MIGRAINE PRODUCTS
IMPAVIDO CAP	-	NC	ANTI-INFECTIVE AGENTS - MISC.
IMPEKLO LOTION	-	NC	DERMATOLOGICALS
IMPLANON IMPLANT, NEXPLANON IMPLANT	-	\$0	CONTRACEPTIVES
IMPOYZ CREAM	-	NC	DERMATOLOGICALS
IMVEXXY SUPP	-	NC	VAGINAL PRODUCTS
INBRIJA INH POWDER (QL= 10 caps/day)	PA-QL	B	ANTIPARKINSON AND RELATED THERAPY AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
INCIVEK TAB	-	NC	ANTIVIRALS
INCRELEX INJ	MSP	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
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	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INQOVI TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INREBIC CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	B	ANTIDIABETICS
INSULIN ASPART INJ (NOVOLOG equiv)	-	B	ANTIDIABETICS
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	B	ANTIDIABETICS
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	B	ANTIDIABETICS
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	B	ANTIDIABETICS
INSULIN SYRINGE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
INTELENCE TAB	-	B	ANTIVIRALS
INTERMEZZO SL TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
INTRAROSA SUPP	-	NC	VAGINAL PRODUCTS
INTRON-A INJ	MSP	B	ANTINEOPLASTICS
INVEGA INJ	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
INVELTYS OPHTH SUSP	-	NC	OPHTHALMIC AGENTS
INVIRASE CAP	-	B	ANTIVIRALS
INVIRASE TAB	-	B	ANTIVIRALS
INVOKAMET TAB	-	NC	ANTIDIABETICS
INVOKAMET XR TAB	-	NC	ANTIDIABETICS
INVOKANA TAB	-	NC	ANTIDIABETICS
IODOFLEX PAD	-	NC	ANTISEPTICS & DISINFECTANTS
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	G	DERMATOLOGICALS
iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv)	-	NC	DERMATOLOGICALS
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC	DERMATOLOGICALS
IOPIDINE OPHTH SOLN 1%	-	B	OPHTHALMIC AGENTS
ipratropium nasal spray (ATROVENT equiv)	-	G	NASAL AGENTS - SYSTEMIC AND TOPICAL
ipratropium neb soln (ATROVENT equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
irbesartan tab (AVAPRO equiv)	-	G	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
irbesartan/hydrochlorothiazide tab (AVALIDE equiv)	-	G	ANTIHYPERTENSIVES
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0	HEMATOPOIETIC AGENTS
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
ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	B	MIGRAINE PRODUCTS
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	G	MIGRAINE PRODUCTS
ISONIAZID SYRUP	-	G	ANTIMYCOBACTERIAL AGENTS
ISONIAZID TAB	-	G	ANTIMYCOBACTERIAL AGENTS
ISOPTO CARBACHOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
ISOPTO HYOSCINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate SL tab	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate tab (ISORDIL equiv)	-	G	ANTIANGINAL AGENTS
isosorbide dinitrate tab 40mg (ISORDIL equiv)	-	G	ANTIANGINAL AGENTS
isosorbide mononitrate ER tab (IMDUR equiv)	-	G	ANTIANGINAL AGENTS
isosorbide mononitrate tab (MONOKET equiv)	-	G	ANTIANGINAL AGENTS
isradipine cap (DYNACIRC equiv)	-	G	CALCIUM CHANNEL BLOCKERS
ISTALOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
ISTURISA TAB 10MG (QL= 6 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ISTURISA TAB 1MG (QL= 8 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ISTURISA TAB 5MG (QL= 2 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
itraconazole cap (SPORANOX equiv)	PA	G	ANTIFUNGALS
itraconazole soln (SPORANOX equiv)	PA	G	ANTIFUNGALS
IVERMECTIN CREAM	-	NC	DERMATOLOGICALS
ivermectin cream (SOOLANTRA equiv)	-	NC	DERMATOLOGICALS
ivermectin lotion (SKLICE equiv) (QL= 1 tube/fill)	PA-QL	G	DERMATOLOGICALS
ivermectin tab (STROMECTOL equiv)	-	G	ANTHELMINTICS
JADENU SPRINKLE	-	NC	ANTIDOTES AND SPECIFIC ANTAGONISTS
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
JANUMET TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JANUMET XR TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JANUVIA TAB (QL= 1 tab/day)	QL-¢	B	ANTIDIABETICS
JARDIANCE TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
JATENZO CAP	-	NC	ANDROGENS-ANABOLIC
JENTADUETO TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
JENTADUETO XR TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
jinteli tab (FEMHRT equiv)	-	G	ESTROGENS
JUBLIA SOLN	-	NC	DERMATOLOGICALS
JULUCA TAB	-	B	ANTIVIRALS
junel FE tab (LOESTRIN FE equiv)	-	\$0	CONTRACEPTIVES
junel tab (LOESTRIN equiv)	-	\$0	CONTRACEPTIVES
JUXTAPID CAP	-	NC	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
JYNARQUE TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
KALETRA TAB	-	B	ANTIVIRALS
KALYDECO PAK (QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
KALYDECO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
KAPSPARGO CAP	-	NC	BETA BLOCKERS
KAPVAY TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
KARBINAL ER SUSP	-	NC	ANTIHISTAMINES
KATERZIA SUSP	-	NC	CALCIUM CHANNEL BLOCKERS
KEFLEX CAP 750MG	-	NC	CEPHALOSPORINS
kelnor tab (DEMULEN equiv)	-	\$0	CONTRACEPTIVES
KERAFOAM	-	NC	DERMATOLOGICALS
KERALAC CREAM	-	NC	DERMATOLOGICALS
KERYDIN SOLN	-	NC	DERMATOLOGICALS
KESIMPTA INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
KETAMINE HCL TROCHES	-	NC	GENERAL ANESTHETICS
KETEK TAB	-	B	ANTI-INFECTIVE AGENTS - MISC.
ketoconazole cream (NIZORAL CREAM equiv)	-	G	DERMATOLOGICALS
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	G	DERMATOLOGICALS
ketoconazole tab (NIZORAL equiv)	-	G	ANTIFUNGALS
KETO-DIASTIX TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
KETOPROFEN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketoprofen cap (ORUDIS equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
KETOPROFEN ER CAP	-	B	ANALGESICS - ANTI-INFLAMMATORY
KETOROLAC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ketorolac inj (TORADOL equiv)	-	NC	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
KETOSTIX	OTC	G	DIAGNOSTIC PRODUCTS
ketotifen ophth soln (ZADITOR equiv)	OTC	EXC	OPHTHALMIC AGENTS
KEVEYIS TAB	-	NC	DIURETICS
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
KHEDEZLA ER TAB	-	NC	ANTIDEPRESSANTS
KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
KISQALI PAK	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
KISQALI TAB	-	NC	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
KLOR-CON M15 TAB	-	B	MINERALS & ELECTROLYTES
KLOR-CON POWDER PACKET 25MEQ	-	B	MINERALS & ELECTROLYTES

** OTC drugs are not a covered benefit.

EXC	Plan Exclusion	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	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
KOMBIGLYZE XR TAB	-	NC	ANTIDIABETICS
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	B	ANTIDIABETICS
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
K-PHOS TAB	-	B	MINERALS & ELECTROLYTES
KRINTAFEL TAB	-	B	ANTIMALARIALS
KRISTALOSE PACK	-	NC	LAXATIVES
KRISTALOSE PACKET	-	NC	LAXATIVES
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
KYNAMRO INJ	-	NC	ANTHYPERLIPIDEMICS
KYNMOBI FILM	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
KYNMOBI TITRATION KIT	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
L.E.T. GEL	-	NC	DERMATOLOGICALS
labetalol tab (NORMODYNE equiv)	-	G	BETA BLOCKERS
LACRISERT OPHTH INSERT	-	NC	OPHTHALMIC AGENTS
lactulose soln	-	G	GASTROINTESTINAL AGENTS - MISC.
LAMICTAL CHEW TAB 2MG	-	B	ANTICONVULSANTS
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)	-	G	ANTICONVULSANTS
lamotrigine ODT kit (LAMICTAL ODT KIT equiv)	-	G	ANTICONVULSANTS
lamotrigine tab (LAMICTAL equiv)	-	G	ANTICONVULSANTS
LAMPIT TAB	-	NC	ANTI-INFECTIVE AGENTS - MISC.
LANCET KIT	OTC	G	MEDICAL DEVICES AND SUPPLIES
LANCETS	OTC	G	MEDICAL DEVICES AND SUPPLIES
LANOXIN INJ	-	NC	CARDIOTONICS
LANOXIN TAB 0.0625MG, 0.1875MG	-	NC	CARDIOTONICS
lansoprazole cap (PREVACID equiv) (Rx Only)	-	G	ULCER DRUGS
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS
LANSOPRAZOLE SUSP	PA	B	ULCER DRUGS
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	G	ULCER DRUGS
lanthanum carbonate chew tab (FOSRENOL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
LANTUS INJ	-	B	ANTIDIABETICS
LANTUS SOLOSTAR INJ	-	B	ANTIDIABETICS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
lapatinib ditosylate tab (TYKERB equiv)	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LASTACRAFT OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days)	QL	G	OPHTHALMIC AGENTS
LATISSE SOLN	-	NC	DERMATOLOGICALS
LATUDA TAB (QL= 1 tab/day; Step Therapy requires trial of quetiapine)	QL-ST-¢	B	ANTIPSYCHOTICS/ANTIMANIC AGENTS
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0	CONTRACEPTIVES
LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	B	ANALGESICS - OPIOID
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/ day)	LMSP-PA-QL	B	ANTIVIRALS
leflunomide tab (ARAVA equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LESCOL CAP	-	NC	ANTIHYPERTENSIVES
LESCOL XL TAB	-	NC	ANTIHYPERTENSIVES
letrozole tab (FEMARA equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
leucovorin tab	-	G	ANTINEOPLASTICS
LEUKERAN TAB	-	B	ANTINEOPLASTICS
LEUKINE INJ	-	NC	HEMATOPOIETIC AGENTS
LEVABUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA)	QL-ST	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
levabuterol neb soln (XOPENEX equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
LEVATOL TAB	-	B	BETA BLOCKERS
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
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.
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 soln (LEVAQUIN equiv)	-	G	FLUOROQUINOLONES
levofloxacin tab (LEVAQUIN equiv)	-	G	FLUOROQUINOLONES
levonorgestrel tab (PLAN B equiv)	OTC	\$0	CONTRACEPTIVES
LEVONORGESTREL TAB 0.75MG	-	\$0	CONTRACEPTIVES
LEVORPHANOL TAB	-	B	ANALGESICS - OPIOID
levorphanol tab (LEVORPHANOL equiv)	-	G	ANALGESICS - OPIOID
levothyroxine tab (SYNTHROID equiv)	-	NC	THYROID AGENTS
LXETTE FOAM	-	NC	DERMATOLOGICALS
LEXIVA SUSP	-	B	ANTIVIRALS
LICART PATCH	-	NC	DERMATOLOGICALS
LIDOCAINE CREAM	-	NC	DERMATOLOGICALS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
lidocaine cream 3% (LIDAMANTLE equiv)	-	G	DERMATOLOGICALS
lidocaine cream 3.88% (LIDOTRAL CREAM equiv)	-	NC	DERMATOLOGICALS
LIDOCAINE GEL	-	G	DERMATOLOGICALS
lidocaine gel (GLYDO equiv)	-	G	DERMATOLOGICALS
lidocaine gel (XYLOCAINE equiv)	-	G	DERMATOLOGICALS
lidocaine lotion	-	NC	DERMATOLOGICALS
lidocaine oint (QL= 36gm/fill)	QL	G	DERMATOLOGICALS
lidocaine oint/transparent dressing kit	-	NC	DERMATOLOGICALS
LIDOCAINE ORAL SOLN 4%	-	B	MOUTH/THROAT/DENTAL AGENTS
lidocaine patch (LIDODERM equiv) (QL= 3 patches/day)	PA-QL	G	DERMATOLOGICALS
lidocaine soln (XYLOCAINE equiv)	-	G	DERMATOLOGICALS
lidocaine viscous soln	-	G	MOUTH/THROAT/DENTAL AGENTS
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	G	ANORECTAL AGENTS
LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT	-	NC	ANORECTAL AGENTS
lidocaine/prilocaine cream (EMLA equiv)	-	G	DERMATOLOGICALS
LIDOCIN GEL	-	NC	DERMATOLOGICALS
LIDOLOG KIT	-	NC	CORTICOSTEROIDS
LIDOSTREAM KIT	-	NC	DERMATOLOGICALS
LIDOTIN PAK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LIDOTRAL CREAM (lidocaine cream equiv)	-	NC	DERMATOLOGICALS
LIDOTREX GEL	-	NC	DERMATOLOGICALS
LIDOVEX CREAM	-	NC	DERMATOLOGICALS
LINDANE LOTION	-	B	DERMATOLOGICALS
lindane lotion	-	G	DERMATOLOGICALS
lindane shampoo	-	G	DERMATOLOGICALS
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	-	NC	GASTROINTESTINAL AGENTS - MISC.
liothyronine tab (CYTOMEL equiv)	-	G	THYROID AGENTS
LIPITOR TAB	-	NC	ANTIHYPERLIPIDEMICS
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	G	ANTIHYPERTENSIVES
lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv)	-	G	ANTIHYPERTENSIVES
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 citrate soln	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
LITHOSTAT TAB	-	B	GENITOURINARY AGENTS - MISCELLANEOUS
LIVALO TAB	-	NC	ANTIHYPERLIPIDEMICS
L-METHYLFOLATE TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LO LOESTRIN TAB	-	NC	CONTRACEPTIVES
LOCOID CREAM	-	NC	DERMATOLOGICALS
LOCOID LIPOCREAM	-	NC	DERMATOLOGICALS
LOCOID OINT	-	NC	DERMATOLOGICALS
LOCOID SOLN	-	NC	DERMATOLOGICALS
LOESTRIN 24 FE TAB	-	NC	CONTRACEPTIVES
LOKELMA PAK	PA	B	MISCELLANEOUS THERAPEUTIC CLASSE

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
LOMAIRA TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
LONHALA MAGNAIR SOLN	-	NC	ASTHMA/ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
LONSURF TAB (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
loperamide cap (IMODIUM equiv)	-	NC	ANTIDIARRHEALS
LOPERAMIDE SOLN	-	NC	ANTIDIARRHEAL/PROBIOTIC AGENTS
lopinavir/ritonavir soln (KALETRA equiv)	-	G	ANTIVIRALS
LOPROX GEL	-	NC	DERMATOLOGICALS
loratadine cap (CLARITIN equiv)	OTC	EXC	ANTIHISTAMINES
lorazepam conc (ATIVAN equiv)	-	G	ANTI-ANXIETY AGENTS
lorazepam tab (ATIVAN equiv)	-	G	ANTI-ANXIETY AGENTS
LORBRENA TAB 100MG (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
LORTAB ELIXIR	-	B	ANALGESICS - OPIOID
LORVATUS PHARMAPAK KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
losartan tab (COZAAR equiv)	-	G	ANTI-HYPERTENSIVES
losartan/hydrochlorothiazide tab (HYZAAR equiv)	-	G	ANTI-HYPERTENSIVES
LOTEMAX OPHTH GEL	-	B	OPHTHALMIC AGENTS
LOTEMAX OPHTH OINT	-	B	OPHTHALMIC AGENTS
LOTEMAX SM GEL 0.38%	-	NC	OPHTHALMIC AGENTS
loteprednol ophth susp (LOTEMAX equiv)	-	G	OPHTHALMIC AGENTS
LOTRIMIN AF CREAM	-	NC	DERMATOLOGICALS
LOTRISONE CREAM	-	NC	DERMATOLOGICALS
LOTRISONE LOTION	-	NC	DERMATOLOGICALS
lovastatin tab (MEVACOR equiv)	-	\$0	ANTI-HYPERLIPIDEMICS
loxapine cap (LOXITANE equiv)	-	G	ANTI-PSYCHOTICS/ANTI-MANIC AGENTS
LUCEMYRA TAB (QL= 84 tabs/7 days)	PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LUCENTIS INJ	MSP-PA	B	OPHTHALMIC AGENTS
LUFYLLIN TAB	-	B	ASTHMA/ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
LULICONAZOLE CREAM, LUZU CREAM	-	NC	DERMATOLOGICALS
LUMIFY OPHTH SOLN 0.25%	-	NC	OPHTHALMIC AGENTS
LUMIGAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
LUMIZYME/MYOZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT PED INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUPRON DEPOT-PED INJ	MSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
LUVIRA CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
LUXIQ FOAM	-	NC	DERMATOLOGICALS
LYNPARZA CAP (Only available through Biologics 800-850-4306, QL= 16 caps/day)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYNPARZA TAB (Only available through Biologics 800-850-4306, QL= 4 tabs/day)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
LYRICA CAP	-	NC	ANTICONVULSANTS
LYRICA CR TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
LYUMJEV INJ	-	NC	ANTIDIABETICS
LYUMJEV KWIKPEN INJ	-	NC	ANTIDIABETICS
MACRILEN PACK	-	NC	DIAGNOSTIC PRODUCTS
MACUGEN INJ	MSP-PA	B	OPHTHALMIC AGENTS
MALARONE TAB	-	NC	ANTIMALARIALS
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	G	DERMATOLOGICALS
maldemar tab (SCOPACE equiv)	-	G	ANTIEMETICS
MAPROTILINE TAB	-	G	ANTIDEPRESSANTS
MARPLAN TAB	-	B	ANTIDEPRESSANTS
MATULANE CAP	-	B	ANTINEOPLASTICS
MAVENCLAD PAK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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 50MG TAB	-	NC	ANTIEMETICS
meclizine chew tab (BONINE equiv) (Rx Only)	-	G	ANTIEMETICS
meclizine tab (ANTIVERT equiv) (Rx Only)	-	G	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	-	B	ANTIMALARIALS
mefloquine tab (LARIAM equiv)	-	G	ANTIMALARIALS
megestrol ES susp (MEGACE ES equiv)	-	G	PROGESTINS
megestrol susp (MEGACE equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
megestrol tab (MEGACE equiv)	-	G	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; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
meloxicam cap (VIVLODEX equiv)	-	NC	ANALGESICS - ANTI-INFLAMMATORY
MELOXICAM COMFORT KIT	-	NC	ANALGESICS - ANTI-INFLAMMATORY
meloxicam tab (MOBIC equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
melphalan tab (ALKERAN equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
MELQUIN 3 SOLN	-	NC	DERMATOLOGICALS
memantine ER cap (NAMENDA XR equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine soln (NAMENDA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
memantine tab (NAMENDA equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
MENACTRA INJ	VAC	\$0	VACCINES
MENEST TAB	-	B	ESTROGENS
MENHIBRIX INJ	VAC	\$0	VACCINES
MENOMUNE INJ	VAC	\$0	VACCINES
MENOSTAR PATCH	-	NC	ESTROGENS
MENTAX CREAM	-	NC	DERMATOLOGICALS
MENVEO INJ	VAC	\$0	VACCINES
MEPERIDINE TAB	-	NC	ANALGESICS - OPIOID
meperidine tab (DEMEROL equiv)	-	NC	ANALGESICS - OPIOID
meprobamate tab (MILTOWN equiv)	-	NC	ANTI-ANXIETY AGENTS
mercaptopurine tab (PURINETHOL equiv)	-	G	ANTINEOPLASTICS
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 supp (CANASA equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
mesalamine tab (ASACOL equiv)	-	NC	GASTROINTESTINAL AGENTS - MISC.
MESNEX TAB	LMSP	B	ANTINEOPLASTICS
METANX CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
METAPROTERENOL SYRUP	-	G	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
METAPROTERENOL TAB	-	B	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
metaxalone tab (SKELAXIN equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
METAXALONE TAB 400MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
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 soln (RIOMET equiv)	-	G	ANTIDIABETICS
metformin tab (GLUCOPHAGE equiv)	-	G	ANTIDIABETICS
methadone soln	-	G	ANALGESICS - OPIOID
methadone tab (DOLOPHINE equiv)	-	G	ANALGESICS - OPIOID
methadose tab	-	G	ANALGESICS - OPIOID
methamphetamine tab (DESOXYN equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methazolamide tab (NEPTAZANE equiv)	-	G	DIURETICS
methenamine hippurate tab (HIPREX equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
methenamine mandelate tab	-	G	ANTI-INFECTIVE AGENTS - MISC.
methimazole tab (TAPAZOLE equiv)	-	G	THYROID AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
METHITEST TAB (Step Therapy requires trial of ANDROGEL or ANDRODERM)	ST	B	ANDROGENS-ANABOLIC
methocarbamol tab (ROBAXIN equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
methotrexate inj	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
methotrexate tab (TREXALL equiv)	-	G	ANTINEOPLASTICS
methoxsalen cap (OXSORALEN ULTRA equiv)	-	G	DERMATOLOGICALS
methscopolamine tab (PAMINE equiv)	-	G	ULCER DRUGS
METHYCLOTHIAZIDE TAB	-	G	DIURETICS
methyl dopa tab (ALDOMET equiv)	-	G	ANTIHYPERTENSIVES
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	G	OXYTOCICS
methylphenidate CD cap (METADATE CD equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate chew tab (METHYLIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER cap (RITALIN LA equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER cap (APTENSIO XR equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METHYLPHENIDATE ER TAB	-	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate ER tab	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
METHYLPHENIDATE ER TAB 72MG	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate soln (METHYLIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylphenidate tab (RITALIN equiv)	-	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
methylprednisolone dose pack (MEDROL equiv)	-	G	CORTICOSTEROIDS
methylprednisolone tab (MEDROL equiv)	-	G	CORTICOSTEROIDS
METHYLTESTOSTERONE CAP	PA	B	ANDROGENS-ANABOLIC
METIPRANOLOL OPHTH SOLN	-	B	OPHTHALMIC AGENTS
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 tab 37.5mg, 75mg (LOPRESSOR equiv)	-	NC	BETA BLOCKERS
METOPROLOL/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	G	ANTIHYPERTENSIVES
METZOZLV ODT	-	NC	GASTROINTESTINAL AGENTS - MISC.
metronidazole cap (FLAGYL equiv)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
metronidazole cream (METROCREAM equiv)	-	G	DERMATOLOGICALS
metronidazole gel (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 vaginal gel (METROGEL equiv)	-	G	VAGINAL PRODUCTS
metyrosine cap (DEMSEER equiv)	-	NC	ANTIHYPERTENSIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
mexiletine hcl cap	-	G	ANTIARRHYTHMICS
MEXPAROX HC CREAM	-	NC	DERMATOLOGICALS
MIACALCIN INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
mibelas chew tab (MINASTRIN equiv)	-	G	CONTRACEPTIVES
MICARDIS HCT TAB	-	NC	ANTIHYPERTENSIVES
MICLARA LIQUID	-	NC	ANTIHISTAMINES
MICORT-HC CREAM	-	NC	DERMATOLOGICALS
MICROVIX LP PAK	-	NC	DERMATOLOGICALS
midodrine tab (PROAMATINE equiv)	-	G	VASOPRESSORS
MIGERGOT SUPP (QL=20 tabs/30 days)	QL	B	MIGRAINE PRODUCTS
MIGLITOL TAB	-	G	ANTIDIABETICS
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	B	HEMATOPOIETIC AGENTS
MILLIPRED DP PAK	-	NC	CORTICOSTEROIDS
MILLIPRED TAB	-	B	CORTICOSTEROIDS
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
minoxidil tab (LONITEN equiv)	-	G	ANTIHYPERTENSIVES
MIRALAX PACKET	-	NC	LAXATIVES
MIRAPEX ER TAB	-	NC	ANTIPARKINSON AGENTS
MIRCERA INJ	-	NC	HEMATOPOIETIC AGENTS
MIRENA IUD	-	\$0	CONTRACEPTIVES
mirtazapine ODT (REMERON equiv)	-	G	ANTIDEPRESSANTS
mirtazapine tab (REMERON equiv)	-	G	ANTIDEPRESSANTS
MIRVASO GEL	-	NC	DERMATOLOGICALS
misoprostol tab (CYTOTEC equiv)	-	G	ULCER DRUGS
MITIGARE CAP	-	B	GOUT AGENTS
M-M-R II INJ	VAC	\$0	VACCINES
modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MODERIBA TAB	-	NC	ANTIVIRALS
moexipril tab (UNIVASC equiv)	-	G	ANTIHYPERTENSIVES
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	G	ANTIHYPERTENSIVES
MOLINDONE TAB	-	NC	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
mometasone cream (ELOCON equiv)	-	G	DERMATOLOGICALS
mometasone nasal spray (NASONEX equiv)	-	EXC	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	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
montelukast granule pack (SINGULAIR equiv)	-	G	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
montelukast tab (SINGULAIR equiv)	-	G	ANTI-ASTHMATIC 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 CAP	-	NC	ANALGESICS - OPIOID
morphine sulfate ER cap (KADIAN equiv)	-	NC	ANALGESICS - OPIOID
morphine sulfate ER tab (MS CONTIN equiv)	-	G	ANALGESICS - OPIOID
morphine sulfate soln	-	G	ANALGESICS - OPIOID
MORPHINE SULFATE SUPP	-	G	ANALGESICS - OPIOID
morphine sulfate tab	-	G	ANALGESICS - OPIOID
MOTTEGRITY TAB	PA	B	GASTROINTESTINAL AGENTS - MISC.
MOVANTIK TAB	PA	B	GASTROINTESTINAL AGENTS - MISC.
MOVIPREP SOLN (Step Therapy requires trial of CLENPIQ)	ST	B	LAXATIVES
MOXATAG TAB	-	NC	PENICILLINS
MOXATAG TAB 775MG	-	NC	PENICILLINS
MOXEZA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
moxifloxacin hcl ophth soln 0.5% (MOXEZA equiv)	-	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
MUCINEX LIQUID	-	NC	COUGH/COLD/ALLERGY
MUCINEX TAB	-	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
MULTIVITAMIN/FLOURIDE CHEW 0.25MG	-	G	MULTIVITAMINS
MULTIVITAMIN/FLOURIDE CHEW 1MG	-	G	MULTIVITAMINS
MULTIVITAMIN/FLUORIDE CHEW TAB	-	G	MULTIVITAMINS
MULTIVITAMIN/FLUORIDE CHEW TAB	-	NC	MULTIVITAMINS
multivitamin/minerals tab (STROVITE equiv)	-	G	MULTIVITAMINS
MULTIVITAMIN/MINERALS TAB	-	NC	MULTIVITAMINS
mupirocin cream (BACTROBAN CREAM equiv)	-	NC	DERMATOLOGICALS
mupirocin oint (BACTROBAN OINT equiv)	-	G	DERMATOLOGICALS
MUSE SUPP (QL= 6 supp/30 days; Step therapy requires trial of sildenafil)	QL-ST	B	CARDIOVASCULAR AGENTS - MISC.
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	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
MYLERAN TAB	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
MYNATAL-Z TAB	-	NC	MULTIVITAMINS
MYRBETRIQ TAB	-	NC	URINARY ANTISPASMODICS
MYTESI TAB	-	NC	ANTIDIARRHEALS
nabumetone tab (RELAFEN equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
nadolol tab (CORCARD equiv)	-	G	BETA BLOCKERS
NAFTIFINE CREAM	-	NC	DERMATOLOGICALS
naftifine cream (NAFTIN equiv)	-	NC	DERMATOLOGICALS
naftifine gel (NAFTIN equiv)	-	NC	DERMATOLOGICALS
NAFTIN CREAM	-	NC	DERMATOLOGICALS
NAFTIN GEL	-	NC	DERMATOLOGICALS
NAFTIN GEL 2%	-	NC	DERMATOLOGICALS
NAGLAZYME INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
naloxone inj	-	G	ANTIDOTES AND SPECIFIC ANTAGONISTS
NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
naloxone prefilled inj (QL= 2 inj/fill)	QL	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
NAPRELAN CR TAB 750MG	-	NC	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN CREAM COMPOUND KIT	-	NC	DERMATOLOGICALS
naproxen EC tab (NAPROSYN EC equiv)	-	G	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 (NAPROSYN equiv)	PA	G	ANALGESICS - ANTI-INFLAMMATORY
NAPROXEN SUSP	PA--	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 (QL= 2 sprays/fill)	QL	B	ANTIDOTES AND SPECIFIC ANTAGONISTS
NARDIL TAB	-	B	ANTIDEPRESSANTS
NASACORT OTC NASAL SPRAY	OTC	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
NASCOBAL NASAL SPRAY	-	B	HEMATOPOIETIC AGENTS
NATACHEW	-	NC	MULTIVITAMINS
NATAZIA TAB	-	B	CONTRACEPTIVES
nateglinide tab (STARLIX equiv)	-	G	ANTIDIABETICS
NATESTO NASAL GEL	-	NC	ANDROGENS-ANABOLIC
NATPARA INJ (Only available through Walgreens 888-347-3416)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
NATROBA SUSP (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS
NAYZILAM SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B	ANTICONVULSANTS
NEBUSAL NEB SOLN	-	B	COUGH/COLD/ALLERGY
NECON TAB	-	\$0	CONTRACEPTIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
NEEVO DHA	-	NC	MULTIVITAMINS
NEFAZODONE TAB	-	G	ANTIDEPRESSANTS
nefazodone tab 50mg, 250mg	-	G	ANTIDEPRESSANTS
neomycin tab	-	G	AMINOGLYCOSIDES
NEOMYCIN/POLYMYXIN/GRAMICIDIN OPHTH SOLN	-	G	OPHTHALMIC AGENTS
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	G	OTIC AGENTS
neomycin/polymixin/hydrocortisone 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	-	G	OPHTHALMIC AGENTS
NEONATAL 19 TAB	-	B	MULTIVITAMINS
NEONATAL FE TAB	-	B	MULTIVITAMINS
NEOSALUS FOAM	-	NC	DERMATOLOGICALS
NEO-SYNALAR CREAM	-	NC	DERMATOLOGICALS
NEPHRON FA TAB	-	B	HEMATOPOIETIC AGENTS
NEPHRO-VITE TAB	-	NC	MULTIVITAMINS
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
NESTABS ABC	-	NC	MULTIVITAMINS
NESTABS DHA	-	NC	MULTIVITAMINS
NESTABS ONE	-	NC	MULTIVITAMINS
NEULASTA INJ	-	NC	HEMATOPOIETIC AGENTS
NEUMEGA INJ	LMSP	B	HEMATOPOIETIC AGENTS
NEUPOGEN INJ	-	NC	HEMATOPOIETIC AGENTS
NEUPRO PATCH	PA	B	ANTIPARKINSON AGENTS
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 (VIRAMUNE equiv)	-	B	ANTIVIRALS
nevirapine susp (VIRAMUNE equiv)	-	G	ANTIVIRALS
nevirapine tab (VIRAMUNE equiv)	-	G	ANTIVIRALS
NEXA PLUS	-	NC	MULTIVITAMINS
NEXAVAR TAB	MSP-PA-SF	B	ANTINEOPLASTICS
NEXICLON XR SUSP	-	B	ANTIHYPERTENSIVES
NEXICLON XR TAB	-	B	ANTIHYPERTENSIVES
NEXIUM 24HR TAB	-	NC	ULCER DRUGS
NEXIUM CAP	-	NC	ULCER DRUGS
NEXIUM GRANULE PACK	-	NC	ULCER DRUGS
NEXLETOL TAB	-	NC	ANTIHYPERLIPIDEMICS
NEXLIZET TAB	-	NC	ANTIHYPERLIPIDEMICS
niacin cap	OTC	EXC	VITAMINS
niacin CR tab (SLO-NIACIN equiv)	OTC	EXC	VITAMINS
niacin ER tab (NIASPAN equiv)	-	G	ANTIHYPERLIPIDEMICS
niacin tab	OTC	EXC	VITAMINS
NIACIN TR TAB	OTC	EXC	VITAMINS
niacinamide tab	OTC	EXC	VITAMINS
NIACOR TAB	-	NC	ANTIHYPERLIPIDEMICS
NIASPAN ER TAB	-	NC	ANTIHYPERLIPIDEMICS
nicardipine cap (CARDENE equiv)	-	G	CALCIUM CHANNEL BLOCKERS

** OTC drugs are not a covered benefit.

EXC	Plan Exclusion	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	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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
nilutamide tab (NILANDRON equiv)	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
nimodipine cap (NIMOTOP equiv)	-	G	CALCIUM CHANNEL BLOCKERS
NINLARO CAP	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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.
nitisinone cap (ORFADIN equiv)	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NITRO-BID OINT	-	B	ANTIANGINAL AGENTS
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)	-	NC	ANTI-INFECTIVE AGENTS - MISC.
NITROGLYCERIN ER CAP	-	G	ANTIANGINAL AGENTS
nitroglycerin lingual spray (NITROLINGUAL equiv)	-	G	ANTIANGINAL AGENTS
nitroglycerin patch (NITRO-DUR equiv)	-	G	ANTIANGINAL AGENTS
nitroglycerin SL tab (NITROSTAT equiv)	-	G	ANTIANGINAL AGENTS
NITROMIST SPRAY	-	B	ANTIANGINAL AGENTS
NITYR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
NIVESTYM INJ	LMSP	B	HEMATOPOIETIC AGENTS
NIZATIDINE CAP	-	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS
nizatidine cap (AXID equiv)	-	G	ULCER DRUGS
nizoral a-d shampoo (NIZORAL equiv)	OTC	NC	DERMATOLOGICALS
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 tab (NORA-QD equiv)	-	\$0	CONTRACEPTIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
norethindrone tab (AYGESTIN equiv)	-	G	PROGESTINS
norethindrone/ethinyl estradiol 21 tab (LOESTRIN 21 equiv)	-	NC	CONTRACEPTIVES
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	NC	CONTRACEPTIVES
norethindrone/ethinyl estradiol tab (LOESTRIN equiv)	-	NC	CONTRACEPTIVES
NORGESIC TAB FORTE	-	NC	MUSCULOSKELETAL THERAPY AGENTS
NORITATE CREAM	-	NC	DERMATOLOGICALS
NOROXIN TAB	-	B	FLUOROQUINOLONES
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
NORTRIPTYLINE SOLN	-	G	ANTIDEPRESSANTS
NORVIR CAP	-	B	ANTIVIRALS
NORVIR POWDER PACK	-	B	ANTIVIRALS
NORVIR SOLN	-	B	ANTIVIRALS
NOVACORT GEL	-	NC	DERMATOLOGICALS
NOVOFINE PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOVOLIN 70/30 FLEXPEN INJ	OTC	B	ANTIDIABETICS
NOVOLIN 70/30 INJ	OTC	B	ANTIDIABETICS
NOVOLIN N FLEXPEN INJ	OTC	B	ANTIDIABETICS
NOVOLIN N INJ	OTC	B	ANTIDIABETICS
NOVOLIN R FLEXPEN INJ	OTC	B	ANTIDIABETICS
NOVOLIN R INJ	OTC	B	ANTIDIABETICS
NOVOLOG FLEXPEN INJ	-	B	ANTIDIABETICS
NOVOLOG INJ	-	B	ANTIDIABETICS
NOVOLOG MIX FLEXPEN INJ	-	B	ANTIDIABETICS
NOVOLOG MIX INJ	-	B	ANTIDIABETICS
NOVOLOG PENFILL INJ	-	B	ANTIDIABETICS
NOVOPEN ECHO	-	B	MEDICAL DEVICES AND SUPPLIES
NOVOSEVEN INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
NOVOTWIST PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	G	MEDICAL DEVICES AND SUPPLIES
NOXAFIL SUSP (QL= 525ml/26 days)	PA-QL	B	ANTIFUNGALS
NOXAFIL TAB	-	NC	ANTIFUNGALS
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	G	THYROID AGENTS
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)	QL	B	ANALGESICS - OPIOID
NUCYNTA TAB	-	B	ANALGESICS - OPIOID
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
nulido pad (NULIDO equiv)	-	NC	DERMATOLOGICALS
NUPLAZID CAP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	LD	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	RS	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation	ST	Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
NUPLAZID TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
NUQUIN HP CREAM	-	NC	DERMATOLOGICALS
NURTEC ODT (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
NUVAKAAN II KIT	-	NC	DERMATOLOGICALS
NUVARING	-	\$0	CONTRACEPTIVES
NUVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
NUZYRA TAB (QL= 2 tabs/day, 30 tabs/180 days; Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B	TETRACYCLINES
NYMALIZE SOLN	-	NC	CALCIUM CHANNEL BLOCKERS
nystatin cream (MYCOSTATIN CREAM equiv)	-	G	DERMATOLOGICALS
nystatin oint	-	G	DERMATOLOGICALS
nystatin powder	-	G	ANTIFUNGALS
nystatin susp	-	G	MOUTH/THROAT/DENTAL AGENTS
nystatin tab	-	G	ANTIFUNGALS
nystatin topical powder	-	G	DERMATOLOGICALS
NYSTATIN VAGINAL TAB	-	G	VAGINAL PRODUCTS
nystatin/triamcinolone cream	-	NC	DERMATOLOGICALS
nystatin/triamcinolone oint	-	NC	DERMATOLOGICALS
NYVEPRIA INJ	-	NC	HEMATOPOIETIC AGENTS
OB COMPLETE ONE	-	NC	MULTIVITAMINS
OB COMPLETE PETITE	-	NC	MULTIVITAMINS
OB COMPLETE PREMIER	-	NC	MULTIVITAMINS
OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF-¢	B	GASTROINTESTINAL AGENTS - MISC.
octreotide inj (SANDOSTATIN equiv)	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ODACTRA SL TAB	-	NC	ALLERGENIC EXTRACTS/BIOLOGICALS MISC
ODEFSEY TAB	-	B	ANTIVIRALS
ODOMZO CAP	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
OFEV CAP (QL= 2 caps/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
ofloxacin ophth soln (OCUFLOX equiv)	-	G	OPHTHALMIC AGENTS
ofloxacin otic soln (FLOXIN equiv)	-	G	OTIC AGENTS
ofloxacin tab (FLOXIN equiv)	-	G	FLUOROQUINOLONES
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.
OLEPTRO TAB	-	B	ANTIDEPRESSANTS
OLLIZAC POWDER	-	NC	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 nasal spray (PATANASE equiv)	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
olopatadine ophth soln 0.1% (PATANOL equiv)	-	G	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%)	QL-ST	G	OPHTHALMIC AGENTS
OLUMIANT TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
OLUX E FOAM	-	NC	DERMATOLOGICALS
OLUX FOAM	-	NC	DERMATOLOGICALS
OLYSIO CAP	-	NC	ANTIVIRALS
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 magnesium DR tab 20mg (PRILOSEC equiv)	OTC	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
omeprazole tab	OTC	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC	ULCER DRUGS
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC	ULCER DRUGS
OMNARIS NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
OMNIPAQUE SOLN	-	NC	DIAGNOSTIC PRODUCTS
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	B	MEDICAL DEVICES AND SUPPLIES
OMNIPOD DASH PODS (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	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ondansetron ODT (ZOFTRAN equiv)	-	G	ANTIEMETICS
ondansetron soln (ZOFTRAN equiv)	-	G	ANTIEMETICS
ONDANSETRON TAB	-	G	ANTIEMETICS
ondansetron tab (ZOFTRAN equiv)	-	G	ANTIEMETICS
ONETOUCH METER	OTC	\$0	MEDICAL DEVICES AND SUPPLIES
ONETOUCH TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
ONETOUCH VERIO TEST STRIP	OTC	G	DIAGNOSTIC PRODUCTS
ONEXTON GEL	-	NC	DERMATOLOGICALS
ONFI SUSP	-	NC	ANTICONVULSANTS
ONFI TAB	-	NC	ANTICONVULSANTS
ONGENTYS CAP	-	NC	ANTIPARKINSON AND RELATED THERAPY AGENTS
ONGLYZA TAB	-	NC	ANTIDIABETICS
ONUREG TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ONYCHO-MED KIT	-	NC	DERMATOLOGICALS
ONZETRA XSAIL	-	NC	MIGRAINE PRODUCTS
OPANA ER TAB (CRUSH RESISTANT)	-	NC	ANALGESICS - OPIOID
OPANA TAB	-	NC	ANALGESICS - OPIOID
opium tincture	-	G	ANTIDIARRHEALS
OPSUMIT TAB (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
ORACIT SOLN	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
ORALAIR SL TAB	-	NC	BIOLOGICALS MISC
ORAVIG TAB	-	B	MOUTH/THROAT/DENTAL AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	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	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
ORAXYL CAP	-	B	TETRACYCLINES
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.
ORFADIN CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORFADIN SUSP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORGOVYX TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	B	ESTROGENS
ORLISSA TAB 150MG (QL= 1 tab/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORLISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
ORKAMBI TAB (QL= 4 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
ORLADEYO CAP	-	NC	HEMATOLOGICAL AGENTS - MISC.
orphenadrine citrate ER tab (NORFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ORTHOVISC/MONOVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
ORTIKOS ER CAP	-	NC	CORTICOSTEROIDS
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
otomax-HC otic soln (CORTANE-B equiv)	-	NC	OTIC AGENTS
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC	OTIC AGENTS
OTOZIN OTIC DROPS	-	NC	OTIC AGENTS
OVACE PLUS CREAM	-	NC	DERMATOLOGICALS
OVACE PLUS LOTION	-	NC	DERMATOLOGICALS
OVACE PLUS FOAM	-	NC	DERMATOLOGICALS
OVEEZA CAP	-	NC	HEMATOPOIETIC AGENTS
oxandrolone tab (OXANDRIN equiv)	-	G	ANDROGENS-ANABOLIC
oxaprozin tab (DAYPRO equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
oxazepam cap (SERAX equiv)	-	G	ANTIANKXIETY AGENTS
OXBRYTA TAB (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B	HEMATOPOIETIC AGENTS
oxcarbazepine susp (TRILEPTAL equiv)	-	G	ANTICONVULSANTS
oxcarbazepine tab (TRILEPTAL equiv)	-	G	ANTICONVULSANTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523)	LD-PA-QL	B	OPHTHALMIC AGENTS
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
oxybutynin tab (DITROPAN equiv)	-	G	URINARY ANTISPASMODICS
oxycodone cap (OXYIR equiv)	-	G	ANALGESICS - OPIOID
oxycodone conc (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
OXYCODONE ER TAB, OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
oxycodone soln (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
oxycodone tab (ROXICODONE equiv)	-	G	ANALGESICS - OPIOID
oxycodone/acetaminophen cap (TYLOX equiv)	-	G	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
OXYCODONE/ASPIRIN TAB	-	G	ANALGESICS - OPIOID
oxycodone/aspirin tab (PERCODAN equiv)	-	G	ANALGESICS - OPIOID
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	G	ANALGESICS - OPIOID
OXYCONTIN CR TAB	-	NC	ANALGESICS - OPIOID
OXYMORPHONE ER TAB	-	NC	ANALGESICS - OPIOID
oxymorphone tab (OPANA equiv)	-	NC	ANALGESICS - OPIOID
OXYTROL PATCH (OTC)	OTC	EXC	URINARY ANTISPASMODICS
OZEMPIC INJ (QL= 1 pack/28 days)	QL	B	ANTIDIABETICS
OZOBAX SOLN	-	NC	MUSCULOSKELETAL THERAPY AGENTS
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 ABILIFY or quetiapine ER)	ST	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PALYNZIQ INJ (QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PANCREAZE CAP, PERTZYE CAP, ULTRESA CAP, ZENPEP CAP	-	NC	DIGESTIVE AIDS
PANCRELIPASE CAP	-	NC	DIGESTIVE AIDS
PANDEL CREAM	-	B	DERMATOLOGICALS
pantoprazole EC tab (PROTONIX equiv)	-	G	ULCER DRUGS
pantoprazole sodium packet (PROTONIX equiv)	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
PARAGARD IUD	-	\$0	CONTRACEPTIVES
paramox hc gel (NOVACORT GEL equiv)	-	NC	DERMATOLOGICALS
PAREGORIC TINCTURE	-	NC	ANTIDIARRHEALS
paricalcitol cap (ZEMPLAR equiv)	-	G	ENDOCRINE AND METABOLIC AGENTS - MISC.
PAROMOMYCIN CAP	-	G	AMINOGLYCOSIDES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSPP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
paromomycin cap (HUMATIN equiv)	-	G	AMINOGLYCOSIDES
paroxetine cap (BRISDELLE equiv)	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
paroxetine ER tab (PAXIL CR equiv)	-	G	ANTIDEPRESSANTS
paroxetine tab (PAXIL equiv)	-	G	ANTIDEPRESSANTS
PAZEO OPHTH SOLN 0.7%	-	NC	OPHTHALMIC AGENTS
pb-belladonna elixir (DONNATAL equiv)	-	NC	ULCER DRUGS
PEAK FLOW METER	OTC	G	MEDICAL DEVICES AND SUPPLIES
pediatric multiple vitamins/fluoride chew tab	-	G	MULTIVITAMINS
pediatric multiple vitamins/fluoride soln	-	G	MULTIVITAMINS
pediatric multiple vitamins/fluoride/iron soln	-	G	MULTIVITAMINS
PEDIZOLPAK THERAPY PACK	-	NC	DERMATOLOGICALS
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (Step Therapy requires trial of CLENPIQ)	ST	G	LAXATIVES
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0	LAXATIVES
PEGANONE TAB	-	B	ANTICONVULSANTS
PEGASYS INJ	LMSP	B	ANTIVIRALS
PEG-INTRON INJ	LMSP	B	ANTIVIRALS
PEMAZYRE TAB (QL= 14 tabs/21 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PEN NEEDLE	OTC	NC	MEDICAL DEVICES AND SUPPLIES
penicillamine cap (CUPRIMINE equiv)	-	NC	MISCELLANEOUS THERAPEUTIC CLASSE
penicillamine tab (DEPEN TITRATAB equiv)	-	G	MISCELLANEOUS THERAPEUTIC CLASSE
penicillin vk soln (VEETIDS equiv)	-	G	PENICILLINS
penicillin vk tab (VEETIDS equiv)	-	G	PENICILLINS
PENLAC SOLN	-	NC	DERMATOLOGICALS
PENNSAID SOLN	-	NC	DERMATOLOGICALS
pentamidine neb soln (NEBUPENT equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
PENTASA CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
pentazocine/acetaminophen tab (TALACEN equiv)	-	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/ANTICHOLINEF CS
PERFOROMIST NEB SOLN	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
perindopril tab (ACEON equiv)	-	G	ANTIHYPERTENSIVES
permethrin cream (ELIMITE CREAM equiv)	-	G	DERMATOLOGICALS
perphenazine tab (TRILAFON equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
PERPHENAZINE/ AMITRIPTYLINE TAB	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
PEXEVA TAB	-	NC	ANTIDEPRESSANTS
phenazopyridine tab (PYRIDIUM equiv)	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
PHENDIMETRAZINE ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
phendimetrazine tab (BONTRIL PDM equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
phenelzine tab (NARDIL equiv)	-	G	ANTIDEPRESSANTS
phenobarbital elixir	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenobarbital tab	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
phenoxybenzamine cap (DIBENZYLIN equiv)	-	G	ANTIHYPERTENSIVES
phentermine cap (ADIPEX equiv) (QL= 1 cap/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
phentermine tab (ADIPEX equiv) (QL= 1 tab/day)	PA-QL	G	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
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	-	NC	VAGINAL AND RELATED PRODUCTS
PHISOHEX LIQUID	-	B	ANTISEPTICS & DISINFECTANTS
PHOSLYRA SOLN	-	B	GASTROINTESTINAL AGENTS - MISC.
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	G	MINERALS & ELECTROLYTES
PHOSPHOLINE OPHTH SOLN	-	B	OPHTHALMIC AGENTS
PHOTREXA OP KIT	-	NC	OPHTHALMIC AGENTS
PHOTREXA VISCOUS OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
phytonadione tab (MEPHYTON equiv)	-	G	VITAMINS
PICATO GEL (QL= 1 box/fill)	QL	B	DERMATOLOGICALS
PIFELTRO TAB	-	B	ANTIVIRALS
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	G	OPHTHALMIC AGENTS
pilocarpine tab (SALAGEN equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
PILOPINE HS OPHTH GEL	-	B	OPHTHALMIC AGENTS
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older)	-	G	DERMATOLOGICALS
PIMOZIDE TAB	-	B	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	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
piroxicam cap (FELDENE equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
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.
PLENVU SOLN	-	NC	LAXATIVES
PLIAGLIS CREAM	-	NC	DERMATOLOGICALS
PLIAGLIS KIT	-	NC	DERMATOLOGICALS
PNEUMOVAX INJ	VAC	\$0	VACCINES
PODIAPN CAP	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
PODOCON SOLN	-	B	DERMATOLOGICALS
podoxolol soln (CONDYLOX equiv)	-	G	DERMATOLOGICALS
polyethylene glycol 3350 powder (MIRALAX equiv)	-	G	LAXATIVES
POLYETHYLENE GLYCOL 8000 GRANULES	-	B	PHARMACEUTICAL ADJUVANTS
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	G	OPHTHALMIC AGENTS
POLY-TUSSIN DM SYRUP	-	NC	COUGH/COLD/ALLERGY
POLY-VI-FLOR SUSP	-	NC	MULTIVITAMINS
POMALYST CAP (QL= 21 caps/28 days)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
posaconazole DR tab (NOXAFIL equiv) (QL= 93 tabs/30 days)	PA-QL	G	ANTIFUNGALS
POT/CHLORIDE EFFER TAB	-	G	MINERALS & ELECTROLYTES
POTABA POWDER PACKET	-	B	VITAMINS
POTABA TAB	-	B	VITAMINS
potassium bicarbonate effer tab (K-LYTE equiv)	-	G	MINERALS & ELECTROLYTES
potassium chloride effer tab (K-LYTE/CL 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 citrate CR tab (UROKIT-K TAB equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
POTIGA TAB (QL= 3 tabs/day)	QL	B	ANTICONVULSANTS
PRADAXA CAP	-	B	ANTICOAGULANTS
PRALUENT INJ (QL= 2 inj/28 days)	PA-QL	B	ANTIHYPERTENSIVES
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 E CREAM	-	B	DERMATOLOGICALS
PRAMOSONE LOTION	-	NC	DERMATOLOGICALS
PRAMOSONE OINT	-	NC	DERMATOLOGICALS
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	G	ANORECTAL AGENTS
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	G	ANORECTAL AGENTS
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	NC	OTIC AGENTS
PRANDIMET TAB	-	NC	ANTIDIABETICS
PRASCION RA CREAM	-	B	DERMATOLOGICALS
prasugrel tab (EFFIENT equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
pravastatin tab (PRAVACHOL equiv)	-	\$0	ANTIHYPERTENSIVES
praziquantel tab (BILTRICIDE equiv)	-	G	ANTHELMINTICS
prazosin cap (MINIPRESS equiv)	-	G	ANTIHYPERTENSIVES
PRECISION XTRA KETONE TEST STRIP	OTC	G	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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
PRED-G OPHTH SOLN	-	B	OPHTHALMIC AGENTS
PREDNICARBATE CREAM	-	B	DERMATOLOGICALS
prednicarbate cream (DERMATOP equiv)	-	G	DERMATOLOGICALS
PREDNICARBATE OIN	-	B	DERMATOLOGICALS
prednisolone ODT (ORAPRED equiv)	-	G	CORTICOSTEROIDS
PREDNISOLONE OPHTH SUSP	-	G	OPHTHALMIC AGENTS
PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
PREDNISOLONE SOLN	-	B	CORTICOSTEROIDS
prednisolone soln (PEDIAPRED equiv)	-	G	CORTICOSTEROIDS
PREDNISOLONE SYRUP	-	G	CORTICOSTEROIDS
prednisolone syrup (PRELONE equiv)	-	G	CORTICOSTEROIDS
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 pack	-	NC	CORTICOSTEROIDS
PREDNISONE SOLN	-	G	CORTICOSTEROIDS
prednisone tab (DELTASONE equiv)	-	G	CORTICOSTEROIDS
PREDNISONE/DIPHENHYDRAMINE KIT	-	NC	CORTICOSTEROIDS
PREFERA OB	-	NC	MULTIVITAMINS
PREFERA OB ONE	-	NC	MULTIVITAMINS
PREFEST TAB	-	B	ESTROGENS
pregabalin cap (LYRICA equiv)	-	G	ANTICONVULSANTS
pregabalin soln (LYRICA equiv)	-	G	ANTICONVULSANTS
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
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 MINI	-	NC	MULTIVITAMINS
PRENATE MINI, TRISTART DHA	-	NC	MULTIVITAMINS
PRENATE TAB	-	NC	MULTIVITAMINS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
PREPOPIK PAK	-	NC	LAXATIVES
PRESTALIA TAB	-	NC	ANTIHYPERTENSIVES
PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	B	ANTIMYCOBACTERIAL AGENTS
PREVACID OTC CAP	OTC	EXC	ULCER DRUGS
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT PASTE	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVIDENT RINSE	-	B	MOUTH/THROAT/DENTAL AGENTS
PREVNAR 13 INJ	VAC	\$0	VACCINES
PREVYMIS TAB	-	NC	ANTIVIRALS
PREZCOBIX TAB	-	B	ANTIVIRALS
PREZISTA SUSP	-	B	ANTIVIRALS
PREZISTA TAB	-	B	ANTIVIRALS
PRIFTIN TAB	-	B	ANTIMYCOBACTERIAL AGENTS
PRILOSEC CAP	-	NC	ULCER DRUGS
PRILOSEC OTC DR TAB	OTC	NC	ULCER DRUGS
PRIMACARE	-	NC	MULTIVITAMINS
primaquine tab (PRIMAQUINE equiv)	-	G	ANTIMALARIALS
primidone tab (MYSOLINE equiv)	-	G	ANTICONSULSANTS
PRIMLEV TAB	-	NC	ANALGESICS - OPIOID
PRIMLEV TAB 10-300MG	-	NC	ANALGESICS - OPIOID
PRIMLEV TAB 5-300MG	-	NC	ANALGESICS - OPIOID
PRIMSOL SOLN	-	B	ANTI-INFECTIVE AGENTS - MISC.
probenecid tab (BENEMID equiv)	-	G	GOUT AGENTS
prochlorperazine supp (COMPAZINE equiv)	-	G	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
prochlorperazine tab (COMPAZINE equiv)	-	G	ANTI-PSYCHOTICS/ANTIMANIC AGENTS
PROCRIT INJ	-	NC	HEMATOPOIETIC AGENTS
PROCTOCORT SUPP	-	NC	ANORECTAL AGENTS
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
progesterone cap (PROMETRIUM equiv)	-	G	PROGESTINS
progesterone oil inj	-	G	PROGESTINS
PROGESTERONE SUPP	PA	B	VAGINAL PRODUCTS
PROGRAF PACKET	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
PROLATE TAB	-	NC	ANALGESICS - OPIOID
PROLENSA OPHTH SOLN	-	B	OPHTHALMIC AGENTS
PROLEUKIN INJ	-	NC	ANTINEOPLASTICS
PROLIA INJ (QL= 1 fill/6 months)	LMSP-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
PROMACTA POWDER	LMSP-PA	B	HEMATOPOIETIC AGENTS
PROMACTA TAB	LMSP-PA	B	HEMATOPOIETIC AGENTS
promethazine DM syrup	-	G	COUGH/COLD/ALLERGY
promethazine supp (PHENERGAN equiv)	-	G	ANTIHISTAMINES
promethazine syrup	-	G	ANTIHISTAMINES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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
propafenone ER cap (RYTHMOL SR equiv)	-	G	ANTIARRHYTHMICS
propafenone tab (RYTHMOL equiv)	-	G	ANTIARRHYTHMICS
PROPANTHELINE TAB	-	B	ULCER DRUGS
proparacaine ophth soln (ALCAINE equiv)	-	G	OPHTHALMIC AGENTS
propranolol ER cap (INDERAL LA equiv)	-	G	BETA BLOCKERS
PROPRANOLOL SOLN	-	G	BETA BLOCKERS
propranolol tab (INDERAL equiv)	-	G	BETA BLOCKERS
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	G	ANTIHYPERTENSIVES
propylthiouracil tab	-	G	THYROID AGENTS
PROQUIN XR TAB	-	NC	FLUOROQUINOLONES
PROSED DS TAB	-	NC	URINARY ANTI-INFECTIVES
PROSTIGMIN TAB	-	B	ANTIMYASTHENIC/CHOLINERGIC AGENTS
PROTHELIAL PASTE	-	NC	MOUTH/THROAT/DENTAL AGENTS
protriptyline tab (VIVACTIL equiv)	-	G	ANTIDEPRESSANTS
PROVIDA DHA	-	NC	MULTIVITAMINS
PROVIDA OB	-	NC	MULTIVITAMINS
PROVIGIL TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
PROZAC WEEKLY CAP	-	NC	ANTIDEPRESSANTS
PROZENA PAD	-	NC	DERMATOLOGICALS
PULMICORT FLEXHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
PULMOZYME INH SOLN	LMSP	B	RESPIRATORY AGENTS - MISC.
PUREFOLIX TAB	-	NC	HEMATOPOIETIC AGENTS
PURIXAN SUSP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
PYLERA CAP	-	B	ULCER DRUGS
PYRAZINAMIDE TAB	-	G	ANTIMYCOBACTERIAL AGENTS
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
pyridostigmine soln (MESTINON equiv)	-	G	ANTIMYASTHENIC/CHOLINERGIC AGENTS
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	ANTIMALARIALS
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC	ANTIMALARIALS
QBRELIS SOLN	PA	B	ANTIHYPERTENSIVES
QBREXZA PAD	-	NC	DERMATOLOGICALS
QDOLO SOLN	-	NC	ANALGESICS - OPIOID
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
QMIIZ ODT TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
QNASL NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
QTERN TAB	-	NC	ANTIDIABETICS
QUALAQUIN CAP	-	NC	ANTIMALARIALS
QUDEXY XR CAP, TOPIRAMATE ER CAP	-	NC	ANTICONVULSANTS
quetiapine tab (SEROQUEL equiv)	-	G	ANTIpsychOTICS/ANTIMANIC AGENTS
quetiapine XR tab (SEROQUEL XR equiv)	-	G	ANTIpsychOTICS/ANTIMANIC AGENTS
QUFLORA PEDIATRIC CHEW TAB	-	B	MULTIVITAMINS
QUILLICHEW ER TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
QUILLIVANT XR SUSP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
quinapril tab (ACCUPRIL equiv)	-	G	ANTIHYPERTENSIVES
quinapril/hydrochlorothiazide tab (ACCURETIC equiv)	-	G	ANTIHYPERTENSIVES
quinidine gluconate CR tab	-	G	ANTIARRHYTHMICS
QUINIDINE SULFATE ER TAB	-	B	ANTIARRHYTHMICS
quinidine sulfate tab	-	G	ANTIARRHYTHMICS
quinine sulfate cap (QUALAQUIN equiv)	-	NC	ANTIMALARIALS
QUINIXIL PAK	-	NC	DERMATOLOGICALS
QVAR INHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
QVAR REDIHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
rabeprazole EC tab (ACIPHEX equiv)	PA	G	ULCER DRUGS
RAGWITEK SL TAB	-	NC	BIOLOGICALS MISC
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0	ENDOCRINE AND METABOLIC AGENTS - MISC.
ramelteon tab (ROZEREM equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ramipril cap (ALTACE equiv)	-	G	ANTIHYPERTENSIVES
ranitidine cap (ZANTAC equiv)	-	NC	ULCER DRUGS
ranitidine syrup (ZANTAC equiv)	-	NC	ULCER DRUGS
ranitidine tab (Rx Only) (ZANTAC equiv)	-	NC	ULCER DRUGS
ranolazine tab (RANEXA equiv)	-	G	ANTIANGINAL AGENTS
rasagiline tab (AZILECT equiv)	¢	G	ANTIPARKINSON AGENTS
RAVICTI LIQUID	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYALDEE CAP	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
RAYOS TAB	-	NC	CORTICOSTEROIDS
REBETOL SOLN	LMSP	B	ANTIVIRALS
REBIF INJ	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
REBLOZYL INJ	-	NC	HEMATOPOIETIC AGENTS
RECOMBINATE INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
RECTIV OINT	-	B	ANORECTAL AGENTS
REDITREX INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
REGRANEX GEL (QL= 30gm/fill)	QL	B	DERMATOLOGICALS
RELAFEN DS TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
RELENZA DISKHALER (QL= 1 inhaler/calendar year)	QL	B	ANTIVIRALS
RELISTOR INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELISTOR INJ KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
RELISTOR TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
RELPAK TAB	-	NC	MIGRAINE PRODUCTS
RELTONE CAP	-	NC	GASTROINTESTINAL AGENTS - MISC.
REMEDIENT CAP	-	NC	MULTIVITAMINS
REMICADE INJ	-	NC	GASTROINTESTINAL AGENTS - MISC.
RENAGEL TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
RENAGEL TAB 800MG	-	NC	GASTROINTESTINAL AGENTS - MISC.
renaphro cap (NEPHROCAP equiv)	-	G	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
REPAGLINIDE TAB	-	NC	ANTIDIABETICS
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	B	ANTIHYPERTENSIVES
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	B	ANTIHYPERTENSIVES
RESCRIPTOR TAB	-	B	ANTIVIRALS
RESERPINE TAB	-	B	ANTIHYPERTENSIVES
RESERVAPAK SYRUP	-	NC	ALTERNATIVE MEDICINES
RESTASIS OPHTH EMULSION	PA	B	OPHTHALMIC AGENTS
RETACRIT INJ	MSP	B	HEMATOPOIETIC AGENTS
RETEVMO CAP (QL= 4 caps/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RETIN-A CREAM (QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization)	PA-QL	B	DERMATOLOGICALS
RETIN-A GEL (QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization)	PA-QL	B	DERMATOLOGICALS
RETIN-A MICRO GEL 0.04%, 0.1%	-	NC	DERMATOLOGICALS
RETIN-A MICRO GEL 0.08%, 0.06%	-	NC	DERMATOLOGICALS
REVATIO SUSP	-	NC	CARDIOVASCULAR AGENTS - MISC.
REVLIMID CAP (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist)	MSP-QL-RS	B	ASSORTED CLASSES
REXAPHENAC CREAM	-	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
REZYST CHEW TAB	-	NC	ANTIDIARRHEALS
RHEUMATREX TAB	-	B	ANALGESICS - ANTI-INFLAMMATORY
RHOFADE CREAM	-	NC	DERMATOLOGICALS
RHOPRESSA OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
RIABNI SOLN	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RIASTAP INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
RIBAPAK TAB	-	NC	ANTIVIRALS
ribavirin cap (REBETOL equiv)	LMSP	B	ANTIVIRALS
ribavirin inh soln (VIRAZOLE equiv)	-	NC	ANTIVIRALS
ribavirin tab (COPEGUS equiv)	LMSP	B	ANTIVIRALS
RIBAVIRIN TAB 400MG	-	NC	ANTIVIRALS
RIDAURA CAP	-	B	ANALGESICS - ANTI-INFLAMMATORY
rifabutin cap (MYCOBUTIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
RIFAMATE CAP	-	B	ANTIMYCOBACTERIAL AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
rifampin cap (RIFADIN equiv)	-	G	ANTIMYCOBACTERIAL AGENTS
riluzole tab (RILUTEK equiv)	-	G	NEUROMUSCULAR AGENTS
RIMANTADINE TAB	-	G	ANTIVIRALS
RINVOQ ER TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
RIOMET ER SUSP	PA	B	ANTIDIABETICS
risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	G	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
rivastigmine cap (EXELON equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
rivastigmine patch (EXELON equiv)	-	G	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
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
ROCKLATAN OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ropinirole ER tab (REQUIP XL equiv)	-	G	ANTIPARKINSON AGENTS
ropinirole tab (REQUIP equiv)	-	G	ANTIPARKINSON AGENTS
ROPIVICAINE/CLONIDINE/KETOROLAC INJ	-	NC	LOCAL ANESTHETICS-PARENTERAL
ROSADAN KIT	-	NC	DERMATOLOGICALS
ROSULA WASH	-	NC	DERMATOLOGICALS
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0	ANTIHYPERTENSIVES
rosuvastatin tab 20mg (CRESTOR equiv)	-	G	ANTIHYPERTENSIVES
rosuvastatin tab 40mg (CRESTOR equiv)	-	G	ANTIHYPERTENSIVES
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0	ANTIHYPERTENSIVES
ROWASA KIT	-	NC	GASTROINTESTINAL AGENTS - MISC.
ROZEREM TAB	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ROZLYTREK CAP (QL= 3 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RUCONEST INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B	HEMATOLOGICAL AGENTS - MISC.
rufinamide susp (BANZEL equiv)	PA	G	ANTICONVULSANTS
RUKOBIA ER TAB	-	NC	ANTIVIRALS
RUZURGI TAB (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B	ANTIMYASTHENIC/CHOLINERGIC AGENTS
RYBELSUS TAB (QL=1 tab/day)	QL	B	ANTIDIABETICS
RYBIX ODT	-	NC	ANALGESICS - OPIOID
RYCLORA SYRUP, DEXCHLORPHENIRAMINE SYRUP	-	NC	ANTIHISTAMINES
RYDAPT CAP	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
RYTARY CAP	-	NC	ANTIPARKINSON AGENTS
RYVENT TAB	-	NC	ANTIHISTAMINES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
SABRIL TAB	-	NC	ANTICONVULSANTS
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SALEX LOTION KIT	-	NC	DERMATOLOGICALS
SALEX SHAMPOO	-	B	DERMATOLOGICALS
salicylic acid soln	-	NC	DERMATOLOGICALS
salicylic acid shampoo (SALEX equiv)	-	G	DERMATOLOGICALS
SALIMEZ FORTE CREAM	-	NC	DERMATOLOGICALS
salsalate tab (DISALCID equiv)	-	G	ANALGESICS - NONNARCOTIC
SAMSCA TAB, TOLVAPTAN TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANCUSO PATCH (QL= 4 patches/fill)	QL	B	ANTIEMETICS
SANDIMMUNE SOLN 100MG/ML	-	B	ASSORTED CLASSES
SANDOSTATIN LAR INJ KIT	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SANTYL OINT (QL= 90gm/30 days)	QL	B	DERMATOLOGICALS
sapropterin dihydrochloride powder packet (KUVAN equiv)	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
sapropterin dihydrochloride soluble tab (KUVAN equiv)	LMSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
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.
SCARCIN GEL	-	NC	DERMATOLOGICALS
scarcin gel (SCARCIN equiv)	-	NC	DERMATOLOGICALS
SCARCIN LIQUID ROLL-ON	-	NC	DERMATOLOGICALS
scopolamine patch (TRANSDERM-SCOP equiv)	-	G	ANTIEMETICS
seb-prev cream (OVACE CREAM equiv)	-	NC	DERMATOLOGICALS
SECONAL CAP	-	B	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SECUADO PATCH	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
SEEBRI NEOHALER CAP	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SEGLUROMET TAB	-	NC	ANTIDIABETICS
SELECT OB + DHA	-	NC	MULTIVITAMINS
selegiline cap (ELDEPRYL equiv)	-	G	ANTIPARKINSON AGENTS
selegiline tab (ELDEPRYL equiv)	-	G	ANTIPARKINSON AGENTS
selenium sulfide lotion	-	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	-	NC	ANTIDIABETICS
SEMGLEE SOLN	-	NC	ANTIDIABETICS
SEMPREX-D CAP	-	EXC	COUGH/COLD/ALLERGY
SENSIPAR TAB	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
SEREVENT DISKUS INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SERNIVO SPRAY	-	NC	DERMATOLOGICALS
SEROQUEL XR TAB	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
sertraline conc (ZOLOFT equiv)	-	G	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.
SEYSARA TAB	-	NC	TETRACYCLINES
SHINGRIX INJ (Covered for members age 50 or older)	VAC	\$0	VACCINES
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SIGNIFOR LAR INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
SIKLOS TAB	-	NC	HEMATOPOIETIC AGENTS
SILALITE PAK MIS	-	NC	DERMATOLOGICALS
sildenafil susp (REVATIO equiv)	-	NC	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)	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	G	DERMATOLOGICALS
SILVERA PAD	-	NC	DERMATOLOGICALS
SIMBRINZA OPHTH SUSP	-	B	OPHTHALMIC AGENTS
SIMPONI ARIA INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMPONI SC INJ	-	NC	ANALGESICS - ANTI-INFLAMMATORY
SIMVASTATIN SUSP	-	NC	ANTIHYPERLIPIDEMICS
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0	ANTIHYPERLIPIDEMICS
simvastatin tab 80mg (ZOCOR equiv)	-	NC	ANTIHYPERLIPIDEMICS
SINUVA NASAL IMPLANT	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
sirolimus soln (RAPAMUNE equiv)	-	G	MISCELLANEOUS THERAPEUTIC CLASSES
sirolimus tab (RAPAMUNE equiv)	-	G	ASSORTED CLASSES
SIRTURO TAB	-	NC	ANTIMYCOBACTERIAL AGENTS
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.
SKELID TAB	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	B	DERMATOLOGICALS
SKYRIZI INJ (QL= 2 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
SLYND TAB	-	B	CONTRACEPTIVES
smz/tmp (DS) tab (BACTRIM DS equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
sodium chloride neb soln (HYPER-SAL equiv)	-	G	COUGH/COLD/ALLERGY
sodium citrate/citric acid soln (BICITRA equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS

** OTC drugs are not a covered benefit.

EXC	Plan Exclusion	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	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride gel (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride paste (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride rinse (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0	MINERALS & ELECTROLYTES
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	G	MOUTH/THROAT/DENTAL AGENTS
SODIUM HYALU INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
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 sulfacetamide gel (OVACE PLUS equiv)	-	NC	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/sulfur cream (PLEXION SCT equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur emulsion (ROSULA equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	G	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 susp (PLEXION TS equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sulfur wash (SUMAXIN WASH equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC	DERMATOLOGICALS
sodium sulfacetamide/urea pad (ROSULA equiv)	-	NC	DERMATOLOGICALS
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/ day)	LMSP-PA-QL	B	ANTIVIRALS
SOLAICE PATCH	-	NC	DERMATOLOGICALS
SOLARAVIX PAK	-	NC	DERMATOLOGICALS
SOLARAZE GEL	-	NC	DERMATOLOGICALS
solifenacin tab (VESICARE equiv)	-	G	URINARY ANTISPASMODICS
SOLIQUA INJ (QL= 15ml/25 days)	PA-QL	B	ANTIDIABETICS
SOLOSEC GRANULES PACKET	-	NC	AMEBICIDES
SOMA TAB 250MG	-	NC	MUSCULOSKELETAL THERAPY AGENTS
SOMATULINE INJ	MSP-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	B	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
SOMNOTE CAP	-	B	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
SOOLANTRA CREAM	-	NC	DERMATOLOGICALS
SORILUX FOAM	-	B	DERMATOLOGICALS
sotalol AF tab (BETAPACE AF equiv)	-	G	BETA BLOCKERS
sotalol tab (BETAPACE equiv)	-	G	BETA BLOCKERS
SOTYLIZE SOLN	-	NC	BETA BLOCKERS
SOVALDI PELLETT PAK	-	NC	ANTIVIRALS
SOVALDI TAB	-	NC	ANTIVIRALS
SPECTRACEF TAB	-	B	CEPHALOSPORINS
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	B	DERMATOLOGICALS
SPIRIVA HANDIHALER	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
spironolactone tab (ALDACTONE equiv)	-	G	DIURETICS
spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv)	-	G	DIURETICS
SPORANOX SOLN	PA	B	ANTIFUNGALS
SPRAVATO NASAL SOLN	-	NC	ANTIDEPRESSANTS
sprintec 28 tab (ORTHO-CYCLEN equiv)	-	\$0	CONTRACEPTIVES
SPRITAM TAB	-	NC	ANTICONVULSANTS
SPRIX NASAL SPRAY	PA	B	ANALGESICS - ANTI-INFLAMMATORY
SPRYCEL TAB	LMSP-PA-SF	B	ANTINEOPLASTICS
SPS SUSP	-	G	MISCELLANEOUS THERAPEUTIC CLASSE
SSKI SOLN	-	B	COUGH/COLD/ALLERGY
STAMARIL INJ	-	NC	VACCINES
stavudine cap (ZERIT equiv)	-	G	ANTIVIRALS
stavudine soln (ZERIT equiv)	-	G	ANTIVIRALS
STAVZOR CAP	-	NC	ANTICONVULSANTS
STEGLATRO TAB	-	NC	ANTIDIABETICS
STEGLUJAN TAB	-	NC	ANTIDIABETICS
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B	DERMATOLOGICALS
STENDRA TAB	-	NC	CARDIOVASCULAR AGENTS - MISC.
STIMATE NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
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
SUBLOCADE INJ	-	NC	ANALGESICS - OPIOID
SUBOXONE SL FILM	-	NC	ANALGESICS - OPIOID
SUBSYS SPRAY	-	NC	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
SUCLEAR KIT	PA	B	LAXATIVES
SUCRAID SOLN	-	NC	DIGESTIVE AIDS
sucrafate susp (CARAFATE equiv)	PA	G	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
sucrafate tab (CARAFATE equiv)	-	G	ULCER DRUGS
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	G	OPHTHALMIC AGENTS
sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv)	-	G	OPHTHALMIC AGENTS
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 KIT	-	NC	DERMATOLOGICALS
SUMADEN XLT KIT	-	NC	DERMATOLOGICALS
SUMANSETRON PAK	-	NC	MIGRAINE PRODUCTS
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 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= 5 inj/fill, 2 fills/30 days)	QL	G	MIGRAINE PRODUCTS
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC	MIGRAINE PRODUCTS
SUMAVEL DOSEPRO INJ	-	NC	MIGRAINE PRODUCTS
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 CHEW TAB	-	B	CEPHALOSPORINS
SUPRAX SUSP 500MG/5ML	-	B	CEPHALOSPORINS
SUPRAX TAB	-	B	CEPHALOSPORINS
SUPREP SOLN	PA	B	LAXATIVES
SUSTIVA TAB	-	B	ANTIVIRALS
SUSTOL INJ	-	NC	ANTIEMETICS
SUTAB TAB	-	NC	LAXATIVES
SUTENT CAP	MSP-PA-SF	B	ANTINEOPLASTICS
SYLATRON INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYMAX DUOTAB	-	B	ULCER DRUGS
SYMDEKO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B	RESPIRATORY AGENTS - MISC.
SYMFI (LO) TAB	-	B	ANTIVIRALS
SYMJEPI INJ (QL= 2 inj/fill)	QL	G	VASOPRESSORS
SYMLINPEN INJ	PA	B	ANTIDIABETICS
SYMPAZAN ORAL FILM	-	NC	ANTICONSULTANTS
SYMPROIC TAB	PA	B	GASTROINTESTINAL AGENTS - MISC.
SYMTUZA TAB	-	B	ANTIVIRALS
SYNAREL NASAL SOLN	-	B	ENDOCRINE AND METABOLIC AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
SYNDROS SOLN	-	NC	ANTIEMETICS
SYNJARDY TAB (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
SYNRIBO INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
SYNTHROID TAB	-	G	THYROID AGENTS
SYNVEXIA TC CREAM	-	NC	DERMATOLOGICALS
SYNVISC INJ	MSP-PA	B	MUSCULOSKELETAL THERAPY 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 oint (PROTOPIC OINT equiv)	-	G	DERMATOLOGICALS
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	B	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 10mg (CIALIS equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 2.5mg (CIALIS equiv) (QL= 1 tab/day)	QL	G	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 20mg (CIALIS equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
tadalafil tab 5mg (CIALIS equiv) (QL= 1 tab/day)	PA-QL	G	CARDIOVASCULAR AGENTS - MISC.
TAFINLAR CAP	LMSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
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 CVS Specialty 800-237-2767)	LD-PA-QL	B	HEMATOLOGICAL AGENTS - MISC.
TALICIA CAP	-	NC	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B	DERMATOLOGICALS
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TALZENNA CAP 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or 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
TARCEVA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TARGADOX TAB	-	NC	TETRACYCLINES
TARGRETIN GEL	LMSP-PA	B	DERMATOLOGICALS
TARKA TAB	-	B	ANTIHYPERTENSIVES
TASIGNA CAP	LMSP-PA-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TASOPROL CREAM KIT	-	NC	DERMATOLOGICALS
tavaborole soln (KERYDIN equiv)	-	NC	DERMATOLOGICALS
TAVALISSE TAB (QL= 2 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	HEMATOLOGICAL AGENTS - MISC.
TAYTULLA CAP	-	NC	CONTRACEPTIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
tazarotene cream 0.1% (TAZORAC equiv)	PA	G	DERMATOLOGICALS
TAZORAC CREAM	-	NC	DERMATOLOGICALS
TAZORAC CREAM 0.05%	PA	B	DERMATOLOGICALS
TAZORAC GEL	-	NC	DERMATOLOGICALS
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TECFIDERA CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECFIDERA STARTER PACK	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TECHNIVIE TAB	-	NC	ANTIVIRALS
TEGSEDI INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TEKAMLO TAB (Step Therapy requires trial of valsartan)	ST	B	ANTIHYPERTENSIVES
TEKTURNA HCT TAB (Step Therapy requires trial of valsartan/hctz)	ST	B	ANTIHYPERTENSIVES
telmisartan tab (MICARDIS equiv)	-	G	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
TEMOVATE SOLN	-	NC	DERMATOLOGICALS
temozolomide cap (TEMODAR equiv)	LMSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
temsirolimus inj (TORISEL equiv)	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
tenofovir disoproxil fumarate tab (VIREAD equiv)	-	G	ANTIVIRALS
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
TERIPARATIDE INJ	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
TEST STRIP (all other test strips)	OTC-PA	B	DIAGNOSTIC PRODUCTS
testosterone cypionate inj (DEPO-TESTOSTERONE equiv)	-	G	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 (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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
TESTOSTERONE GEL PUMP	-	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-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
tetracycline cap	-	NC	TETRACYCLINES
THALOMID CAP	MSP-PA	B	ASSORTED CLASSES
THEOCHRON TAB	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline CR tab (QUIBRON-T equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline ER tab (UNIPHYL equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
theophylline soln	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
THIOLA EC TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
THIOLA TAB	-	NC	GENITOURINARY AGENTS - MISCELLANEOUS
thioridazine tab (MELLARIL equiv)	-	G	ANTIpsychOTICS/ANTIMANIC AGENTS
thiothixene cap (NAVANE equiv)	-	G	ANTIpsychOTICS/ANTIMANIC AGENTS
THRIVITE RX	-	NC	MULTIVITAMINS
THYQUIDITY SOLN	-	NC	THYROID AGENTS
THYROLAR TAB	-	B	THYROID AGENTS
tiagabine tab (GABITRIL equiv)	-	G	ANTICONVULSANTS
TIBSOVO TAB (QL= 2 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TICANASE PAK	-	NC	NASAL AGENTS - SYSTEMIC AND TOPICAL
ticlopidine tab (TICLID equiv)	-	G	HEMATOLOGICAL AGENTS - MISC.
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 tab (BLOCADREN equiv)	-	G	BETA BLOCKERS
TIMOLOL OPHTH GEL SOLN	-	B	OPHTHALMIC AGENTS
TIMOPTIC OCUDOSE OPHTH SOLN 0.25%	-	B	OPHTHALMIC AGENTS
tinidazole tab (TINDAMAX equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
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)	PA	G	MUSCULOSKELETAL THERAPY AGENTS
TIZANIDINE COMFORT KIT	-	NC	MUSCULOSKELETAL THERAPY AGENTS
tizanidine tab (ZANAFLEX equiv)	-	G	MUSCULOSKELETAL THERAPY AGENTS
TOBI PODHALER	MSP-PA	B	AMINOGLYCOSIDES
TOBRADEX OPHTH OINT	-	B	OPHTHALMIC AGENTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
TOBRADEX ST OPHTH SUSP	-	B	OPHTHALMIC AGENTS
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	B	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
TOLAZAMIDE TAB	-	G	ANTIDIABETICS
TOLBUTAMIDE TAB	-	B	ANTIDIABETICS
tolcapone tab (TASMAR equiv)	-	G	ANTIPARKINSON AGENTS
tolmetin cap (TOLECTIN DS equiv)	-	G	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
TOLMETIN TAB	-	B	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 (SAMSCA equiv)	-	NC	ENDOCRINE AND METABOLIC 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 sprinkle cap (TOPAMAX equiv)	-	G	ANTICONSULTANTS
topiramate tab (TOPAMAX equiv)	-	G	ANTICONSULTANTS
toremifene tab (FARESTON equiv)	-	G	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TORISEL INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
torseamide 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 32MG (QL=4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TRADJENTA TAB (QL= 1 tab/day)	QL	B	ANTIDIABETICS
TRAMADOL COMPOUND KIT	-	NC	DERMATOLOGICALS
TRAMADOL ER CAP	-	NC	ANALGESICS - OPIOID
tramadol ER tab (ULTRAM ER equiv)	-	G	ANALGESICS - OPIOID
TRAMADOL HCL ER CAP	-	NC	ANALGESICS - OPIOID
TRAMADOL HCL TAB 100MG	-	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 (TARKA equiv)	-	G	ANTIHYPERTENSIVES
tranexamic acid tab (LYSTEDA equiv)	-	G	HEMOSTATICS
tranylcypromine tab (PARNATE equiv)	-	G	ANTIDEPRESSANTS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
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 300mg (DESYREL equiv)	-	NC	ANTIDEPRESSANTS
TREANDA INJ	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TRELEGY ELLIPTA INHALER	-	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
TREMFYA INJ (QL= 1 inj/56 days)	LMSP-PA-QL	B	DERMATOLOGICALS
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	B	ANTINEOPLASTICS
tretinoin cream (QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G	DERMATOLOGICALS
tretinoin gel (QL= 20gm/fill)	PA-QL	G	DERMATOLOGICALS
tretinoin gel (RETIN-A GEL equiv) (QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G	DERMATOLOGICALS
tretinoin gel 0.05% (ATRALIN equiv)	-	NC	DERMATOLOGICALS
tretinoin gel pump 0.04% (TRETINOIN GEL PUMP 0.04% equiv)	-	NC	DERMATOLOGICALS
tretinoin gel pump 0.1% (TRETINOIN GEL PUMP 0.1% equiv)	-	NC	DERMATOLOGICALS
TRETIN-X CREAM	-	NC	DERMATOLOGICALS
TREXALL TAB	-	NC	ANTINEOPLASTICS
TREXIMET TAB	-	NC	MIGRAINE PRODUCTS
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC	ANALGESICS - OPIOID
triamcinolone acetone oint (TRIANEX equiv)	-	NC	DERMATOLOGICALS
triamcinolone cream	-	G	DERMATOLOGICALS
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 (KENALOG equiv)	-	NC	DERMATOLOGICALS
triamterene cap (DYRENIUM equiv)	-	G	DIURETICS
triamterene/hydrochlorothiazide cap (DYAZIDE equiv)	-	G	DIURETICS
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	B	DIURETICS
triamterene/hydrochlorothiazide tab (MAXZIDE equiv)	-	G	DIURETICS
TRIANEX OINT	-	NC	DERMATOLOGICALS
triazolam tab (HALCION equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
TRIBENZOR TAB	-	NC	ANTIHYPERTENSIVES
TRICARE PRENATAL CHEWABLE	-	NC	MULTIVITAMINS
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC	DIAGNOSTIC PRODUCTS
TRICHOPHYTON MENTAGROPHYTES SOLN	-	NC	ALLERGENIC EXTRACTS/BIOLOGICALS MISC

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
tricitrates soln (POLYCITRA-LC equiv)	-	G	GENITOURINARY AGENTS - MISCELLANEOUS
tricon cap (TRINSICON equiv)	-	G	HEMATOPOIETIC AGENTS
trientine cap (SYPRINE equiv)	MSP-PA	B	MISCELLANEOUS THERAPEUTIC CLASSES
trifluoperazine tab (STELAZINE equiv)	-	G	ANTIPSYCHOTICS/ANTIMANIC AGENTS
TRIFLURIDINE OPHTH SOLN	-	G	OPHTHALMIC AGENTS
trifluridine ophth soln (VIOPTIC equiv)	-	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 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Maxor Pharmacy 800-658-6046 or 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
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0	LAXATIVES
trimethobenzamide cap (TIGAN equiv)	-	G	ANTIEMETICS
trimethoprim tab (PROLOPRIM equiv)	-	G	ANTI-INFECTIVE AGENTS - MISC.
trimipramine cap (SURMONTIL equiv)	-	G	ANTIDEPRESSANTS
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL	B	ANTIDEPRESSANTS
tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv)	-	\$0	CONTRACEPTIVES
TRIUMEQ TAB	-	B	ANTIVIRALS
TRIVISC INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
TROKENDI XR CAP	PA	B	ANTICONVULSANTS
tropicamide ophth soln (MYDRIACYL equiv)	-	G	OPHTHALMIC AGENTS
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
tropium chloride SR cap (SANCTURA XR equiv)	-	G	URINARY ANTISPASMODICS
tropium tab (SANCTURA equiv)	-	G	URINARY ANTISPASMODICS
TRULANCE TAB	PA	B	GASTROINTESTINAL AGENTS - MISC.
TRULICITY INJ (QL= 4 pens/28 days)	QL	B	ANTIDIABETICS
TRUMENBA INJ	VAC	\$0	VACCINES
TUDORZA PRESSAIR INHALER	-	NC	ASTHMATIC 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
TUSSI-PRES LIQUID	-	NC	COUGH/COLD/ALLERGY
TUSSLIN LIQUID	OTC	NC	COUGH/COLD/ALLERGY
TUXARIN ER TAB	-	NC	COUGH/COLD/ALLERGY
TUZISTRA XR SUSP	-	NC	COUGH/COLD/ALLERGY
TWINRIX INJ	VAC	\$0	VACCINES
TWIRLA PATCH	-	NC	CONTRACEPTIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSPP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
TYBLUME TAB	-	\$0	CONTRACEPTIVES
TYBOST TAB	-	NC	ANTIVIRALS
TYKERB TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
TYMLOS INJ	LMSP	B	ENDOCRINE AND METABOLIC AGENTS - MISC.
TYSABRI INJ	MSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
TYVASO INH SOLN (QL= 1 ampule/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
TYZEKA TAB	-	NC	ANTIVIRALS
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	B	MIGRAINE PRODUCTS
UCERIS RECTAL FOAM	-	B	ANORECTAL AGENTS
U-CORT CREAM	-	B	DERMATOLOGICALS
UDENYCA INJ	-	NC	HEMATOPOIETIC AGENTS
ULESFIA LOTION (QL= 4 bottles/fill)	QL	B	DERMATOLOGICALS
ULORIC TAB	-	NC	GOUT AGENTS
ULTRAVATE LOTION	-	NC	DERMATOLOGICALS
ULTRAVATE PAC KIT	-	NC	DERMATOLOGICALS
UMECTA EMULSION	-	NC	DERMATOLOGICALS
UMECTA PD EMULSION	-	NC	DERMATOLOGICALS
UMECTA SUSP	-	NC	DERMATOLOGICALS
UPNEEQ SOLN	-	NC	OPHTHALMIC AGENTS
UPTRAVI TAB (QL= 2 tabs/day; 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 LOTION	-	NC	DERMATOLOGICALS
urea lotion (KERALAC LOTION equiv)	-	NC	DERMATOLOGICALS
UREA NAIL KIT	-	NC	DERMATOLOGICALS
UREA SUSP	-	NC	DERMATOLOGICALS
urea susp 40% (UMECTA equiv)	-	NC	DERMATOLOGICALS
UROQID #2 TAB	-	B	URINARY ANTI-INFECTIVES
ursodiol cap (ACTIGALL equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
ursodiol tab (URSO (FORTE) equiv)	-	G	GASTROINTESTINAL AGENTS - MISC.
UTA cap	-	NC	ANTI-INFECTIVE AGENTS - MISC.
UTIBRON NEOHALER CAP	-	NC	ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS
valacyclovir tab (VALTREX equiv)	-	G	ANTIVIRALS
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Avella (877) 546-5779)	LD-PA-QL	B	DERMATOLOGICALS
valganciclovir soln (VALCYTE equiv)	-	G	ANTIVIRALS
valganciclovir tab (VALCYTE equiv)	-	G	ANTIVIRALS
valproate inj (DEPAICON equiv)	-	NC	ANTICONVULSANTS
valproic acid cap (DEPAKENE equiv)	-	G	ANTICONVULSANTS
valproic acid syrup (DEPAKENE equiv)	-	G	ANTICONVULSANTS
valsartan tab (DIOVAN equiv)	-	G	ANTI-HYPERTENSIVES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv)	-	G	ANTIHYPERTENSIVES
VALTOCO NASAL SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B	ANTICONVULSANTS
VALTURNA TAB (Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan)	ST	B	ANTIHYPERTENSIVES
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	G	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN INJ	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANCOMYCIN SOLN	-	NC	ANTI-INFECTIVE AGENTS - MISC.
VANIQA CREAM	-	EXC	DERMATOLOGICALS
VANOS CREAM	-	NC	DERMATOLOGICALS
vardenafil ODT (STAXYN equiv)	-	NC	CARDIOVASCULAR AGENTS - MISC.
vardenafil tab (LEVITRA equiv)	-	NC	CARDIOVASCULAR 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 0.5GM (QL= 4 caps/day)	PA-QL	B	ANTIHYPERLIPIDEMICS
VASCEPA CAP 1GM (QL= 4 caps/day)	PA-QL	G	ANTIHYPERLIPIDEMICS
vasolex oint (XENADERM equiv)	-	NC	DERMATOLOGICALS
VAXCHORA SUSP	VAC	\$0	VACCINES
VAXELIS INJ	-	NC	TOXOIDS
VECAMYL TAB	-	NC	ANTIHYPERTENSIVES
VELCADE INJ	MSP-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
velivet tab (CYCLESSA equiv)	-	\$0	CONTRACEPTIVES
VELPHORO CHEW TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VELTASSA POWDER	PA	B	ASSORTED CLASSES
VEMLIDY TAB	-	B	ANTIVIRALS
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	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
VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
VERAMYST NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
VERAPAMIL CAP 100MG	-	G	CALCIUM CHANNEL BLOCKERS
VERAPAMIL ER CAP 200MG	-	G	CALCIUM CHANNEL BLOCKERS
VERAPAMIL ER CAP 300MG	-	G	CALCIUM CHANNEL BLOCKERS
verapamil SR cap (VERELAN equiv)	-	G	CALCIUM CHANNEL BLOCKERS
VERAPAMIL SR CAP 360mg	-	G	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 PM ER CAP 100MG, 300MG	-	B	CALCIUM CHANNEL BLOCKERS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
VERELAN SR CAP 360mg	-	B	CALCIUM CHANNEL BLOCKERS
VERSACLOZ SUSP	-	NC	ANTIPSYCHOTICS/ANTIMANIC AGENTS
VERZENIO TAB (QL= 2 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VESICARE TAB	-	NC	URINARY ANTISPASMODICS
VEXOL OPHTH SUSP	-	B	OPHTHALMIC AGENTS
V-GO INJ KIT (QL= 1 kit/day)	QL	B	MEDICAL DEVICES AND SUPPLIES
VIBERZI TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
VIBRAMYCIN SYRUP	-	B	TETRACYCLINES
VICTOZA INJ (QL= 9ml/30 days)	QL	B	ANTIDIABETICS
VICTRELIS CAP	-	NC	ANTIVIRALS
VIDEX SOLN	-	B	ANTIVIRALS
VIEKIRA XR TAB	-	NC	ANTIVIRALS
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0	CONTRACEPTIVES
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416 or PantherRx 855-726-8479)	LD-PA	B	ANTICONVULSANTS
vigabatrin tab (SABRIL equiv) (Only available through Walgreens 888-347-3416)	LD-PA	B	ANTICONVULSANTS
VIGAMOX OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
VIIBRYD STARTER KIT	-	NC	ANTIDEPRESSANTS
VIMOVO TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIMPAT SOLN	-	B	ANTICONVULSANTS
VIMPAT TAB (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
VINATE II	-	G	MULTIVITAMINS
VINATE M	-	G	MULTIVITAMINS
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0	CONTRACEPTIVES
VIRACEPT POWDER	-	B	ANTIVIRALS
VIRACEPT TAB	-	B	ANTIVIRALS
VIREAD TAB	-	B	ANTIVIRALS
VISCO-3 INJ	-	NC	MUSCULOSKELETAL THERAPY AGENTS
VISICOL TAB	-	B	LAXATIVES
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
VITEKTA TAB	-	B	ANTIVIRALS
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VITRAKVI SOLN (QL= 10ml/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
VITRECYL IRON TAB	-	NC	MULTIVITAMINS
VITRECYL TAB	-	NC	MULTIVITAMINS
VIVELLE-DOT PATCH	-	NC	ESTROGENS
VIVITROL INJ	LMSP	B	ANTIDOTES
VIVLODEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
VIVOTIF BERNA CAP (QL= 4 caps/fill)	QL-VAC	\$0	VACCINES
VIZIMPRO TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
VOGELXO PUMP	-	NC	ANDROGENS-ANABOLIC
VOPAC 5 CREAM	-	B	DERMATOLOGICALS
VOPAC CREAM	-	NC	DERMATOLOGICALS
VOPAC GB CREAM	-	NC	DERMATOLOGICALS
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	G	ANTIFUNGALS
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	G	ANTIFUNGALS
VOSEVI TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANTIVIRALS
VOTRIENT TAB	LMSP-PA-SF	B	ANTINEOPLASTICS
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
VTOL SOLN	-	NC	ANALGESICS - NONNARCOTIC
VUMERITY CAP	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYLEESI INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
VYNDAMAX CAP (QL= 1 cap/day)	MSP-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VYNDAQEL CAP (QL= 4 caps/day)	MSP-PA-QL	B	CARDIOVASCULAR AGENTS - MISC.
VYTONE CREAM 1.9-1%	-	NC	DERMATOLOGICALS
VYVANSE CAP	-	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
VYVANSE CHEW TAB	-	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
VYZULTA SOLN	-	NC	OPHTHALMIC AGENTS
WAKIX TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS
warfarin tab (COUMADIN equiv)	-	G	ANTICOAGULANTS
WELCHOL PACK	-	NC	ANTIHYPERLIPIDEMICS
WELCHOL TAB	-	NC	ANTIHYPERLIPIDEMICS
WELLBUTRIN SR TAB	-	NC	ANTIDEPRESSANTS
WELLBUTRIN XL TAB	-	NC	ANTIDEPRESSANTS
WESTCORT OINT	-	NC	DERMATOLOGICALS
WINLEVI CREAM	-	NC	DERMATOLOGICALS
WPR PLUS	-	NC	DERMATOLOGICALS
WYNZORA CREAM	-	NC	DERMATOLOGICALS
XADAGO TAB (QL= 1 tab/day)	PA-QL	B	ANTIPARKINSON AGENTS
XALIX SOL	-	NC	DERMATOLOGICALS
XALKORI CAP (QL= 2 caps/day)	MSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
XAQUIL XR TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
XARELTO STARTER PACK	-	B	ANTICOAGULANTS
XARELTO TAB	-	B	ANTICOAGULANTS
XARTEMIS XR TAB	-	NC	ANALGESICS - OPIOID
XATMEP SOLN	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI PAK 50-200MG (QL= 2 tabs/day)	QL	B	ANTICONVULSANTS
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/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
XELJANZ TAB (QL= 2 tabs/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
XELJANZ XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B	ANALGESICS - ANTI-INFLAMMATORY
XELPROS OPTH EMULSION	-	NC	OPHTHALMIC AGENTS
XEMBIFY INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B	PASSIVE IMMUNIZING AND TREATMENT AGENTS
XENADERM OINT	-	NC	DERMATOLOGICALS
XENAZINE TAB	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XENICAL CAP	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//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	MSP-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 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	B	ANTIDIABETICS
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	B	ANTIDIABETICS
XIIDRA OPTH SOLN	PA	B	OPHTHALMIC AGENTS
XODOL TAB 10MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 5MG-300MG	-	NC	ANALGESICS - OPIOID
XODOL TAB 7.5MG-300MG	-	NC	ANALGESICS - OPIOID
XOFLUZA TAB	-	NC	ANTIVIRALS
XOLAIR INJ	LMSP-PA	B	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
XOLEGEL	-	NC	DERMATOLOGICALS
XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XPOVIO PAK (QL= 32 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XTAMPZA ER CAP (QL= 120 caps/30 days)	QL	B	ANALGESICS - OPIOID

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
XTANDI CAP	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
XULANE PATCH	-	\$0	CONTRACEPTIVES
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	B	ANTIDIABETICS
XURIDEN POWDER	-	NC	ENDOCRINE AND METABOLIC AGENTS - MISC.
XYNTHA INJ	MSP-PA	B	HEMATOLOGICAL AGENTS - MISC.
XYOSTED INJ	-	NC	ANDROGENS-ANABOLIC
XYREM SOLN (QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 314-587-4050)	LD-PA-QL	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYWAV SOLN	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
XYZAL SOLN	-	EXC	ANTIHISTAMINES
XYZAL TAB	-	EXC	ANTIHISTAMINES
XYZBAC TAB	-	NC	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS
YAZ TAB	-	NC	CONTRACEPTIVES
YBUPHEN TAB	-	NC	ANALGESICS - ANTI-INFLAMMATORY
YODOXIN TAB	-	B	AMEBICIDES
YONSA TAB	-	NC	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
YOSPRALA TAB	-	NC	HEMATOLOGICAL AGENTS - MISC.
YUPELRI SOLN	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZADITOR OPHTH SOLN	OTC	NC	OPHTHALMIC AGENTS
zafirlukast tab (ACCOLATE equiv)	-	G	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
zaleplon cap (SONATA equiv)	-	G	HYPNOTICS/SEDATIVES/SLEEP DISORDEI AGENTS
ZANTAC EFFER TAB	-	NC	ULCER DRUGS
ZARXIO INJ	LMSP	B	HEMATOPOIETIC AGENTS
ZAVESCA CAP	-	NC	HEMATOPOIETIC AGENTS
ZECUITY PAD	-	NC	MIGRAINE PRODUCTS
ZEGERID CAP	-	NC	ULCER DRUGS
ZEGERID CAP OTC	OTC	EXC	ULCER DRUGS
ZEGERID POWDER PACK	-	NC	ULCER DRUGS
ZEJULA CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELAPAR ODT	-	NC	ANTIPARKINSON AGENTS
ZELBORAF TAB (QL= 8 tabs/day)	MSP-PA-QL	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZELNORM TAB	-	NC	GASTROINTESTINAL AGENTS - MISC.
ZENZEDI TAB	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS
ZEPATIER TAB	-	NC	ANTIVIRALS
ZEPOSIA CAP	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
ZEPOSIA STARTER PACK	LMSP-PA	B	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
ZERIT SOLN	-	B	ANTIVIRALS
ZERVIATE OPHTH SOLN	-	NC	OPHTHALMIC AGENTS
ZETIA TAB	-	NC	ANTIHYPERTENSIVES
ZETONNA NASAL SPRAY	-	EXC	NASAL AGENTS - SYSTEMIC AND TOPICAL
zidovudine cap (RETROVIR equiv)	-	G	ANTIVIRALS
zidovudine syrup (RETROVIR equiv)	-	G	ANTIVIRALS
zidovudine tab (RETROVIR equiv)	-	G	ANTIVIRALS
ZIEXTENZO INJ	MSP	B	HEMATOPOIETIC AGENTS
ZILACAINE PAK	-	NC	DERMATOLOGICALS
zileuton ER tab (ZYFLO CR equiv)	-	NC	ASTHMA AND BRONCHODILATOR AGENTS
ZILXI FOAM	-	NC	DERMATOLOGICALS
ZINBRYTA INJ	-	NC	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.
zinc sulfate cap	-	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
ZMAX SUSP	-	B	MACROLIDES
ZOCOR TAB 80MG	-	NC	ANTIHYPERTENSIVES
ZOHYDRO ER CAP	-	NC	ANALGESICS - OPIOID
ZOKINVY CAP	-	NC	MISCELLANEOUS THERAPEUTIC CLASSES
ZOLADEX INJ	MSP	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZOLINZA CAP	LMSP-PA-SF	B	ANTINEOPLASTICS
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G	MIGRAINE PRODUCTS
ZOLMITRIPTAN SPRAY, ZOMIG 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)	PA-QL	G	MIGRAINE PRODUCTS
ZOLPAK KIT	-	NC	DERMATOLOGICALS
zolpidem ER tab (AMBIEN CR equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
zolpidem tab (AMBIEN equiv) (QL= 1 tab/day)	QL	G	HYPNOTICS
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOLPIMIST SPRAY	-	NC	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS
ZOMIG TAB	-	NC	MIGRAINE PRODUCTS
ZONATUSS CAP 150MG	-	NC	COUGH/COLD/ALLERGY
zonisamide cap (ZONEGRAN equiv)	-	G	ANTICONSULTANTS
ZONTIVITY TAB (Restricted to Cardiology Specialist)	RS	B	HEMATOLOGICAL AGENTS - MISC.
ZORPRIN TAB	-	B	ANALGESICS - NONNARCOTIC
ZORTRESS TAB 1MG	PA	B	ASSORTED CLASSES
ZORVOLEX CAP	-	NC	ANALGESICS - ANTI-INFLAMMATORY
ZOSTAVAX INJ (Covered for members age 50 or older)	VAC	\$0	VACCINES
ZOVIRAX OINT	-	NC	DERMATOLOGICALS
ZUBSOLV SL TAB	-	NC	ANALGESICS - OPIOID
ZUPLLENZ SL FILM	-	NC	ANTIEMETICS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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 Cont.
Alphabetical Index
Last Updated 2/1/2021

Drug Name	Special Code	Tier	Category
ZURAMPIC TAB	-	NC	GOUT AGENTS
ZYCLARA CREAM	-	NC	DERMATOLOGICALS
ZYCLARA CREAM, IMIQUIMOD CREAM	-	NC	DERMATOLOGICALS
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYFLO TAB	-	NC	ANTIASTHMATIC AND BRONCHODILATOR AGENTS
ZYKADIA CAP (QL= 3 caps/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYKADIA TAB (QL= 3 tabs/day)	LMSP-PA-QL-SF	B	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	B	OPHTHALMIC AGENTS
ZYPITAMAG TAB	-	NC	ANTIHYPERLIPIDEMICS

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
VYVANSE CAP	-	B
VYVANSE CHEW TAB	-	B
ADDERALL XR CAP	-	G
amphetamine/dextroamphetamine tab (ADDERALL equiv)	-	G
dextroamphetamine ER cap (DEXEDRINE equiv)	-	G
dextroamphetamine soln (PROCENTRA equiv)	-	G
dextroamphetamine tab (DEXEDRINE equiv)	-	G
ADZENYS ER SUSP, AMPHETAMINE ER SUSP	-	NC
ADZENYS XR TAB	-	NC
amphetamine tab (EVEKEO equiv)	-	NC
amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv)	-	NC
DYANAVEL XR SUSP	-	NC
EVEKEO ODT	-	NC
methamphetamine tab (DESOXYN equiv)	-	NC
MYDAYIS CAP	-	NC
ZENZEDI TAB	-	NC
zenzedi tab 5mg (DEXEDRINE equiv)	-	NC
ANALECTICS		
caffeine citrate soln (CAFCIT equiv) (Only covered for members less than 1 year old)	-	G
CAFCIT INJ	-	NC
ANOREXIANTS NON-AMPHETAMINE		
phentermine cap (ADIPEX equiv) (QL= 1 cap/day)	PA-QL	G
phentermine tab (ADIPEX equiv) (QL= 1 tab/day)	PA-QL	G
benzphetamine tab	-	NC
DIETHYLPROPION ER TAB	-	NC
diethylpropion tab	-	NC
LOMAIRA TAB	-	NC
PHENDIMETRAZINE ER TAB	-	NC
phendimetrazine tab (BONTRIL PDM equiv)	-	NC
ANTI-OBESITY AGENTS		
IMCIVREE INJ	-	NC
XENICAL CAP	-	NC
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine cap (STRATTERA CAP equiv)	-	G
guanfacine ER tab (INTUNIV equiv)	-	G
clonidine ER tab (KAPVAY equiv)	-	NC
KAPVAY TAB	-	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 PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
STIMULANTS - MISC.		
METHYLPHENIDATE ER TAB	-	B
armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day)	PA-QL	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont.		
dexmethylphenidate ER cap (FOCALIN XR equiv)	-	G
dexmethylphenidate tab (FOCALIN equiv)	-	G
methylphenidate CD cap (METADATE CD equiv)	-	G
methylphenidate chew tab (METHYLIN equiv)	-	G
methylphenidate ER cap (RITALIN LA equiv)	-	G
methylphenidate ER tab	-	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
COTEMPLA XR ODT	-	NC
DAYTRANA PATCH	-	NC
FOCALIN XR CAP	-	NC
methylphenidate ER cap (APTENSIO XR equiv)	-	NC
METHYLPHENIDATE ER TAB 72MG	-	NC
NUVIGIL TAB	-	NC
PROVIGIL TAB	-	NC
QUILLICHEW ER TAB	-	NC
QUILLIVANT XR SUSP	-	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

YODOXIN TAB	-	B
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	MSP-PA	B
tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist)	LMSP-RS	B
neomycin tab	-	G
PAROMOMYCIN CAP	-	G
paromomycin cap (HUMATIN equiv)	-	G
KITABIS PAK NEB SOLN	-	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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
XELJANZ TAB (QL= 2 tabs/day)	LMSP-PA-QL	B
XELJANZ XR TAB (QL= 1 tab/day)	LMSP-PA-QL	B
ANTIRHEUMATIC ANTIMETABOLITES		
RHEUMATREX TAB	-	B
REDITREX INJ	-	NC
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
HUMIRA INJ 10MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ 20MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ 40MG (QL= 2 syringes/28 days)	LMSP-PA-QL	B
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK (QL= 1 pack/fill, 1 fill/plan year)	LMSP-PA-QL	B
HUMIRA PEN INJ 40MG (QL= 2 pens/28 days)	LMSP-PA-QL	B
SIMPONI ARIA INJ	-	NC
SIMPONI SC INJ	-	NC
GOLD COMPOUNDS		
RIDAURA CAP	-	B
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ	MSP-PA	B
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 ACTPEN INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
ACTEMRA IV INJ	MSP-PA	B
ACTEMRA SC INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
KEVZARA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
KETOPROFEN ER CAP	-	B
SPRIX NASAL SPRAY	PA	B
TOLMETIN TAB	-	B
celecoxib cap (CELEBREX equiv) (QL= 2 caps/day)	QL	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
FLURBIPROFEN TAB	-	G
flurbiprofen tab (ANSAID equiv)	-	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 tab (TORADOL equiv) (QL= 20 tabs/5 days)	QL	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANALGESICS - ANTI-INFLAMMATORY Cont.		
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 EC tab (NAPROSYN EC equiv)	-	G
naproxen sodium tab (ANAPROX equiv)	-	G
naproxen susp (NAPROSYN equiv)	PA	G
naproxen tab (NAPROSYN equiv)	-	G
oxaprozin tab (DAYPRO equiv)	-	G
piroxicam cap (FELDENE equiv)	-	G
sulindac tab (CLINORIL equiv)	-	G
tolmetin cap (TOLECTIN DS equiv)	-	G
ARTHROTEC TAB	-	NC
CELEBREX CAP	-	NC
diclofenac/misoprostol DR tab (ARTHROTEC equiv)	-	NC
DUEXIS TAB	-	NC
fenoprofen calcium tab	-	NC
FENOPROFEN CAP	-	NC
FENOPROFEN TAB	-	NC
IBU 600-EZS KIT	-	NC
INDOCIN SUPP	-	NC
INDOCIN SUSP	-	NC
INDOMETHACIN CAP, TIVORBEX CAP	-	NC
INFLATHERM PAK	-	NC
KETOPROFEN CAP	-	NC
ketoprofen cap (ORUDIS equiv)	-	NC
KETOROLAC INJ	-	NC
ketorolac inj (TORADOL equiv)	-	NC
mefenamic acid cap (PONSTEL equiv)	-	NC
meloxicam cap (VIVLODEX equiv)	-	NC
MELOXICAM COMFORT KIT	-	NC
NAPRELAN CR TAB	-	NC
NAPRELAN CR TAB 750MG	-	NC
naproxen sodium CR tab (NAPRELAN CR equiv)	-	NC
NAPROXEN SUSP	-	NC
naproxen/esomeprazole magnesium DR tab (VIMOVO equiv)	-	NC
QMIIZ ODT TAB	-	NC
RELAFEN DS TAB	-	NC
TIVORBEX CAP	-	NC
TOLMETIN CAP	-	NC
VIMOVO TAB	-	NC
VIVLODEX CAP	-	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
--	------------	---

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANALGESICS - ANTI-INFLAMMATORY Cont.

OTEZLA TAB (QL= 2 tabs/day)	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 cap	-	G
------------------------------	---	---

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/caffeine cap (FIORICET equiv)	-	NC
--	---	----

butalbital/acetaminophen/caffeine soln	-	NC
--	---	----

BUTALBITAL/ASPIRIN/CAFFEINE TAB	-	NC
---------------------------------	---	----

DOLGIC PLUS TAB	-	NC
-----------------	---	----

VTOL SOLN	-	NC
-----------	---	----

SALICYLATES

aspirin chew tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
--	-----	-----

aspirin ec tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
--	-----	-----

aspirin ec tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
--	-----	-----

aspirin tab 325mg (Covered for males age 45-79 and females age 55-79)	OTC	\$0
---	-----	-----

aspirin tab 81mg (Covered for males age 45-79; Covered for females (no age restriction))	OTC	\$0
---	-----	-----

ZORPRIN TAB	-	B
-------------	---	---

CHOLINE MAGNESIUM TRISALICYLATE TAB	-	G
-------------------------------------	---	---

choline magnesium trisalicylate tab (TRILISATE equiv)	-	G
---	---	---

diflunisal tab (DOLOBID equiv)	-	G
--------------------------------	---	---

salsalate tab (DISALCID equiv)	-	G
--------------------------------	---	---

ANALGESICS - OPIOID

OPIOID AGONISTS

ABSTRAL SL TAB (QL= 120 tabs/30 days)	PA-QL	B
---------------------------------------	-------	---

CODEINE SULFATE SOLN	-	B
----------------------	---	---

FENTORA TAB, FENTANYL BUCCAL TAB (QL= 120 tabs/30 days)	PA-QL	B
---	-------	---

HYSINGLA ER TAB (QL= 1 tab/day)	QL	B
---------------------------------	----	---

LAZANDA NASAL SPRAY (QL= 15 bottles/30 days)	PA-QL	B
--	-------	---

LEVORPHANOL 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
NUCYNTA ER TAB (QL= 2 tabs/day)	QL	B
NUCYNTA TAB	-	B
XTAMPZA ER CAP (QL= 120 caps/30 days)	QL	B
CODEINE SULFATE TAB	-	G
fentanyl citrate lollipop (ACTIQ equiv) (QL= 120 lozenges/30 days)	PA-QL	G
fentanyl patch (DURAGESIC equiv)	-	G
HYDROMORPHONE SUPP	-	G
hydromorphone tab (DILAUDID equiv)	-	G
levorphanol tab (LEVORPHANOL equiv)	-	G
methadone soln	-	G
methadone tab (DOLOPHINE equiv)	-	G
methadose tab	-	G
morphine sulfate ER tab (MS CONTIN equiv)	-	G
morphine sulfate soln	-	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
tramadol ER tab (ULTRAM ER equiv)	-	G
tramadol tab (ULTRAM equiv)	-	G
ARYMO ER TAB	-	NC
DSUVIA SL TAB	-	NC
EMBEDA CAP	-	NC
EXALGO TAB	-	NC
fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv)	-	NC
hydrocodone bitartrate ER cap (ZOHYDRO equiv)	-	NC
hydromorphone ER tab (EXALGO TAB equiv)	-	NC
MEPERIDINE TAB	-	NC
meperidine tab (DEMEROL equiv)	-	NC
MORPHABOND TAB	-	NC
MORPHINE SULFATE ER BEAD CAP	-	NC
MORPHINE SULFATE ER CAP	-	NC
morphine sulfate ER cap (KADIAN equiv)	-	NC
OPANA ER TAB (CRUSH RESISTANT)	-	NC
OPANA TAB	-	NC
OXYCODONE ER TAB, OXYCONTIN CR TAB	-	NC
OXYCONTIN CR TAB	-	NC
OXYMORPHONE ER TAB	-	NC
oxymorphone tab (OPANA equiv)	-	NC
QDOLO SOLN	-	NC
RYBIX ODT	-	NC
SUBSYS SPRAY	-	NC
TRAMADOL ER CAP	-	NC
TRAMADOL HCL ER CAP	-	NC
TRAMADOL HCL TAB 100MG	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
ZOHYDRO ER CAP	-	NC
OPIOID COMBINATIONS		
CAPITAL/CODEINE SUSP	-	B
LORTAB ELIXIR	-	B
acetaminophen/codeine soln	-	G
acetaminophen/codeine tab (TYLENOL/CODEINE equiv)	-	G
aspirin/codeine tab	-	G
hydrocodone/acetaminophen cap (LORCET equiv)	-	G
hydrocodone/acetaminophen soln (HYCET, LORTAB equiv)	-	G
hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv)	-	G
hydrocodone/acetaminophen tab (LORTAB equiv)	-	G
hydrocodone/ibuprofen tab (VICOPROFEN equiv)	-	G
oxycodone/acetaminophen cap (TYLOX equiv)	-	G
OXYCODONE/ACETAMINOPHEN SOLN	-	G
oxycodone/acetaminophen tab (PERCOCET equiv)	-	G
OXYCODONE/ASPIRIN TAB	-	G
oxycodone/aspirin tab (PERCODAN equiv)	-	G
oxycodone/ibuprofen tab (COMBUNOX equiv)	-	G
pentazocine/acetaminophen tab (TALACEN equiv)	-	G
tramadol/acetaminophen tab (ULTRACET equiv)	-	G
ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB	-	NC
APADAZ TAB	-	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	-	NC
PRIMLEV TAB 10-300MG	-	NC
PRIMLEV TAB 5-300MG	-	NC
PROLATE TAB	-	NC
TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP	-	NC
VERDROCET TAB 2.5MG-325MG	-	NC
XARTEMIS XR TAB	-	NC
XODOL TAB 10MG-300MG	-	NC
XODOL TAB 5MG-300MG	-	NC
XODOL TAB 7.5MG-300MG	-	NC
OPIOID PARTIAL AGONISTS		
buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days)	QL	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 (TALWIN NX equiv)	-	G
BELBUCA FILM	-	NC
BUNAVAIL FILM	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANALGESICS - OPIOID Cont.		
SUBLOCADE INJ	-	NC
SUBOXONE SL FILM	-	NC
ZUBSOLV SL TAB	-	NC

ANDROGENS-ANABOLIC

ANABOLIC STEROIDS		
oxandrolone tab (OXANDRIN equiv)	-	G
ANDROGENS		
ANDRODERM PATCH (QL= 1 patch/day)	PA-QL	B
ANDROXY TAB	-	B
METHITEST TAB (Step Therapy requires trial of ANDROGEL or ANDRODERM)	ST	B
METHYLTESTOSTERONE CAP	PA	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
ANDROGEL PUMP 1%	-	NC
JATENZO CAP	-	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 (ANDROGEL equiv)	-	NC
testosterone gel 1.62% 1.25gm (ANDROGEL equiv)	-	NC
testosterone gel 1.62% 2.5gm (ANDROGEL equiv)	-	NC
TESTOSTERONE GEL PUMP	-	NC
TESTOSTERONE GEL, VOGELXO GEL	-	NC
VOGELXO PUMP	-	NC
XYOSTED INJ	-	NC

ANORECTAL AGENTS

INTRARECTAL STEROIDS		
CORTIFOAM	-	B
UCERIS RECTAL FOAM	-	B
hydrocortisone enema (CORTENEMA equiv)	-	G

RECTAL COMBINATIONS		
ANALPRAM-E KIT	-	B
PROCTOFOAM HC FOAM	-	B
lidocaine/hydrocortisone cream (ANAMANTLE equiv)	-	G
pramoxine/hydrocortisone cream (ANALPRAM HC equiv)	-	G
pramoxine/hydrocortisone cream kit (ANALPRAM-HC equiv)	-	G
LIDOCAINE/HYDROCORTISONE RECTAL CREAM 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANORECTAL AGENTS Cont.

RECTAL STEROIDS

hydrocortisone supp (ANUSOL HC equiv)	-	G
proctosol HC cream (ANUSOL HC equiv)	-	G
anusol-HC supp	-	NC
PROCTOCORT SUPP	-	NC

VASODILATING AGENTS

RECTIV OINT	-	B
-------------	---	---

ANTHELMINTICS

ANTHELMINTICS

BENZNIDAZOLE TAB	PA	B
BILTRICIDE TAB	-	B
ivermectin tab (STROMECTOL equiv)	-	G
praziquantel tab (BILTRICIDE equiv)	-	G
EGATEN TAB	-	NC
EMVERM TAB	-	NC

ANTIANGINAL AGENTS

ANTIANGINALS-OTHER

ranolazine tab (RANEXA equiv)	-	G
-------------------------------	---	---

NITRATES

NITRO-BID OINT	-	B
NITROMIST SPRAY	-	B
isosorbide dinitrate ER tab (ISOCHRON equiv)	-	G
isosorbide dinitrate SL tab	-	G
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 patch (NITRO-DUR equiv)	-	G
nitroglycerin SL tab (NITROSTAT equiv)	-	G
GONITRO POWDER	-	NC
NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR	-	NC

ANTIANGIETY AGENTS

ANTIANGIETY AGENTS - MISC.

bupirone tab (BUSPAR equiv)	-	G
hydroxyzine pamoate cap (VISTARIL equiv)	-	G
hydroxyzine syrup (ATARAX equiv)	-	G
hydroxyzine tab (ATARAX equiv)	-	G
bupirone tab 30mg (BUSPAR equiv)	-	NC
meprobamate tab (MILTOWN equiv)	-	NC

BENZODIAZEPINES

alprazolam ER tab (XANAX XR equiv)	-	G
alprazolam ODT (NIRAVAM equiv)	-	G
alprazolam tab (XANAX 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIANGIOTENSIN AGENTS Cont.		
chlorthalidone cap (LIBRIUM equiv)	-	G
clorazepate tab (TRANXENE-T equiv)	-	G
diazepam conc (VALIUM equiv)	-	G
DIAZEPAM SOLN	-	G
diazepam tab (VALIUM equiv)	-	G
lorazepam conc (ATIVAN equiv)	-	G
lorazepam tab (ATIVAN equiv)	-	G
oxazepam cap (SERAX equiv)	-	G

ANTIARRHYTHMICS

ANTIARRHYTHMICS TYPE I-A

NORPACE CR CAP	-	B
QUINIDINE SULFATE ER TAB	-	B
disopyramide cap (NORPACE equiv)	-	G
disopyramide ER cap (NORPACE CR equiv)	-	G
quinidine gluconate CR tab	-	G
quinidine sulfate tab	-	G

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)	MSP-PA-QL	B
NUCALA INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
XOLAIR INJ	LMSP-PA	B

ANTI-INFLAMMATORY AGENTS

cromolyn neb soln (INTAL equiv)	-	NC
---------------------------------	---	----

BRONCHODILATORS - ANTICHOLINERGICS

ATROVENT HFA INHALER	-	B
INCRUSE ELLIPTA INHALER	-	B
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL)	QL-ST	B
ipratropium neb soln (ATROVENT equiv)	-	G
LONHALA MAGNAIR SOLN	-	NC
SEEBRI NEOHALER CAP	-	NC
SPIRIVA HANDIHALER	-	NC
SPIRIVA RESPIMAT INHALER 2.5MCG/ACT	-	NC
TUDORZA PRESSAIR INHALER	-	NC
YUPELRI 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
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
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
DALIRESP TAB	-	B
STEROID INHALANTS		
ARNUITY ELLIPTA INHALER	-	G
ASMANEX HFA INHALER	-	G
ASMANEX INHALER	-	G
budesonide inh susp (PULMICORT equiv)	-	G
FLOVENT DISKUS INHALER	-	G
FLOVENT HFA INHALER	-	G
ALVESCO INHALER	-	NC
ARMONAIR DIGITAL INHALER 113MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 232MCG/ACT	-	NC
ARMONAIR DIGITAL INHALER 55MCG/ACT	-	NC
ARMONAIR RESPICLICK	-	NC
PULMICORT FLEXHALER	-	NC
QVAR INHALER	-	NC
QVAR REDIHALER	-	NC
SYMPATHOMIMETICS		
ADVAIR HFA INHALER	-	B
ALBUTEROL TAB ER	-	B
ANORO ELLIPTA INHALER	-	B
BREO ELLIPTA INHALER	-	B
BREZTRI AEROSPHERE INHALER	-	B
BROVANA NEB SOLN (Step Therapy requires trial of PERFOROMIST)	ST	B
COMBIVENT 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 VENTOLIN HFA)	QL-ST	B
METAPROTERENOL TAB	-	B
PERFOROMIST NEB SOLN	-	B
SEREVENT DISKUS INHALER	-	B
STIOLTO INHALER	-	B
STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days)	QL	B
TRELEGY ELLIPTA INHALER	-	B
ADVAIR DISKUS INHALER	-	G
albuterol neb soln	-	G
albuterol sulfate ER tab (VOSPIRE ER equiv)	-	G
albuterol sulfate syrup	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont.		
albuterol sulfate tab	-	G
albuterol/ipratropium neb soln (DUONEB equiv)	-	G
FLUTICASONE/SALMETEROL INHALER	-	G
levalbuterol neb soln (XOPENEX equiv)	-	G
METAPROTERENOL SYRUP	-	G
terbutaline sulfate tab (BRETHINE equiv)	-	G
VENTOLIN HFA INHALER (QL= 2 inhalers/30 days)	QL	G
AIRDUO POWDER INHALER W/SENSOR	-	NC
AIRDUO RESPICLICK	-	NC
ALBUTEROL HFA INHALER	-	NC
albuterol HFA inhaler (PROAIR equiv)	-	NC
albuterol HFA inhaler (PROVENTIL equiv)	-	NC
BEVESPI AEROSPHERE INHALER	-	NC
BUDESONIDE/FORMOTEROL INHALER, SYMBICORT INHALER	-	NC
DUAKLIR INHALER	-	NC
fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv)	-	NC
UTIBRON NEOHALER CAP	-	NC
XANTHINES		
ELIXOPHYLLIN ELIXIR	-	B
LUFYLLIN TAB	-	B
aminophylline tab	-	G
THEOCHRON TAB	-	G
theophylline CR tab (QUIBRON-T equiv)	-	G
theophylline ER tab (UNIPHYL equiv)	-	G
theophylline soln	-	G
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin tab (COUMADIN equiv)	-	G
DIRECT FACTOR XA INHIBITORS		
ELIQUIS TAB, ELIQUIS STARTER PACK	-	B
XARELTO STARTER PACK	-	B
XARELTO TAB	-	B
BEVYXXA CAP	-	NC
SAVAYSA TAB	-	NC
HEPARINS AND HEPARINOID-LIKE AGENTS		
FRAGMIN INJ	-	B
enoxaparin inj (LOVENOX equiv) (QL= 17 days supply)	QL	G
fondaparinux inj (ARIXTRA equiv)	-	G
ARIXTRA INJ	-	NC
THROMBIN INHIBITORS		
PRADAXA CAP	-	B
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA TAB	-	B
FYCOMPA SUSP	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
ANTICONVULSANTS - BENZODIAZEPINES		
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 2 packs/fill)	QL	B
NAYZILAM SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B
VALTOCO NASAL SPRAY (QL= 2 packs/fill; Restricted to Neurology Specialist)	QL-RS	B
clobazam tab (ONFI equiv)	PA	G
clonazepam ODT (KLONOPIN equiv)	-	G
clonazepam tab (KLONOPIN equiv)	-	G
clobazam susp (ONFI equiv)	-	NC
ONFI SUSP	-	NC
ONFI TAB	-	NC
SYMPAZAN ORAL FILM	-	NC
ANTICONVULSANTS - MISC.		
BANZEL SUSP	PA	B
BANZEL TAB	PA	B
DIACOMIT CAP (Only available through US Bioservices 888-518-7246)	LD-PA	B
DIACOMIT POWDER PACK (Only available through US Bioservices 888-518-7246)	LD-PA	B
EPIDIOLEX SOLN (Only available through Walgreens 888-347-3416)	LD-PA	B
LAMICTAL CHEW TAB 2MG	-	B
LAMICTAL ODT KIT, LAMICTAL XR KIT	-	B
POTIGA TAB (QL= 3 tabs/day)	QL	B
TROKENDI XR CAP	PA	B
VIMPAT SOLN	-	B
VIMPAT TAB (QL= 2 tabs/day)	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 (NEURONTIN equiv)	-	G
gabapentin soln (NEURONTIN equiv)	-	G
gabapentin tab (NEURONTIN equiv)	-	G
lamotrigine chew tab (LAMICTAL equiv)	-	G
lamotrigine ER tab (LAMICTAL XR equiv)	-	G
lamotrigine ODT (LAMICTAL equiv)	-	G
lamotrigine ODT kit (LAMICTAL ODT 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)	-	G
pregabalin soln (LYRICA equiv)	-	G
primidone tab (MYSOLINE equiv)	-	G
rufinamide susp (BANZEL equiv)	PA	G
topiramate sprinkle cap (TOPAMAX 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
topiramate tab (TOPAMAX equiv)	-	G
zonisamide cap (ZONEGRAN equiv)	-	G
APTIOM TAB	-	NC
BRIVIACT INJ 50MG/5ML	-	NC
BRIVIACT SOLN 10MG/ML	-	NC
BRIVIACT TAB	-	NC
FINTEPLA SOLN	-	NC
LYRICA CAP	-	NC
OXTELLAR XR TAB	-	NC
QUDEXY XR CAP, TOPIRAMATE ER CAP	-	NC
SPRITAM TAB	-	NC
CARBAMATES		
XCOPRI PAK 150-200MG (QL= 2 tabs/day)	QL	B
XCOPRI PAK 50-200MG (QL= 2 tabs/day)	QL	B
XCOPRI TAB 150MG, 200MG (QL= 2 tabs/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
FELBATOL TAB	-	NC
GABA MODULATORS		
vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Walgreens 888-347-3416 or PantherRx 855-726-8479)	LD-PA	B
vigabatrin tab (SABRIL equiv) (Only available through Walgreens 888-347-3416)	LD-PA	B
tiagabine tab (GABITRIL equiv)	-	G
SABRIL TAB	-	NC
HYDANTOINS		
DILANTIN CAP 30MG	-	B
PEGANONE TAB	-	B
phenytoin cap (DILANTIN equiv)	-	G
phenytoin chew tab (DILANTIN equiv)	-	G
phenytoin susp (DILANTIN equiv)	-	G
SUCCINIMIDES		
CELONTIN CAP	-	B
ethosuximide cap (ZARONTIN equiv)	-	G
ethosuximide soln (ZARONTIN 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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTICONVULSANTS Cont.		
valproate inj (DEPACON equiv)	-	NC
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine ODT (REMERON equiv)	-	G
mirtazapine tab (REMERON equiv)	-	G
ANTIDEPRESSANTS - MISC.		
bupropion ER tab (WELLBUTRIN equiv)	-	G
bupropion tab (WELLBUTRIN equiv)	-	G
bupropion XL tab (WELLBUTRIN XL equiv)	-	G
MAPROTILINE TAB	-	G
APLENZIN TAB	-	NC
FORFIVO XL TAB	-	NC
WELLBUTRIN SR TAB	-	NC
WELLBUTRIN XL TAB	-	NC
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
EMSAM PATCH	-	B
MARPLAN TAB	-	B
NARDIL TAB	-	B
phenelzine tab (NARDIL equiv)	-	G
tranylcypromine tab (PARNATE equiv)	-	G
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS		
SPRAVATO NASAL SOLN	-	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,	ST	G
fluvoxamine or paroxetine)		
fluvoxamine tab (LUVOX equiv)	-	G
paroxetine ER tab (PAXIL CR equiv)	-	G
paroxetine tab (PAXIL equiv)	-	G
sertraline conc (ZOLOFT equiv)	-	G
sertraline tab (ZOLOFT equiv)	-	G
fluoxetine tab 60mg	-	NC
fluoxetine weekly cap (PROZAC equiv)	-	NC
PEXEVA TAB	-	NC
PROZAC WEEKLY CAP	-	NC
SEROTONIN MODULATORS		
OLEPTRO TAB	-	B
TRINTELLIX TAB (QL= 1 tab/day)	PA-QL	B
NEFAZODONE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANTIDEPRESSANTS Cont.

nefazodone tab 50mg, 250mg	-	G
trazodone tab (DESYREL equiv)	-	G
trazodone tab 300mg (DESYREL equiv)	-	NC
VIIBRYD STARTER KIT	-	NC

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

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
EFFEXOR XR CAP	-	NC
FETZIMA CAP	-	NC
FETZIMA TITRATION PACK	-	NC
KHEDEZLA ER TAB	-	NC
venlafaxine ER tab	-	NC

TRICYCLIC AGENTS

amitriptyline tab (ELAVIL equiv)	-	G
AMOXAPINE TAB	-	G
clomipramine cap (ANAFRANIL equiv)	-	G
desipramine tab (NORPRAMIN equiv)	-	G
DOXEPIN CAP	-	G
doxepin cap (SINEQUAN equiv)	-	G
doxepin conc (SINEQUAN equiv)	-	G
imipramine pamoate cap (TOFRANIL PM equiv)	-	G
imipramine tab (TOFRANIL equiv)	-	G
nortriptyline cap (PAMELOR equiv)	-	G
nortriptyline oral soln (NORTRIPTYLINE equiv)	-	G
NORTRIPTYLINE SOLN	-	G
protriptyline tab (VIVACTIL equiv)	-	G
trimipramine cap (SURMONTIL equiv)	-	G

ANTIDIABETICS

ALPHA-GLUCOSIDASE INHIBITORS

acarbose tab (PRECOSE equiv)	-	G
MIGLITOL TAB	-	G

ANTIDIABETIC - AMYLIN ANALOGS

SYMLINPEN INJ	PA	B
---------------	----	---

ANTIDIABETIC COMBINATIONS

AVANDAMET TAB	-	B
AVANDARYL TAB	-	B
GLYXAMBI TAB (QL= 1 tab/day)	QL	B
JANUMET TAB (QL= 2 tabs/day)	QL	B
JANUMET XR TAB (QL= 2 tabs/day)	QL	B
JENTADUETO TAB (QL= 2 tabs/day)	QL	B
JENTADUETO XR TAB (QL= 2 tabs/day)	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
SOLIQUA INJ (QL= 15ml/25 days)	PA-QL	B
SYNJARDY TAB (QL= 2 tabs/day)	QL	B
SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day)	QL	B
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day)	QL	B
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day)	QL	B
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day)	QL	B
XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day)	QL	B
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day)	QL	B
XULTOPHY INJ (QL= 15ml/30 days)	PA-QL	B
glipizide/metformin tab (METAGLIP equiv)	-	G
glyburide/metformin tab (GLUCOVANCE equiv)	-	G
ACTOPLUS MET TAB	-	NC
ACTOPLUS MET XR TAB	-	NC
ALOGLIPTIN/METFORMIN TAB, KAZANO TAB	-	NC
ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB	-	NC
DUETACT TAB	-	NC
INVOKAMET TAB	-	NC
INVOKAMET 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
REPAGLINIDE TAB	-	NC
SEGLUROMET TAB	-	NC
STEGLUJAN TAB	-	NC
BIGUANIDES		
RIOMET ER SUSP	PA	B
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
DIABETIC OTHER		
BAQSIMI NASAL POWDER (QL= 2 inhalations/fill)	QL	B
GLUCAGEN HYPOKIT INJ (QL= 2 inj/fill)	QL	B
GLUCAGON EMR INJ (QL= 2 inj/fill)	QL	B
GLUCAGON KIT (QL= 2 inj/fill)	QL	B
GVOKE INJ (QL= 2 inj/fill)	QL	B
GVOKE PFS INJ (QL= 2 inj/fill)	QL	B
KORLYM TAB (Only available through Korlym SPARK program 855-4Korlym (855-456-7596))	LD-PA	B
diazoxide susp (PROGLYCEM equiv)	-	G
glucagon (rdna) for inj kit (GLUCAGON equiv) (QL= 2 inj/fill)	QL	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB (QL= 1 tab/day)	QL-¢	B
TRAJENTA TAB (QL= 1 tab/day)	QL	B
ALOGLIPTIN TAB, NESINA TAB	-	NC
ONGLYZA TAB	-	NC
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB	-	B
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
BYDUREON BCISE AUTO INJ (QL= 4 inj/28 days)	QL	B
BYDUREON INJ (QL= 4 inj/28 days)	QL	B
BYDUREON PEN INJ (QL= 4 inj/28 days)	QL	B
BYETTA INJ (Step Therapy requires trial of VICTOZA or BYDUREON)	ST	B
OZEMPIC INJ (QL= 1 pack/28 days)	QL	B
RYBELSUS TAB (QL=1 tab/day)	QL	B
TRULICITY INJ (QL= 4 pens/28 days)	QL	B
VICTOZA INJ (QL= 9ml/30 days)	QL	B
ADLYXIN INJ	-	NC
TANZEUM INJ	-	NC
INSULIN		
ADMELOG INJ, INSULIN LISPRO INJ	PA	B
ADMELOG SOLOSTAR INJ, INSULIN LISPRO KWIKPEN INJ (JUNIOR)	PA	B
APIDRA INJ	PA	B
APIDRA SOLOSTAR INJ	PA	B
FIASP FLEXTOUCH INJ	-	B
FIASP INJ	-	B
FIASP PENFILL INJ	-	B
HUMALOG INJ	PA	B
HUMALOG KWIKPEN INJ	PA	B
HUMALOG MIX INJ	PA	B
HUMALOG MIX KWIKPEN INJ, INSULIN LISPRO PROTAMINE INJ	PA	B
HUMULIN MIX INJ	OTC-PA	B
HUMULIN MIX PEN INJ	OTC-PA	B
HUMULIN N INJ	OTC-PA	B
HUMULIN N PEN INJ	OTC-PA	B
HUMULIN R INJ	OTC-PA	B
HUMULIN R INJ U-500	-	B
HUMULIN R U-500 KWIKPEN INJ	-	B
INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv)	-	B
INSULIN ASPART INJ (NOVOLOG equiv)	-	B
INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv)	-	B
INSULIN ASPART MIX INJ (NOVOLOG equiv)	-	B
INSULIN ASPART PENFILL INJ (NOVOLOG equiv)	-	B
LANTUS INJ	-	B
LANTUS SOLOSTAR INJ	-	B
LEVEMIR FLEXTOUCH INJ	-	B
LEVEMIR INJ	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIDIABETICS Cont.		
NOVOLIN 70/30 FLEXPEN INJ	OTC	B
NOVOLIN 70/30 INJ	OTC	B
NOVOLIN N FLEXPEN INJ	OTC	B
NOVOLIN N INJ	OTC	B
NOVOLIN R FLEXPEN INJ	OTC	B
NOVOLIN R INJ	OTC	B
NOVOLOG FLEXPEN INJ	-	B
NOVOLOG INJ	-	B
NOVOLOG MIX FLEXPEN INJ	-	B
NOVOLOG MIX INJ	-	B
NOVOLOG PENFILL INJ	-	B
TOUJEO MAX SOLOSTAR INJ	-	B
TOUJEO SOLOSTAR INJ	-	B
TRESIBA FLEXTOUCH INJ	-	B
TRESIBA INJ	-	B
BASAGLAR INJ	-	NC
HUMALOG PEN INJ	-	NC
LYUMJEV INJ	-	NC
LYUMJEV KWIKPEN INJ	-	NC
SEMGLEE INJ	-	NC
SEMGLEE SOLN	-	NC
INSULIN SENSITIZING AGENTS		
AVANDIA TAB	-	B
pioglitazone tab (ACTOS equiv)	-	G
MEGLITINIDE ANALOGUES		
nateglinide tab (STARLIX equiv)	-	G
repaglinide tab (PRANDIN equiv)	-	G
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB (QL= 1 tab/day)	QL	B
JARDIANCE TAB (QL= 1 tab/day)	QL	B
INVOKANA TAB	-	NC
STEGLATRO TAB	-	NC
SULFONYLUREAS		
TOLBUTAMIDE TAB	-	B
chlorpropamide tab (DIABINESE equiv)	-	G
glimepiride tab (AMARYL equiv)	-	G
glipizide ER tab (GLUCOTROL XL equiv)	-	G
glipizide tab (GLUCOTROL equiv)	-	G
glyburide micronized tab (GLYNASE equiv)	-	G
glyburide tab (MICRONASE equiv)	-	G
TOLAZAMIDE TAB	-	G
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS		
DIPHENOXYLATE/ATROPINE LIQUID	-	G
LOPERAMIDE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANTIDIARRHEALS

ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS

MYTESI TAB	-	NC
------------	---	----

ANTIDIARRHEAL AGENTS - MISC.

REZYST CHEW TAB	-	NC
VSL #3 CAP	-	NC

ANTIDIARRHEAL COMBINATIONS

EVIVO LIQUID	-	NC
--------------	---	----

ANTIPERISTALTIC AGENTS

diphenoxylate/atropine tab (LOMOTIL equiv)	-	G
opium tincture	-	G
loperamide cap (IMODIUM equiv)	-	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
FERRIPROX TAB (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B

OPIOID ANTAGONISTS

VIVITROL INJ	LMSP	B
naltrexone tab (REVIEWA equiv)	-	G
EVZIO INJ	-	NC

ANTIDOTES AND SPECIFIC ANTAGONISTS

ANTIDOTES - CHELATING AGENTS

deferasirox granules packet (JADENU equiv)	LMSP	B
deferasirox tab (EXJADE equiv)	LMSP	B
deferasirox tab 90mg, 360mg (JADENU equiv)	LMSP	B
deferiprone tab (FERRIPROX equiv) (Only available through Ferriprox Total Care 866-758-7071)	LD-PA	B
deferasirox tab 180mg (JADENU equiv)	-	NC
JADENU SPRINKLE	-	NC

ANTIDOTES AND SPECIFIC ANTAGONISTS

CETYLEV TAB	-	NC
-------------	---	----

OPIOID ANTAGONISTS

NALOXONE PREFILLED INJ (QL= 2 inj/fill)	QL	B
NARCAN NASAL SPRAY (QL= 2 sprays/fill)	QL	B
naloxone inj	-	G
naloxone prefilled inj (QL= 2 inj/fill)	QL	G
EVZIO INJ	-	NC

ANTIEMETICS

5-HT3 RECEPTOR ANTAGONISTS

ANZEMET TAB (QL= 9 tabs/fill)	QL	B
GRANISOL SOLN (QL= 60ml/fill)	QL	B
SANCUSO PATCH (QL= 4 patches/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.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	LD	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	RS	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation	ST	Step Therapy
	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIEMETICS Cont.		
granisetron tab (KYTRIL equiv) (QL= 9 tabs/fill)	QL	G
ondansetron ODT (ZOFTRAN equiv)	-	G
ondansetron soln (ZOFTRAN equiv)	-	G
ONDANSETRON TAB	-	G
ondansetron tab (ZOFTRAN equiv)	-	G
SUSTOL INJ	-	NC
ZUPLENZ SL FILM	-	NC
ANTIEMETICS - ANTICHOLINERGIC		
maldemar tab (SCOPACE equiv)	-	G
meclizine chew tab (BONINE equiv) (Rx Only)	-	G
meclizine tab (ANTIVERT equiv) (Rx Only)	-	G
scopolamine patch (TRANSDERM-SCOP equiv)	-	G
trimethobenzamide cap (TIGAN equiv)	-	G
MECLIZINE 50MG TAB	-	NC
ANTIEMETICS - MISCELLANEOUS		
AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist)	QL-RS	B
CESAMET CAP	-	B
dronabinol cap (MARINOL equiv)	PA	G
doxylamine/pyridoxine dr tab (DICLEGIS equiv)	-	NC
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
ANTIFUNGALS		
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 powder	-	G
nystatin tab	-	G
terbinafine tab (LAMISIL equiv)	-	G
IMIDAZOLE-RELATED ANTIFUNGALS		
NOXAFIL SUSP (QL= 525ml/26 days)	PA-QL	B
SPORANOX SOLN	PA	B
fluconazole susp (DIFLUCAN equiv)	-	G
fluconazole tab (DIFLUCAN equiv)	-	G
itraconazole cap (SPORANOX equiv)	PA	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
voriconazole susp (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	G
voriconazole tab (VFEND equiv) (Restricted to Infectious Disease Specialist)	RS	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANTIFUNGALS Cont.

CRESEMBA CAP	-	NC
NOXAFIL TAB	-	NC
TOLSURA CAP	-	NC

ANTIHISTAMINES

ANTIHISTAMINES - ALKYLAMINES

chlorpheniramine ER cap	-	G
MICLARA LIQUID	-	NC
RYCLORA SYRUP, DEXCHLORPHENIRAMINE SYRUP	-	NC

ANTIHISTAMINES - ETHANOLAMINES

CARBINOXAMINE SOLN	-	G
carbinoxamine soln (PALGIC equiv)	-	G
CARBINOXAMINE TAB	-	G
carbinoxamine tab (PALGIC equiv)	-	G
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	G
KARBINAL ER SUSP	-	NC
RYVENT TAB	-	NC

ANTIHISTAMINES - NON-SEDATING

CLARINEX REDITAB	-	EXC
CLARINEX SYRUP	-	EXC
CLARINEX TAB	-	EXC
CLARITIN CAP	OTC	EXC
DESLORATADINE ODT	-	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

ANTIHISTAMINES - PHENOTHIAZINES

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	-	NC
--------------	---	----

ANTIHYPERLIPIDEMICS - COMBINATIONS

ezetimibe/simvastatin tab (VYTORIN equiv)	-	NC
ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage)	-	NC
NEXLIZET TAB	-	NC
OMEGA-3 RX PAK COMPLETE	-	NC

ANTIHYPERLIPIDEMICS - MISC.

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
VASCEPA CAP 0.5GM (QL= 4 caps/day)	PA-QL	B
omega-3-acid ethyl esters cap (LOVAZA equiv)	-	G
VASCEPA CAP 1GM (QL= 4 caps/day)	PA-QL	G
icosapent ethyl cap 1gm (VASCEPA equiv)	-	NC
KYNAMRO INJ	-	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		
FENOFIBRIC TAB, FIBRICOR TAB	-	B
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, LOFIBRA CAP	-	NC
fenofibrate cap 43mg, 130mg (ANTARA equiv)	-	NC
FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG	-	NC
fenofibrate tab 40mg, 120mg (FENOGLIDE equiv)	-	NC
TRIGLIDE TAB	-	NC
TRILIPIX CAP	-	NC
HMG COA REDUCTASE INHIBITORS		
atorvastatin tab 10mg (LIPITOR equiv)	-	\$0
atorvastatin tab 20mg (LIPITOR equiv)	-	\$0
lovastatin tab (MEVACOR equiv)	-	\$0
pravastatin tab (PRAVACHOL equiv)	-	\$0
rosuvastatin tab 10mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0
rosuvastatin tab 5mg (CRESTOR equiv) (QL= 1 tab/day)	QL	\$0
simvastatin tab (ZOCOR equiv) (80mg is Not Covered)	-	\$0
atorvastatin tab 40mg (LIPITOR equiv)	-	G
atorvastatin tab 80mg (LIPITOR equiv)	-	G
rosuvastatin tab 20mg (CRESTOR equiv)	-	G
rosuvastatin tab 40mg (CRESTOR equiv)	-	G
ALTOPREV TAB	-	NC
CRESTOR TAB	-	NC
CRESTOR TAB 20MG	-	NC
EZALLOR SPRINKLE CAP	-	NC
FLOLIPID 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
fluvastatin cap (LESCOL equiv)	-	NC
fluvastatin ER tab (LESCOL XL equiv)	-	NC
LESCOL CAP	-	NC
LESCOL XL TAB	-	NC
LIPITOR TAB	-	NC
LIVALO TAB	-	NC
SIMVASTATIN SUSP	-	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		
PRALUENT INJ (QL= 2 inj/28 days)	PA-QL	B
REPATHA INJ (QL= 2 inj/28 days)	PA-QL	B
REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days)	PA-QL	B
ANTIHYPERTENSIVES		
ACE INHIBITORS		
EPANED PREMIXED SOLN	PA	B
EPANED SOLN	PA	B
QBRELIS SOLN	PA	B
benazepril tab (LOTENSIN equiv)	-	G
captopril tab (CAPOTEN equiv)	-	G
enalapril tab (VASOTEC equiv)	-	G
fosinopril tab (MONOPRIL equiv)	-	G
lisinopril tab (PRINIVIL/ZESTRIL equiv)	-	G
moexipril tab (UNIVASC equiv)	-	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
DEMSEER CAP	-	NC
metyrosine cap (DEMSEER equiv)	-	NC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan tab (AVAPRO equiv)	-	G
losartan tab (COZAAR 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
olmesartan tab (BENICAR equiv)	-	G
telmisartan tab (MICARDIS equiv)	-	G
valsartan tab (DIOVAN equiv)	-	G
ATACAND TAB	-	NC
candesartan tab (ATACAND equiv)	-	NC
DIOVAN TAB	-	NC
EDARBI TAB	-	NC
EPROSARTAN TAB	-	NC
ANTIADRENERGIC ANTIHYPERTENSIVES		
CATAPRES-TTS PATCH	-	B
GUANABENZ TAB	-	B
NEXICLON XR SUSP	-	B
NEXICLON XR TAB	-	B
RESERPINE 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
ANTIHYPERTENSIVE COMBINATIONS		
AMTURNIDE TAB (Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan)	ST	B
CORZIDE TAB 80-5MG	-	B
TARKA TAB	-	B
TEKAMLO TAB (Step Therapy requires trial of valsartan)	ST	B
TEKTURNA HCT TAB (Step Therapy requires trial of valsartan/hctz)	ST	B
VALTURNA TAB (Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan)	ST	B
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
METHYLDOPA/HYDROCHLOROTHIAZIDE TAB	-	G
METOPROLOL/HYDROCHLOROTHIAZIDE TAB	-	G
metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv)	-	G
MOEXIPRIL/HYDROCHLOROTHIAZIDE TAB	-	G
moexipril/hydrochlorothiazide tab (UNIRETIC equiv)	-	G
olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv)	-	G
PROPRANOLOL/HYDROCHLOROTHIAZIDE TAB	-	G
quinapril/hydrochlorothiazide tab (ACCURETIC 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIHYPERTENSIVES Cont.		
trandolapril/verapamil ER tab (TARKA 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
telmisartan/amlodipine tab (TWINSTA equiv)	-	NC
telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv)	-	NC
TRIBENZOR TAB	-	NC
ANTIHYPERTENSIVES - MISC.		
VECAMEYL TAB	-	NC
DIRECT RENIN INHIBITORS		
aliskiren tab (TEKTURNA equiv) (Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan)	ST-¢	G
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab (INSPRA equiv)	¢	G
VASODILATORS		
hydralazine tab (APRESOLINE equiv)	-	G
minoxidil tab (LONITEN equiv)	-	G
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
FIRST METRONIDAZOLE SUSP	-	B
FLAGYL ER TAB	-	B
PRIMSOL SOLN	-	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 (PROLOPRIM equiv)	-	G
AEMCOLO TAB	-	NC
FLAGYL CAP	-	NC
IMPAVIDO CAP	-	NC
metronidazole cap (FLAGYL equiv)	-	NC
ANTI-INFECTIVE MISC. - COMBINATIONS		
HYOPHEN TAB	-	B
erythromycin/sulfisoxazole susp (PEDIAZOLE equiv)	-	G
hyophen tab (PROSED DS equiv)	-	G
smz/tmp (DS) tab (BACTRIM DS 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTI-INFECTIVE AGENTS - MISC. Cont.		
smz/tmp susp (BACTRIM, SEPTRA equiv)	-	G
UTA cap	-	NC
ANTIPROTOZOAL AGENTS		
ALINIA SUSP (QL= 60ml/3 days)	PA-QL	B
atovaquone susp (MEPRON equiv)	-	G
nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days)	PA-QL	G
LAMPIT TAB	-	NC
GLYCOPEPTIDES		
FIRST-VANCOMYCIN SOLN	-	G
FIRVANQ SOLN	-	G
vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill)	QL	G
VANCOMYCIN INJ	-	NC
VANCOMYCIN SOLN	-	NC
KETOLIDES		
KETEK TAB	-	B
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
linezolid susp (Restricted to Infectious Disease Specialist)	RS	G
linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist)	RS	G
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
methenamine mandelate tab	-	G
nitrofurantoin macrocrystals cap (MACRODANTIN equiv)	-	G
nitrofurantoin monohydrate cap (MACROBID equiv)	-	G
nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv)	-	NC
nitrofurantoin susp (FURADANTIN equiv)	-	NC
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
FANSIDAR TAB	-	B
atovaquone/proguanil tab (MALARONE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANTIMALARIALS Cont.

MALARONE TAB	-	NC
PYRIMETHAMINE/LEUCOVORIN CAP	-	NC

ANTIMALARIALS

KRINTAFEL TAB	-	B
MEFLOQUINE TAB	-	B
pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
chloroquine tab (ARALEN equiv)	-	G
hydroxychloroquine tab (PLAQUENIL equiv)	-	G
mefloquine tab (LARIAM equiv)	-	G
primaquine tab (PRIMAQUINE equiv)	-	G
ARAKODA TAB	-	NC
QUALAQUIN CAP	-	NC
quinine sulfate cap (QUALAQUIN equiv)	-	NC

ANTIMYASTHENIC/CHOLINERGIC AGENTS

ANTIMYASTHENIC/CHOLINERGIC AGENTS

PROSTIGMIN TAB	-	B
RUZURGI TAB (Only available through PantheRx Pharmacy 855-726-8479)	LD-PA	B
pyridostigmine CR tab (MESTINON equiv)	-	G
pyridostigmine tab (MESTINON equiv)	-	G
pyridostigmine soln (MESTINON equiv)	-	G
FIRDAPSE TAB	-	NC
PYRIDOSTIGMINE TAB 30MG	-	NC

ANTIMYCOBACTERIAL AGENTS

ANTI TB COMBINATIONS

RIFAMATE CAP	-	B
--------------	---	---

ANTIMYCOBACTERIAL AGENTS

PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist)	QL-RS	B
PRIFTIN TAB	-	B
ethambutol tab (MYAMBUTOL equiv)	-	G
ISONIAZID SYRUP	-	G
isoniazid tab	-	G
pyrazinamide tab	-	G
rifabutin cap (MYCOBUTIN equiv)	-	G
rifampin cap (RIFADIN equiv)	-	G
CYCLOSERINE CAP	-	NC
cycloserine cap (CYCLOSERINE CAP equiv)	-	NC
SIRTURO TAB	-	NC

ANTINEOPLASTICS

ALKYLATING AGENTS

HEXALEN CAP	-	B
LEUKERAN TAB	-	B
cyclophosphamide tab (CYTOXAN equiv)	-	G

ANTIMETABOLITES

TABLOID TAB	-	B
mercaptopurine tab (PURINETHOL 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTINEOPLASTICS Cont.		
methotrexate tab (TREXALL equiv)	-	G
TREXALL TAB	-	NC
ANTINEOPLASTIC ENZYME INHIBITORS		
IRESSA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
NEXAVAR TAB	MSP-PA-SF	B
SPRYCEL TAB	LMSP-PA-SF	B
SUTENT CAP	MSP-PA-SF	B
VOTRIENT TAB	LMSP-PA-SF	B
ZOLINZA CAP	LMSP-PA-SF	B
ANTINEOPLASTICS MISC.		
ACTIMMUNE INJ (Only available through Walgreens 888-347-3416)	LD-PA	B
ALFERON-N INJ	LMSP	B
INTRON-A INJ	MSP	B
MATULANE CAP	-	B
tretinoin cap (VESANOID equiv)	LMSP	B
hydroxyurea cap (HYDREA equiv)	-	G
PROLEUKIN INJ	-	NC
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS		
MESNEX TAB	LMSP	B
leucovorin tab	-	G
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP	LMSP-PA	B
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
AFINITOR TAB 10MG (QL= 1 tab/day)	LMSP-PA-QL-SF	B
GLEOSTINE/LOMUSTINE CAP	-	B
MYLERAN TAB	LMSP	B
temozolomide cap (TEMODAR equiv)	LMSP	B
cyclophosphamide cap	-	G
melphalan tab (ALKERAN equiv)	-	G
TREANDA INJ	-	NC
ANTIMETABOLITES		
azacitidine inj (VIDAZA equiv)	MSP	B
capecitabine tab (XELODA equiv)	LMSP	B
METHOTREXATE INJ	-	G
ONUREG TAB	-	NC
PURIXAN SUSP	-	NC
XATMEP SOLN	-	NC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
AVASTIN INJ	MSP-PA	B
ANTINEOPLASTIC - ANTIBODIES		
ARZERRA INJ	MSP-PA	B
HERCEPTIN INJ	MSP-PA	B
RITUXAN INJ	MSP-PA	B
GAZYVA 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.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
RIABNI SOLN	-	NC
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA STARTER PACK (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
VENCLEXTA TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP	MSP-PA-SF	B
ODOMZO CAP	LMSP-PA-SF	B
DAURISMO TAB	-	NC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
anastrozole tab (ARIMIDEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
exemestane tab (AROMASIN equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
tamoxifen tab (NOLVADEX equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day)	LMSP-QL	B
EMCYT CAP	-	B
ERLEADA TAB (QL= 4 tabs/day)	LMSP-PA-QL	B
FIRMAGON INJ	MSP	B
LYSODREN TAB (Only available through Walgreens 888-347-3416)	LD	B
nilutamide tab (NILANDRON equiv)	LMSP	B
NUBEQA TAB (QL= 4 tabs/day)	MSP-PA-QL-SF	B
ZOLADEX INJ	MSP	B
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
toremifene tab (FARESTON equiv)	-	G
abiraterone acetate tab 500mg (ZYTIGA equiv)	-	NC
HYDROXYPROGESTERONE CAPROATE INJ	-	NC
ORGOVYX TAB	-	NC
XTANDI CAP	-	NC
YONSA TAB	-	NC
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP (QL= 21 caps/28 days)	MSP-PA-QL	B
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK (QL= 32 tabs/28 days; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ANTINEOPLASTIC COMBINATIONS		
LONSURF TAB (Only available through Walgreens 888-347-3416)	LD-PA	B
HERCEPTIN HYLECTA INJ	-	NC
INQOVI TAB	-	NC
KISQALI PAK	-	NC
ANTINEOPLASTIC ENZYME INHIBITORS		
AFINITOR DISPERZ (QL= 1 tab/day)	LMSP-PA-QL-SF	B
ALECENSA CAP (QL= 8 caps/day)	LMSP-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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B
BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B
BALVERSA TAB 5MG (QL= 1 tab/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B
BOSULIF TAB	MSP-PA-SF	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 Biologics 800-850-4306)	LD-PA-QL-SF	B
CABOMETYX TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B
CALQUENCE CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
CAPRELSA TAB (Only available through Biologics 800-850-4306)	LD-PA	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)	MSP-PA-QL	B
erlotinib tab (TARCEVA equiv)	LMSP-PA-SF	B
everolimus tab (AFINITOR equiv) (QL= 1 tab/day)	LMSP-PA-QL-SF	B
FARYDAK CAP (QL= 6 caps/21 days)	MSP-PA-QL	B
GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
IBRANCE CAP (QL= 21 caps/28 days)	MSP-PA-QL	B
IBRANCE TAB (QL= 21 caps/28 days)	MSP-PA-QL	B
ICLUSIG TAB (Only available through AcariaHealth 800-511-5144)	LD-PA-SF	B
IDHIFA TAB (QL= 1 tab/day)	MSP-PA-QL	B
imatinib tab (GLEEVEC equiv)	LMSP	B
IMBRUVICA CAP 140MG (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
IMBRUVICA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
INLYTA TAB (QL= 8 tabs/day)	MSP-PA-QL-SF	B
JAKAFI TAB (QL= 2 tabs/day)	MSP-PA-QL	B
KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
lapatinib ditosylate tab (TYKERB equiv)	LMSP-PA	B
LENVIMA CAP (QL= 3 caps/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
LORBRENA TAB 100MG (QL= 1 tab/day)	MSP-PA-QL-SF	B
LORBRENA TAB 25MG (QL= 3 tabs/day)	MSP-PA-QL-SF	B
LYNPARZA CAP (Only available through Biologics 800-850-4306, QL= 16 caps/day)	LD-PA-QL-SF	B
LYNPARZA TAB (Only available through Biologics 800-850-4306, QL= 4 tabs/day)	LD-PA-QL-SF	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; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
NINLARO CAP	MSP-PA	B
PEMAZYRE TAB (QL= 14 tabs/21 days; Only available through Biologics 800-850-4306)	LD-PA-QL	B
PIQRAY TAB	LMSP-PA-SF	B
QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL	B
RETEVMO CAP (QL= 4 caps/day)	LMSP-PA-QL-SF	B
ROZLYTREK CAP (QL= 3 caps/day)	MSP-PA-QL-SF	B
RUBRACA TAB (QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779)	LD-PA-QL-SF	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont.		
RYDAPT CAP	LMSP-PA	B
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
TAGRISSO TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
TALZENNA CAP 0.25MG (QL= 3 caps/day)	MSP-PA-QL-SF	B
TALZENNA CAP 1MG (QL= 1 cap/day)	MSP-PA-QL-SF	B
TASIGNA CAP	LMSP-PA-SF	B
TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633)	LD-PA-QL	B
temsirolimus inj (TORISEL equiv)	MSP-PA	B
TIBSOVO TAB (QL= 2 tabs/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL	B
TORISEL INJ	MSP-PA	B
TUKYSA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
VELCADE INJ	MSP-PA	B
VERZENIO TAB (QL= 2 tabs/day)	LMSP-PA-QL-SF	B
VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B
VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B
VITRAKVI SOLN (QL= 10ml/day; Only available through US Bioservices 888-518-7246)	LD-PA-QL-SF	B
VIZIMPRO TAB (QL= 1 tab/day)	MSP-PA-QL-SF	B
XALKORI CAP (QL= 2 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 CAP (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
ZELBORAF TAB (QL= 8 tabs/day)	MSP-PA-QL	B
ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118)	LD-PA	B
ZYKADIA CAP (QL= 3 caps/day)	LMSP-PA-QL-SF	B
ZYKADIA TAB (QL= 3 tabs/day)	LMSP-PA-QL-SF	B
AFINITOR TAB 2.5MG, 5MG, 7.5MG	-	NC
ALUNBRIG PAK	-	NC
GAVRETO CAP	-	NC
INREBIC CAP	-	NC
KISQALI TAB	-	NC
TARCEVA TAB	-	NC
TYKERB TAB	-	NC

ANTINEOPLASTICS MISC.

bexarotene cap (TARGRETIN equiv)	LMSP-PA-SF	B
SYLATRON INJ	-	NC
SYNRIBO INJ	-	NC

MITOTIC INHIBITORS

ETOPOSIDE CAP	LMSP	B
---------------	------	---

ANTIPARKINSON AGENTS

ANTIPARKINSON ADJUVANTS

carbidopa tab (LODOSYN equiv)	-	G
-------------------------------	---	---

ANTIPARKINSON ANTICHOLINERGICS

benztropine tab	-	G
trihexyphenidyl tab (ARTANE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANTIPARKINSON AGENTS Cont.

ANTIPARKINSON COMT INHIBITORS

entacapone tab (COMTAN equiv)	-	G
tolcapone tab (TASMAR equiv)	-	G

ANTIPARKINSON DOPAMINERGICS

CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv)	-	B
NEUPRO PATCH	PA	B
amantadine cap (SYMMETREL equiv)	-	G
amantadine syrup (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
APOKYN INJ	-	NC
DUOPA ENTERAL SUSP	-	NC
GOCOVRI CAP	-	NC
MIRAPEX ER TAB	-	NC
RYTARY CAP	-	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	-	NC
--------------	---	----

ANTIPARKINSON DOPAMINERGICS

INBRIJA INH POWDER (QL= 10 caps/day)	PA-QL	B
KYNMOBI FILM	-	NC
KYNMOBI TITRATION KIT	-	NC
OSMOLEX ER TAB	-	NC

ANTIPSYCHOTICS/ANTIMANIC AGENTS

ANTIMANIC AGENTS

lithium carbonate cap (ESKALITH ER equiv)	-	G
lithium carbonate ER tab (LITHOBID equiv)	-	G
lithium carbonate tab	-	G
LITHIUM CITRATE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.

ANTIPSYCHOTICS - MISC.

EQUETRO CAP	-	B
LATUDA TAB (QL= 1 tab/day; Step Therapy requires trial of quetiapine)	QL-ST-¢	B
ziprasidone cap (GEODON equiv)	-	G
CAPLYTA CAP	-	NC
NUPLAZID CAP	-	NC
NUPLAZID TAB	-	NC
VRAYLAR CAP	-	NC
VRAYLAR PACK	-	NC

BENZISOXAZOLES

FANAPT TAB (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B
FANAPT TITRATION PACK (QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	B
RISPERIDONE ODT	-	B
paliperidone ER tab (INVEGA equiv) (Step Therapy requires trial of ABILIFY or quetiapine ER)	ST	G
risperidone ODT (RISPERDAL M equiv)	-	G
risperidone soln (RISPERDAL equiv)	-	G
risperidone tab (RISPERDAL equiv)	-	G
INVEGA INJ	-	NC

BUTYROPHENONES

haloperidol lactate conc (HALDOL equiv)	-	G
haloperidol tab (HALDOL equiv)	-	G

DIBENZAPINES

CLOZAPINE ODT	-	B
CLOZAPINE ODT, FAZACLO ODT	-	B
asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER)	QL-ST	G
CLOZAPINE ODT 12.5MG	-	G
clozapine ODT 25mg, 100mg (CLOZAPINE, FAZACLO equiv)	-	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
SECUADO PATCH	-	NC
SEROQUEL XR TAB	-	NC
VERSACLOZ SUSP	-	NC

DIHYDROINDOLONES

MOLINDONE TAB	-	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 tab (MELLARIL 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont.		
trifluoperazine tab (STELAZINE equiv)	-	G
QUINOLINONE DERIVATIVES		
ABILIFY DISCMELT (QL= 2 tabs/day)	QL	B
ABILIFY SOLN	-	B
aripiprazole ODT (ABILIFY equiv) (QL= 2 tabs/day)	QL	G
aripiprazole soln (ABILIFY equiv)	-	G
aripiprazole tab (ABILIFY equiv)	-	G
ABILIFY MYCITE TAB	-	NC
REXULTI TAB	-	NC
THIOXANTHENES		
thiothixene cap (NAVANE equiv)	-	G
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
HYLAMEND GEL FIRST AID	-	NC
CHLORINE ANTISEPTICS		
PHISOHEX LIQUID	-	B
IODINE ANTISEPTICS		
IODOFLEX PAD	-	NC
ANTIVIRALS		
ANTIRETROVIRALS		
emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv)	-	\$0
APTIVUS CAP	-	B
APTIVUS SOLN	-	B
BIKTARVY TAB	-	B
CIMDUO TAB	-	B
COMPLERA TAB	-	B
CRIXIVAN CAP	-	B
DELSTRIGO TAB	-	B
DESCOVY TAB	PA	B
DOVATO TAB	-	B
EDURANT TAB	-	B
EMTRIVA CAP	-	B
EMTRIVA SOLN	-	B
EVOTAZ TAB	-	B
FUZEON INJ	LMSP	B
GENVOYA TAB	-	B
INTELENCE TAB	-	B
INVIRASE CAP	-	B
INVIRASE TAB	-	B
ISENTRESS (HD) TAB	-	B
ISENTRESS CHEW TAB	-	B
ISENTRESS POWDER PACK	-	B
JULUCA TAB	-	B
KALETRA TAB	-	B
LEXIVA SUSP	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
NEVIRAPINE SUSP (VIRAMUNE equiv)	-	B
NORVIR CAP	-	B
NORVIR POWDER PACK	-	B
NORVIR SOLN	-	B
ODEFSEY TAB	-	B
PIFELTRO TAB	-	B
PREZCOBIX TAB	-	B
PREZISTA SUSP	-	B
PREZISTA TAB	-	B
RESCRIPTOR TAB	-	B
REYATAZ POWDER PACK	-	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 TAB	-	B
VIDEX SOLN	-	B
VIRACEPT POWDER	-	B
VIRACEPT TAB	-	B
VIREAD TAB	-	B
VITEKTA TAB	-	B
ZERIT SOLN	-	B
abacavir soln (ZIAGEN equiv)	-	G
abacavir tab (ZIAGEN equiv)	-	G
abacavir/lamivudine tab (EPZICOM equiv)	-	G
abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv)	-	G
atazanavir cap (REYATAZ equiv)	-	G
didanosine DR cap (VIDEX EC equiv)	-	G
DIDANOSINE DR CAP, VIDEX EC CAP	-	G
efavirenz cap (SUSTIVA 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
emtricitabine cap (EMTRIVA 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
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 (VIRAMUNE equiv)	-	G
nevirapine tab (VIRAMUNE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
ritonavir tab (NORVIR equiv)	-	G
stavudine cap (ZERIT equiv)	-	G
stavudine soln (ZERIT 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
RUKOBIA ER TAB	-	NC
TYBOST TAB	-	NC
CMV AGENTS		
GANCICLOVIR CAP	-	B
GANCICLOVIR INJ	MSP	B
ganciclovir inj (CYTOVENE equiv)	MSP	B
valganciclovir soln (VALCYTE equiv)	-	G
valganciclovir tab (VALCYTE equiv)	-	G
PREVYMIS TAB	-	NC
HEPATITIS AGENTS		
EPIVIR HBV SOLN	-	B
LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/ day)	LMSP-PA-QL	B
MAVYRET TAB (QL= 3 tabs/day)	LMSP-PA-QL	B
PEGASYS INJ	LMSP	B
PEG-INTRON INJ	LMSP	B
REBETOL SOLN	LMSP	B
ribavirin cap (REBETOL equiv)	LMSP	B
ribavirin tab (COPEGUS equiv)	LMSP	B
SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/ day)	LMSP-PA-QL	B
VEMLIDY TAB	-	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
BARACLUDE SOLN	-	NC
DAKLINZA TAB	-	NC
EPCLUSA TAB	-	NC
HARVONI PELLETT PAK	-	NC
HARVONI TAB	-	NC
INCIVEK TAB	-	NC
MODERIBA TAB	-	NC
OLYSIO CAP	-	NC
RIBAPAK TAB	-	NC
RIBAVIRIN TAB 400MG	-	NC
SOVALDI PELLETT PAK	-	NC
SOVALDI TAB	-	NC
TECHNIVIE TAB	-	NC
TYZEKA 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ANTIVIRALS Cont.		
VICTRELIS CAP	-	NC
VIEKIRA XR 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	-	G
XOFLUZA TAB	-	NC
RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS		
ribavirin inh soln (VIRAZOLE equiv)	-	NC
ASSORTED CLASSES		
CHELATING AGENTS		
D-PENAMINE TAB	-	B
ENZYMES		
XIAFLEX INJ	MSP-PA	B
IMMUNOMODULATORS		
REVLIMID CAP (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist)	MSP-QL-RS	B
THALOMID CAP	MSP-PA	B
IMMUNOSUPPRESSIVE AGENTS		
SANDIMMUNE SOLN 100MG/ML	-	B
ZORTRESS TAB 1MG	PA	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
AZASAN TAB	-	NC
ENVARUSUS XR TAB	-	NC
POTASSIUM REMOVING RESINS		
VELTASSA POWDER	PA	B
sodium polystyrene powder (KAYEXALATE 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ASSORTED CLASSES Cont.

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

BETA BLOCKERS CARDIO-SELECTIVE

BYSTOLIC TAB	¢	B
FIRST ATENOLOL SOLN	-	B
FIRST METOPROLOL ORAL SOLN	-	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
KAPSPARGO CAP	-	NC
metoprolol tab 37.5mg, 75mg (LOPRESSOR equiv)	-	NC

BETA BLOCKERS NON-SELECTIVE

LEVATOL TAB	-	B
nadolol tab (CORGARD equiv)	-	G
pindolol tab (VISKEN equiv)	-	G
propranolol ER cap (INDERAL LA equiv)	-	G
PROPRANOLOL SOLN	-	G
propranolol tab (INDERAL equiv)	-	G
sotalol AF tab (BETAPACE AF equiv)	-	G
sotalol tab (BETAPACE equiv)	-	G
timolol maleate tab (BLOCADREN equiv)	-	G
HEMANGEOL SOLN	-	NC
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

CARDENE SR CAP	-	B
COVERA-HS TAB	-	B
DYNACIRC CR 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
CALCIUM CHANNEL BLOCKERS Cont.		
VERELAN PM ER CAP 100MG, 300MG	-	B
VERELAN SR CAP 360mg	-	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 ER tab (CARDIZEM LA equiv)	-	G
diltiazem tab (CARDIZEM equiv)	-	G
felodipine ER tab (PLENDIL equiv)	-	G
isradipine cap (DYNACIRC equiv)	-	G
nicardipine cap (CARDENE 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 CAP 100MG	-	G
VERAPAMIL ER CAP 200MG	-	G
VERAPAMIL ER CAP 300MG	-	G
verapamil SR cap (VERELAN equiv)	-	G
VERAPAMIL SR CAP 360mg	-	G
verapamil SR tab (CALAN SR, ISOPTIN SR equiv)	-	G
verapamil tab (CALAN equiv)	-	G
CONJUPRI TAB	-	NC
KATERZIA SUSP	-	NC
NYMALIZE SOLN	-	NC

CARDIOTONICS

CARDIAC GLYCOSIDES

DIGOXIN SOLN	-	G
digoxin soln (LANOXIN equiv)	-	G
digoxin tab (LANOXIN equiv)	-	G
LANOXIN INJ	-	NC
LANOXIN TAB 0.0625MG, 0.1875MG	-	NC

CARDIOVASCULAR AGENTS - MISC.

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

ENTRESTO TAB (QL= 2 tabs/day)	PA-QL	B
amlodipine/atorvastatin tab (CADUET equiv)	-	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
MUSE SUPP (QL= 6 supp/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 (CIALIS equiv) (QL= 1 tab/day)	QL	G
tadalafil tab 5mg (CIALIS equiv) (QL= 1 tab/day)	PA-QL	G
LEVITRA 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
CARDIOVASCULAR AGENTS - MISC. Cont.		
STENDRA TAB	-	NC
tadalafil tab 10mg (CIALIS equiv)	-	NC
tadalafil tab 20mg (CIALIS equiv)	-	NC
vardenafil ODT (STAXYN equiv)	-	NC
vardenafil tab (LEVITRA equiv)	-	NC
PROSTAGLANDIN VASODILATORS		
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 INH SOLN (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
ORENITRAM TAB	-	NC
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Lumicera 855-847-3553 or Walgreens 888-347-3416)	LD-QL-RS	B
bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B
OPSUMIT TAB (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
TRACLEER TAB 32MG (QL=4 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
tadalafil tab (PAH) (ADCIRCA equiv)	LMSP-PA	B
sildenafil tab 20mg (REVATIO equiv)	PA	G
ADCIRCA TAB	-	NC
REVATIO SUSP	-	NC
sildenafil susp (REVATIO equiv)	-	NC
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
SINUS NODE INHIBITORS		
CORLANOR SOLN	PA	B
CORLANOR TAB	PA	B
TRANSTHYRETIN STABILIZERS		
VYNDAMAX CAP (QL= 1 cap/day)	MSP-PA-QL	B
VYNDAQEL CAP (QL= 4 caps/day)	MSP-PA-QL	B

CEPHALOSPORINS

CEPHALOSPORINS - 1ST GENERATION

cefadroxil cap (DURICEF equiv)	-	G
cefadroxil susp (DURICEF equiv)	-	G
CEFADROXIL TAB	-	G
cefadroxil tab (DURICEF equiv)	-	G
cephalexin cap (KEFLEX equiv)	-	G
cephalexin susp (KEFLEX equiv)	-	G
cephalexin cap 750mg (KEFLEX 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

CEPHALOSPORINS Cont.

CEPHALEXIN TAB	-	NC
DAXBIA CAP	-	NC
KEFLEX CAP 750MG	-	NC

CEPHALOSPORINS - 2ND GENERATION

CEFACTOR ER TAB	-	B
CEFACTOR SUSP	-	B
CEFACTOR CAP	-	G
cefaclor cap (CECLOR equiv)	-	G
cefprozil susp (CEFZIL equiv)	-	G
cefprozil tab (CEFZIL equiv)	-	G
cefuroxime susp (CEFTIN equiv)	-	G
cefuroxime tab (CEFTIN equiv)	-	G

CEPHALOSPORINS - 3RD GENERATION

CEDAX CAP	-	B
CEDAX SUSP	-	B
CEFDITOREN TAB	-	B
SPECTRACEF TAB	-	B
SUPRAX CAP	-	B
SUPRAX CHEW TAB	-	B
SUPRAX SUSP 500MG/5ML	-	B
SUPRAX TAB	-	B
cefdinir cap (OMNICEF equiv)	-	G
cefdinir susp (OMNICEF equiv)	-	G
cefixime cap (SUPRAX equiv)	-	G
cefixime susp (SUPRAX equiv)	-	G
cefepodoxime proxetil susp (VANTIN equiv)	-	G
cefepodoxime proxetil tab (VANTIN equiv)	-	G

CONTRACEPTIVES

COMBINATION CONTRACEPTIVES - ORAL

amethyst tab (LYBREL equiv)	-	\$0
ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv)	-	\$0
cryselle tab	-	\$0
enpresse tab (TRI-LEVELLEN equiv)	-	\$0
gianvi tab, ocella tab (YASMIN, YAZ equiv)	-	\$0
isibloom tab, enskyce tab, apri tab (DESOGEN equiv)	-	\$0
junel FE tab (LOESTRIN FE equiv)	-	\$0
junel tab (LOESTRIN equiv)	-	\$0
kelnor tab (DEMULEN equiv)	-	\$0
layolis FE tab, wymzya FE tab (FEMCON FE equiv)	-	\$0
NECON TAB	-	\$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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
CONTRACEPTIVES Cont.		
velivet tab (CYCLESSA equiv)	-	\$0
vienva tab, lessina tab, kurvelo tab (ALESSE equiv)	-	\$0
viorele tab, kariva tab (MIRCETTE equiv)	-	\$0
NATAZIA TAB	-	B
mibelas chew tab (MINASTRIN equiv)	-	G
BALCOLTRA TAB	-	NC
BEYAZ TAB	-	NC
drosiprenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv)	-	NC
drosiprenone/ethinyl estradiol/levomefolate tab (SAFYRAL equiv)	-	NC
FALESSA KIT	-	NC
LO LOESTRIN TAB	-	NC
LOESTRIN 24 FE TAB	-	NC
norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv)	-	NC
norethindrone/ethinyl estradiol 21 tab (LOESTRIN 21 equiv)	-	NC
norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv)	-	NC
norethindrone/ethinyl estradiol tab (LOESTRIN equiv)	-	NC
TAYTULLA CAP	-	NC
YAZ TAB	-	NC
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
XULANE PATCH	-	\$0
TWIRLA PATCH	-	NC
COMBINATION CONTRACEPTIVES - VAGINAL		
NUVARING	-	\$0
ANNOVERA RING	-	NC
eluryng vaginal ring (NUVARING equiv)	-	NC
COPPER CONTRACEPTIVES - IUD		
PARAGARD IUD	-	\$0
EMERGENCY CONTRACEPTIVES		
ELLA TAB	-	\$0
levonorgestrel tab (PLAN B equiv)	OTC	\$0
LEVONORGESTREL TAB 0.75MG	-	\$0
PLAN B TAB	OTC	\$0
PROGESTIN CONTRACEPTIVES - IMPLANTS		
IMPLANON IMPLANT, 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
SLYND TAB	-	B

CORTICOSTEROIDS

GLUCOCORTICOSTEROIDS

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
CORTICOSTEROIDS Cont.		
CORTISONE ACETATE TAB	-	B
MILLIPRED TAB	-	B
PREDNISOLONE SOLN	-	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 SOLN	-	G
dexamethasone tab (DECADRON equiv)	-	G
hydrocortisone tab (CORTEF equiv)	-	G
methylprednisolone dose pack (MEDROL equiv)	-	G
methylprednisolone tab (MEDROL equiv)	-	G
prednisolone ODT (ORAPRED equiv)	-	G
prednisolone soln (PEDIAPRED equiv)	-	G
PREDNISOLONE SYRUP	-	G
prednisolone syrup (PRELONE equiv)	-	G
PREDNISON SOLN	-	G
prednisone tab (DELTASONE equiv)	-	G
ALKINDI SPRINKLE CAP	-	NC
CORTEF TAB	-	NC
dexamethasone pak (DEXPAK equiv)	-	NC
DEXPAK TAB	-	NC
DXEVO 11-DAY PAK	-	NC
EMFLAZA SUSP	-	NC
EMFLAZA TAB	-	NC
FLO-PRED SUSP	-	NC
HEMADY TAB	-	NC
LIDOLOG KIT	-	NC
MEDROL TAB	-	NC
MILLIPRED DP PAK	-	NC
ORTIKOS ER CAP	-	NC
prednisone pack	-	NC
PREDNISON/DIPHENHYDRAMINE KIT	-	NC
RAYOS TAB	-	NC

MINERALOCORTICIDS

fludrocortisone tab (FLORINEF equiv)	-	G
--------------------------------------	---	---

COUGH/COLD/ALLERGY

ANTITUSSIVES

benzonatate cap (TESSALON equiv)	-	G
hydrocodone/homatropine syrup (HYCODAN equiv)	-	G
tussigon tab (HYCODAN equiv)	-	G
benzonatate cap 150mg (ZONATUSS equiv)	-	NC
ZONATUSS CAP 150MG	-	NC

COUGH/COLD/ALLERGY COMBINATIONS

HYDROCODONE/CHLORPHENIRAMINE/PSEUDOEPHEDRINE LIQUID (QL= 120ml/fill, 2 fills/month)	QL	B
CLARINEX-D 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.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier																														
COUGH/COLD/ALLERGY Cont.																																
DECON-A LIQUID	OTC	EXC																														
SEMPREX-D CAP	-	EXC																														
GUAIFENESIN/CODEINE SYRUP (QL= 240ml/fill)	OTC-QL	G																														
guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) (QL= 240ml/fill)	OTC-QL	G																														
hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days)	QL	G																														
hydrocodone/chlorpheniramine/pseudoephedrine liquid (ZUTRIPRO equiv) (QL= 120ml/fill, 2 fills/month)	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																														
HDC DM SYRUP	-	NC																														
HYCOFENIX SOLN	-	NC																														
MUCINEX LIQUID	-	NC																														
POLY-TUSSIN DM SYRUP	-	NC																														
TUSSICAPS	-	NC																														
TUSSI-PRES LIQUID	-	NC																														
TUSSLIN LIQUID	OTC	NC																														
TUXARIN ER TAB	-	NC																														
TUZISTRA XR SUSP	-	NC																														
EXPECTORANTS																																
SSKI SOLN	-	B																														
GUAIFENESEN SYRUP	-	NC																														
MUCINEX TAB	-	NC																														
MISC. RESPIRATORY INHALANTS																																
NEBUSAL NEB SOLN	-	B																														
sodium chloride neb soln (HYPER-SAL equiv)	-	G																														
MUCOLYTICS																																
acetylcysteine soln (MUCOMYST equiv)	-	G																														
DERMATOLOGICALS																																
ACNE PRODUCTS																																
EPIDUO FORTE GEL	PA	B																														
PRASCION RA CREAM	-	B																														
RETIN-A CREAM (QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization)	PA-QL	B																														
RETIN-A GEL (QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization)	PA-QL	B																														
DIFFERIN OTC GEL 0.1%	OTC	EXC																														
amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (AC CUTANE equiv)	-	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																														
ERY PAD	-	G																														
erythromycin 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.																																
<table border="0"> <tr> <td>EXC</td> <td>Plan Exclusion</td> <td>INF</td> <td>Infertility</td> <td>LD</td> <td>Limited Distribution</td> </tr> <tr> <td>LMSP</td> <td>Lumicera Mandatory Specialty Pharmacy Program</td> <td>MSP</td> <td>Mandatory Specialty Pharmacy Program</td> <td>OTC</td> <td>Over-the-Counter</td> </tr> <tr> <td>PA</td> <td>Prior Authorization</td> <td>QL</td> <td>Quantity Limit</td> <td>RS</td> <td>Restricted to Specialist</td> </tr> <tr> <td>SF</td> <td>Limited to two 15 day fills per month for first 3 months</td> <td>SMKG</td> <td>Smoking Cessation</td> <td>ST</td> <td>Step Therapy</td> </tr> <tr> <td>VAC</td> <td>Vaccine Program</td> <td>¢</td> <td>RxCENTS</td> <td></td> <td></td> </tr> </table>	EXC	Plan Exclusion	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	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				
EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
erythromycin pad	-	G
erythromycin soln	-	G
erythromycin/benzoyl peroxide gel	-	G
sodium sulfacetamide lotion (KLARON equiv)	-	G
sodium sulfacetamide/sulfur gel (ROSULA equiv)	-	G
tretinoin cream (QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G
tretinoin gel (QL= 20gm/fill)	PA-QL	G
tretinoin gel (RETIN-A GEL equiv) (QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization)	PA-QL	G
ABSORICA CAP	-	NC
ABSORICA LD CAP	-	NC
ACZONE GEL, DAPSONE GEL 7.5%	-	NC
adapalene cream (DIFFERIN equiv)	-	NC
adapalene gel (DIFFERIN equiv)	-	NC
ADAPALENE LOTION (DIFFERIN equiv)	-	NC
adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv)	-	NC
ADAPALENE/BENZOYL PEROXIDE PAD	-	NC
AKLIEF CREAM	-	NC
AL TRENO LOTION	-	NC
AMZEEQ FOAM	-	NC
ARAZLO LOTION	-	NC
ATRALIN GEL	-	NC
AVAR AEROSOL FOAM	-	NC
AVAR GEL	-	NC
AVAR PAD	-	NC
AZELEX CREAM	-	NC
BENZAC WASH	-	NC
BENZOYL PEROXIDE CREAM	OTC	NC
BENZOYL PEROXIDE/HYDROCORTISONE LOTION	-	NC
benzoyl peroxide/hydrocortisone lotion (VANOXIDE-HC equiv)	-	NC
CLINDACIN KIT	-	NC
CLINDAGEL	-	NC
clindamycin foam (EVOCLIN equiv)	-	NC
clindamycin/benzoyl peroxide gel (BENZACLIN equiv)	-	NC
clindamycin/tretinoin gel (ZIANA equiv)	-	NC
dapsone gel (ACZONE equiv)	-	NC
EPIDUO GEL 0.1-2.5%	-	NC
EVOCLIN FOAM	-	NC
FABIOR AEROSOL FOAM	-	NC
NUCARACLINPA KIT	-	NC
NUCARARXPAK KIT	-	NC
ONEXTON GEL	-	NC
RETIN-A MICRO GEL 0.04%, 0.1%	-	NC
RETIN-A MICRO GEL 0.08%, 0.06%	-	NC
ROSULA WASH	-	NC
sodium sulfacetamide/sulfur cream (PLEXION SCT equiv)	-	NC
sodium sulfacetamide/sulfur emulsion (ROSAC WASH equiv)	-	NC
sodium sulfacetamide/sulfur emulsion (ROSULA 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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 susp (PLEXION TS equiv)	-	NC
sodium sulfacetamide/sulfur wash (SUMAXIN WASH equiv)	-	NC
sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv)	-	NC
SUMADAN KIT	-	NC
SUMADEN XLT KIT	-	NC
tretinoin gel 0.05% (ATRALIN equiv)	-	NC
tretinoin gel pump 0.04% (TRETINOIN GEL PUMP 0.04% equiv)	-	NC
tretinoin gel pump 0.1% (TRETINOIN GEL PUMP 0.1% equiv)	-	NC
TRETIN-X 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		
CORTISPORIN CREAM	-	B
CORTISPORIN OINT	-	B
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
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
clotrimazole cream (LOTRIMIN AF CREAM equiv) (Rx Only)	-	G
econazole cream (SPECTAZOLE equiv) (QL= 30gm/30 days)	QL	G
iodoquinol/hydrocortisone cream 1% (VYTONE equiv)	-	G
ketoconazole cream (NIZORAL CREAM equiv)	-	G
ketoconazole shampoo (NIZORAL SHAMPOO equiv)	-	G
nystatin cream (MYCOSTATIN CREAM equiv)	-	G
nystatin 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.

EXC	NC =Not Covered Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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/betamethasone cream (LOTRISONE equiv)	-	NC
clotrimazole/betamethasone lotion (LOTRISONE equiv)	-	NC
ECONASIL KIT	-	NC
ECOZA FOAM	-	NC
ERTACZO CREAM	-	NC
EXELDERM CREAM, SULCONAZOLE CREAM	-	NC
EXELDERM SOLN	-	NC
EXELDERM SOLN, SULCONAZOLE SOLN	-	NC
iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv)	-	NC
iodoquinol/hydrocortisone/aloe polysaccharide gel (ALCORTIN A equiv)	-	NC
JUBLIA SOLN	-	NC
KERYDIN SOLN	-	NC
LOPROX GEL	-	NC
LOTRIMIN AF CREAM	-	NC
LOTRISONE CREAM	-	NC
LOTRISONE LOTION	-	NC
LULICONAZOLE CREAM, LUZU CREAM	-	NC
MENTAX CREAM	-	NC
NAFTIFINE CREAM	-	NC
naftifine cream (NAFTIN equiv)	-	NC
naftifine gel (NAFTIN equiv)	-	NC
NAFTIN CREAM	-	NC
NAFTIN GEL	-	NC
NAFTIN GEL 2%	-	NC
nizoral a-d shampoo (NIZORAL equiv)	OTC	NC
nystatin/triamcinolone cream	-	NC
nystatin/triamcinolone oint	-	NC
ONYCHO-MED KIT	-	NC
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

DICLOFENAC PATCH, FLECTOR PATCH (QL= 30 patches/fill; Step Therapy requires trial of celecoxib)	QL-ST	B
VOPAC 5 CREAM	-	B
diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill)	QL	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.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	LD	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	RS	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation	ST	Step Therapy
	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
diclofenac soln 1.5% (PENNSAID equiv)	-	NC
DICLOTREX PAK	-	NC
DST PLUS PAK KIT	-	NC
GABAPENTIN/NAPROXEN CREAM COMPOUND KIT	-	NC
LICART PATCH	-	NC
NAPROXEN CREAM COMPOUND KIT	-	NC
PENNSAID SOLN	-	NC
REXAPHENAC CREAM	-	NC
VOPAC CREAM	-	NC
VOPAC GB CREAM	-	NC
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
FLUOROURACIL SOLN	-	B
PICATO GEL (QL= 1 box/fill)	QL	B
TARGRETIN GEL	LMSP-PA	B
VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Avella (877) 546-5779)	LD-PA-QL	B
fluorouracil cream (EFUDEX CREAM equiv)	-	G
CARAC CREAM	-	NC
diclofenac gel (SOLARAZE equiv)	-	NC
FLUORAC CREAM	-	NC
FLUOROPLEX CREAM	-	NC
FLUOROURACIL CREAM 0.5%	-	NC
KLISYRI OINT	-	NC
SOLARAVIX PAK	-	NC
SOLARAZE GEL	-	NC
ANTIPRURITICS - TOPICAL		
DOXEPIN CREAM, PRUDOXIN CREAM, ZONALON CREAM	-	NC
ANTIPSORIATICS		
8-MOP CAP	-	B
CALCIPOTRIENE FOAM, SORILUX FOAM	-	B
SKYRIZI INJ (QL= 2 inj/84 days)	LMSP-PA-QL	B
SORILUX FOAM	-	B
STELARA INJ (QL= 1 inj/84 days)	LMSP-PA-QL	B
TALTZ INJ (QL= 1 inj/28 days)	LMSP-PA-QL	B
TAZORAC CREAM 0.05%	PA	B
TREMFYA INJ (QL= 1 inj/56 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
methoxsalen cap (OXSORALEN ULTRA equiv)	-	G
tazarotene cream 0.1% (TAZORAC equiv)	PA	G
CALCITRIOL OINT	-	NC
COSENTYX INJ (1-PACK)	-	NC
COSENTYX INJ (2-PACK)	-	NC
SILIQ INJ	-	NC
TAZORAC 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
TAZORAC GEL	-	NC
ANTISEBORRHEIC PRODUCTS		
selenium sulfide lotion	-	G
selenium sulfide shampoo (SELSEB equiv)	-	G
sodium sulfacetamide wash (OVACE WASH equiv)	-	G
ESKATA SOLN	-	NC
OVACE PLUS CREAM	-	NC
OVACE PLUS LOTION	-	NC
OVACE PLUS FOAM	-	NC
seb-prev cream (OVACE CREAM equiv)	-	NC
selenium sulfide shampoo 2.3% (SELRX equiv)	-	NC
sodium sulfacetamide gel (OVACE PLUS equiv)	-	NC
sodium sulfacetamide shampoo (OVACE equiv)	-	NC
sodium sulfacetamide/urea pad (ROSULA equiv)	-	NC
ANTIVIRALS - TOPICAL		
acyclovir cream (ZOVIRAX equiv)	PA	G
acyclovir oint (ZOVIRAX OINT equiv)	-	NC
DENAVIR CREAM	-	NC
XERESE CREAM	-	NC
ZOVIRAX OINT	-	NC
BURN PRODUCTS		
SULFAMYLLON CREAM	-	B
silver sulfadiazine cream (SILVADENE CREAM equiv)	-	G
CORTICOSTEROIDS - TOPICAL		
BETAMETHASONE AUGMENTED GEL	-	B
EPIFOAM AEROSOL	-	B
PANDEL CREAM	-	B
PRAMOSONE E CREAM	-	B
PREDNICARBATE CREAM	-	B
PREDNICARBATE OIN	-	B
U-CORT CREAM	-	B
alclometasone cream (ACLOVATE equiv)	-	G
alclometasone oint (ACLOVATE OINT equiv)	-	G
betamethasone augmented cream (DIPROLENE AF CREAM equiv)	-	G
betamethasone augmented gel	-	G
betamethasone augmented lotion (DIPROLENE LOTION equiv)	-	G
betamethasone augmented oint (DIPROLENE OINT equiv)	-	G
betamethasone dipropionate cream (DIPROSONE CREAM equiv)	-	G
betamethasone dipropionate lotion	-	G
betamethasone dipropionate 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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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
hydrocortisone cream (PROCTOCORT equiv)	-	G
hydrocortisone lotion (HYTONE equiv)	-	G
hydrocortisone oint	-	G
hydrocortisone pramoxine cream (PRAMOSONE equiv)	-	G
mometasone cream (ELOCON equiv)	-	G
mometasone oint (ELOCON equiv)	-	G
mometasone soln (ELOCON equiv)	-	G
prednicarbate cream (DERMATOP equiv)	-	G
triamcinolone cream	-	G
triamcinolone lotion	-	G
triamcinolone oint	-	G
ALA SCALP LOTION	-	NC
AMCINONIDE CREAM 0.1%	-	NC
AMCINONIDE LOTION	-	NC
AMCINONIDE OINT	-	NC
APEXICON E CREAM (PSORCON E equiv)	-	NC
BESER KIT 0.05%	-	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
CLOBETAVIX KIT	-	NC
CLOBEX LOTION	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
CLOBEX SHAMPOO	-	NC
CLOCORTOLONE CREAM	-	NC
CLODERM CREAM	-	NC
CORDRAN CREAM 0.025%	-	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 (TOPICORT equiv)	-	NC
desoximetasone oint 0.05% (TOPICORT equiv)	-	NC
DIFLORASONE CREAM	-	NC
diflorasone oint	-	NC
DUOBRII LOTION	-	NC
ENSTILAR FOAM	-	NC
fluocinonide cream 0.1% (VANOS CREAM equiv)	-	NC
FLUOPAR KIT	-	NC
FLUOVIX PAK	-	NC
flurandrenolide cream (CORDRAN equiv)	-	NC
flurandrenolide lotion (CORDRAN equiv)	-	NC
flurandrenolide oint (CORDRAN equiv)	-	NC
fluticasone propionate lotion (CUTIVATE equiv)	-	NC
halcinonide cream (HALOG equiv)	-	NC
HALOG CREAM	-	NC
HALOG OINT	-	NC
HALOG SOLN	-	NC
halonate pac kit (ULTRAVATE KIT equiv)	-	NC
HC BUTYRATE SOLN	-	NC
HC-LIDOCAINE CREAM	-	NC
hydrocortisone butyrate cream (LOCOID equiv)	-	NC
hydrocortisone butyrate lipocream (LOCOID equiv)	-	NC
hydrocortisone butyrate oint (LOCOID equiv)	-	NC
hydrocortisone butyrate soln (LOCOID equiv)	-	NC
hydrocortisone lotion (LOCOID equiv)	-	NC
hydrocortisone valerate cream (WESTCORT equiv)	-	NC
hydrocortisone valerate oint (WESTCORT equiv)	-	NC
IMPEKLO LOTION	-	NC
IMPOYZ 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
LEXETTE FOAM	-	NC
LOCOID CREAM	-	NC
LOCOID LIPOCREAM	-	NC
LOCOID OINT	-	NC
LOCOID SOLN	-	NC
LUXIQ FOAM	-	NC
MEXPAROX HC CREAM	-	NC
MICORT-HC CREAM	-	NC
NOVACORT GEL	-	NC
OLUX E FOAM	-	NC
OLUX FOAM	-	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
TEMOVATE 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 acetone oint (TRIANEX equiv)	-	NC
triamcinolone spray (KENALOG equiv)	-	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
ECZEMA AGENTS		
DUPIXENT INJ (QL= 2 inj/ 28 days)	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
EMOLLIENT/KERATOLYTIC AGENTS		
DERMASORB XM KIT	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
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 LOTION	-	NC
urea lotion (KERALAC LOTION equiv)	-	NC
UREA NAIL KIT	-	NC
UREA SUSP	-	NC
urea susp 40% (UMECTA equiv)	-	NC
EMOLLIENTS		
ammonium lactate cream (LAC-HYDRIN equiv)	-	G
ammonium lactate lotion (LAC-HYDRIN equiv)	-	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		
finasteride tab (PROPECIA equiv)	-	EXC
bimatoprost topical soln (LATISSE equiv)	-	NC
LATISSE SOLN	-	NC
HAIR REDUCTION AGENTS		
VANIQA CREAM	-	EXC
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream (ALDARA equiv)	-	G
ZYCLARA CREAM	-	NC
ZYCLARA CREAM, IMIQUIMOD CREAM	-	NC
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
pimecrolimus cream (ELIDEL equiv) (Covered for members 2 years or older)	-	G
tacrolimus oint (PROTOPIC OINT equiv)	-	G
KERATOLYTIC/ANTIMITOTIC AGENTS		
CONDYLOX GEL	-	B
PODOCON SOLN	-	B
SALEX SHAMPOO	-	B
podofilox soln (CONDYLOX equiv)	-	G
salicylic acid shampoo (SALEX equiv)	-	G
SALEX LOTION KIT	-	NC
salicylic acid 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
SALIMEZ FORTE CREAM	-	NC
XALIX SOL	-	NC
LOCAL ANESTHETICS - TOPICAL		
lidocaine cream 3% (LIDAMANTLE equiv)	-	G
LIDOCAINE GEL	-	G
lidocaine gel (GLYDO equiv)	-	G
lidocaine gel (XYLOCAINE equiv)	-	G
lidocaine oint (QL= 36gm/fill)	QL	G
lidocaine patch (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
GEN7T LOTION	-	NC
GEN7T PLUS LOTION	-	NC
GEN7T PLUS PAD	-	NC
L.E.T. GEL	-	NC
LIDOCAINE CREAM	-	NC
lidocaine cream 3.88% (LIDOTRAL CREAM equiv)	-	NC
lidocaine lotion	-	NC
lidocaine oint/transparent dressing kit	-	NC
LIDOCIN GEL	-	NC
LIDOSTREAM KIT	-	NC
LIDOTRAL CREAM (lidocaine cream equiv)	-	NC
LIDOTREX GEL	-	NC
LIDOVEX CREAM	-	NC
MEDI-PATCH W/LIDOCAINE PATCH	-	NC
MICROVIX LP PAK	-	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
SYNVEXIA TC CREAM	-	NC
WPR PLUS	-	NC
ZILACAINE PAK	-	NC
MISC. DERMATOLOGICAL PRODUCTS		
NEOSALUS FOAM	-	NC
MISC. TOPICAL		
aluminum chloride soln (DRYSOL equiv)	-	G
DRYSOL SOLN	-	G
DERMACINRX 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
HYCLODEX SOLN	-	NC
QBREXZA PAD	-	NC
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OINT	-	NC
PIGMENTING-DEPIGMENTING AGENTS		
hydroquinone cream (LUSTRA equiv)	-	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
FINACEA PLUS KIT	-	B
azelaic acid gel (FINACEA equiv)	-	G
metronidazole cream (METROCREAM equiv)	-	G
metronidazole gel (METROGEL equiv)	-	G
metronidazole gel 1% (METROGEL equiv) (Step Therapy requires trial of metronidazole gel 0.75%)	ST	G
metronidazole lotion (METROLOTION equiv)	-	G
DOXYCYCLINE CAP, ORACEA CAP	-	NC
IVERMECTIN CREAM	-	NC
ivermectin cream (SOOLANTRA equiv)	-	NC
MIRVASO GEL	-	NC
NORITATE CREAM	-	NC
RHOFADE CREAM	-	NC
ROSADAN KIT	-	NC
SOOLANTRA CREAM	-	NC
ZILXI FOAM	-	NC
SCABICIDES & PEDICULICIDES		
CROTAN LOTION	-	B
EURAX CREAM	-	B
LINDANE LOTION	-	B
NATROBA SUSP (QL= 1 bottle/fill)	QL	B
SKLICE LOTION (QL= 1 tube/fill)	PA-QL	B
SPINOSAD SUSP (QL= 1 bottle/fill)	QL	B
ULESFIA LOTION (QL= 4 bottles/fill)	QL	B
ivermectin lotion (SKLICE equiv) (QL= 1 tube/fill)	PA-QL	G
lindane lotion	-	G
lindane shampoo	-	G
malathion lotion (OVIDE equiv) (QL= 2 bottles/fill)	QL	G
permethrin cream (ELIMITE CREAM equiv)	-	G
SCAR TREATMENT PRODUCTS		
SCARCIN GEL	-	NC
scarcin gel (SCARCIN equiv)	-	NC
SCARCIN LIQUID ROLL-ON	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DERMATOLOGICALS Cont.		
SILIPAC KIT	-	NC
WOUND CARE PRODUCTS		
REGRANEX GEL (QL= 30gm/fill)	QL	B
ALEVICYN SOLN DERMAL	-	NC
BIAFINE EMULSION	-	NC
cicatrace kit (REXASIL equiv)	-	NC
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC BIOLOGICALS		
TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN	-	NC
DIAGNOSTIC DRUGS		
GLUCAGEN INJ	-	B
GLUCAGON DIAGNOSTIC INJ	-	NC
MACRILEN PACK	-	NC
DIAGNOSTIC PRODUCTS, MISC.		
FREESTYLE LITE TEST STRIP	OTC	G
DIAGNOSTIC TESTS		
ACCU-CHEK AVIVA PLUS TEST STRIP	OTC-PA	B
ACCU-CHEK GUIDE TEST STRIP	OTC-PA	B
ACCU-CHEK SMARTVIEW TEST STRIP	OTC-PA	B
ACCU-CHEK TEST STRIP	OTC-PA	B
TEST STRIP (all other test strips)	OTC-PA	B
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
ONETOUCH TEST STRIP	OTC	G
ONETOUCH VERIO TEST STRIP	OTC	G
PRECISION XTRA KETONE TEST STRIP	OTC	G
PRECISION XTRA TEST STRIP	OTC	G
RADIOGRAPHIC CONTRAST MEDIA		
OMNIPAQUE SOLN	-	NC
SITZMARKS CAP	-	NC
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
ASTAMED MYO CAP	-	NC
DEPLIN CAP	-	NC
ELIGEN B12 TAB	-	NC
FALESSA TAB	-	NC
GLYGEST PAK	-	NC
L-METHYLFOLATE TAB	-	NC
LUVIRA CAP	-	NC
METANX CAP	-	NC
OLLIZAC POWDER	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS Cont.		
PODIAPN CAP	-	NC
XAQUIL XR TAB	-	NC
XYZBAC TAB	-	NC
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP	-	B
PANCREAZE CAP, PERTZYE CAP, ULTRESA CAP, ZENPEP CAP	-	NC
PANCRELIPASE CAP	-	NC
SUCRAID SOLN	-	NC
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide ER cap (DIAMOX SEQUEL equiv)	-	G
acetazolamide tab	-	G
methazolamide tab (NEPTAZANE equiv)	-	G
KEVEYIS TAB	-	NC
DIURETIC COMBINATIONS		
TRIAMTERENE/HYDROCHLOROTHIAZIDE CAP 50-25mg	-	B
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		
bumetanide tab (BUMEX equiv)	-	G
ethacrynic tab (EDECRIN equiv)	-	G
FUROSEMIDE SOLN	-	G
furosemide soln (LASIX equiv)	-	G
furosemide tab (LASIX equiv)	-	G
torsemide tab (DEMADEX equiv)	-	G
POTASSIUM SPARING DIURETICS		
DYRENIUM CAP	-	B
amiloride tab (MIDAMOR equiv)	-	G
spironolactone tab (ALDACTONE equiv)	-	G
triamterene cap (DYRENIUM equiv)	-	G
CAROSPIR SUSP	-	NC
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
DIURIL SUSP	-	B
CHLOROTHIAZIDE TAB	-	G
chlorothiazide tab (DIURIL equiv)	-	G
CHLORTHALIDONE TAB	-	G
hydrochlorothiazide cap (MICROZIDE equiv)	-	G
hydrochlorothiazide tab (HYDRODIURIL equiv)	-	G
indapamide tab (LOZOL equiv)	-	G
METHYCLOTHIAZIDE TAB	-	G
metolazone tab (ZAROXOLYN equiv)	-	G

ENDOCRINE AND METABOLIC AGENTS - MISC.

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

** OTC drugs are not a covered benefit.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB 10MG (QL= 6 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
ISTURISA TAB 1MG (QL= 8 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
ISTURISA TAB 5MG (QL= 2 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007)	LD-PA-QL	B
BONE DENSITY REGULATORS		
ALENDRONATE TAB 40MG	-	B
FORTEO INJ	LMSP	B
FORTICAL NASAL SPRAY	-	B
FOSAMAX+D TAB (Step Therapy requires trial of ACTONEL)	ST	B
MIACALCIN INJ	LMSP	B
NATPARA INJ (Only available through Walgreens 888-347-3416)	LD-PA	B
PROLIA INJ (QL= 1 fill/6 months)	LMSP-QL	B
SKELID TAB	-	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 DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate)	ST	G
risedronate tab (ACTONEL equiv)	-	G
BINOSTO TAB	-	NC
TERIPARATIDE INJ	-	NC
FERTILITY REGULATORS		
CLOMIPHENE CITRATE TAB	INF	G
GNRH/LHRH ANTAGONISTS		
ganirelix ac inj (GANIRELIX equiv)	INF-MSP	B
ORLISSA TAB 150MG (QL= 1 tab/day)	PA-QL	B
ORLISSA TAB 200MG (QL= 2 tabs/day)	PA-QL	B
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	B
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA INJ	-	EXC
GROWTH HORMONES		
GENOTROPIN INJ	LMSP-PA	B
HUMATROPE INJ, ZOMACTON INJ	-	NC
NORDITROPIN INJ, NUTROPIN AQ INJ	-	NC
OMNITROPE INJ	-	NC
SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ	-	NC
HORMONE RECEPTOR MODULATORS		
raloxifene tab (EVISTA equiv) (Covered at \$0 for women 35 years or older; All other members covered at generic copay)	-	\$0
OSPHENA TAB	-	NC
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ	MSP	B
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
LUPRON DEPOT PED INJ	MSP	B
LUPRON DEPOT-PED INJ	MSP	B
SUPPRELIN LA INJ	MSP-PA	B
SYNAREL NASAL SOLN	-	B
FENSOLVI INJ	-	NC
METABOLIC MODIFIERS		
ALDURAZYME INJ	MSP-PA	B
CALCITRIOL INJ	LMSP	B
CYSTADANE POWDER	MSP-PA	B
ELAPRASE INJ	MSP-PA	B
FABRAZYME INJ	MSP-PA	B
GALAFOLD CAP (QL= 15 caps/30 days; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
LUMIZYME/MYOZYME INJ	MSP-PA	B
NAGLAZYME INJ	MSP-PA	B
PALYNZIQ INJ (QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118)	LD-PA-QL-SF	B
sapropterin dihydrochloride powder packet (KUVAN equiv)	LMSP-PA	B
sapropterin dihydrochloride soluble tab (KUVAN equiv)	LMSP-PA	B
STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479)	LD-PA	B
calcitriol cap (ROCALTROL equiv)	-	G
calcitriol soln (ROCALTROL equiv)	-	G
cinacalcet tab (SENSIPAR equiv)	-	G
DOXERCALCIFEROL CAP	-	G
doxercalciferol cap (HECTOROL equiv)	-	G
levocarnitine soln (CARNITOR equiv)	-	G
levocarnitine tab (CARNITOR equiv)	-	G
paricalcitol cap (ZEMPLAR equiv)	-	G
sodium phenylbutyrate powder (BUPHENYL equiv)	-	G
sodium phenylbutyrate tab (BUPHENYL equiv)	-	G
CARBAGLU TAB	-	NC
KUVAN POWDER PACK	-	NC
KUVAN TAB	-	NC
MYALEPT INJ	-	NC
nitisinone cap (ORFADIN equiv)	-	NC
NITYR TAB	-	NC
ORFADIN CAP	-	NC
ORFADIN SUSP	-	NC
RAVICTI LIQUID	-	NC
RAYALDEE CAP	-	NC
SENSIPAR TAB	-	NC
XURIDEN POWDER	-	NC
POSTERIOR PITUITARY HORMONES		
DDAVP NASAL SOLN	-	B
STIMATE NASAL SOLN	-	B
desmopressin acetate inj (DDAVP equiv)	-	G
desmopressin acetate nasal spray (DDAVP equiv)	-	G
desmopressin acetate tab (DDAVP 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ENDOCRINE AND METABOLIC AGENTS - MISC. Cont.		
desmopressin nasal soln (DDAVP equiv)	-	G
NOCDURNA SL TAB	-	NC
NOCTIVA EMULSION SPRAY	-	NC
PROLACTIN INHIBITORS		
cabergoline tab (DOSTINEX equiv)	-	G
SOMATOSTATIC AGENTS		
octreotide inj (SANDOSTATIN equiv)	LMSP	B
SIGNIFOR INJ (QL= 2 vials/day; Only available through Accredo 800-803-2523)	LD-PA-QL	B
SOMATULINE INJ	MSP-PA	B
BYNFEZIA PEN INJ	-	NC
MYCAPSSA CAP	-	NC
SANDOSTATIN LAR INJ KIT	-	NC
SIGNIFOR LAR INJ	-	NC
VASOPRESSIN RECEPTOR ANTAGONISTS		
JYNARQUE PAK (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
JYNARQUE TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416)	LD-PA-QL	B
SAMSCA TAB, TOLVAPTAN TAB	-	NC
tolvaptan tab (SAMSCA equiv)	-	NC
ESTROGENS		
ESTROGEN COMBINATIONS		
DUAVEE TAB	-	B
ORIAHNN CAP (QL= 2 caps/day)	PA-QL	B
PREFEST TAB	-	B
PREMPHASE TAB, PREMPRO TAB	-	B
esterified estrogens/methyltestosterone tab (ESTRATEST equiv)	-	G
estradiol/norethindrone tab (ACTIVEVELLA equiv)	-	G
jinteli tab (FEMHRT equiv)	-	G
ANGELIQ TAB	-	NC
BIJUVA CAP	-	NC
CLIMARA PRO PATCH	-	NC
COMBIPATCH	-	NC
FEMHRT TAB	-	NC
ESTROGENS		
CENESTIN TAB	-	B
MENEST TAB	-	B
PREMARIN TAB	-	B
DEPO-ESTRADIOL INJ	-	G
estradiol patch (CLIMARA equiv)	-	G
estradiol patch (VIVELLE-DOT equiv)	-	G
estradiol tab (ESTRACE equiv)	-	G
ESTROPIPATE TAB	-	G
estropipate tab (OGEN equiv)	-	G
ALORA PATCH	-	NC
CLIMARA PATCH	-	NC
DIVIGEL GEL, ELESTRIN GEL	-	NC
EVAMIST SPRAY	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ESTROGENS Cont.		
MENOSTAR PATCH	-	NC
VIVELLE-DOT PATCH	-	NC
FLUOROQUINOLONES		
FLUOROQUINOLONES		
BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist)	QL-RS	B
CIPRO SUSP 5%	-	B
CIPROFLOXACIN 100MG TAB	-	B
CIPROFLOXACIN ER TAB	-	B
NOROXIN 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 (FLOXIN equiv)	-	G
FACTIVE TAB	-	NC
PROQUIN XR TAB	-	NC
GASTROINTESTINAL AGENTS - MISC.		
5-HT4 RECEPTOR AGONISTS		
MOTTEGRITY TAB	PA	B
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB	PA	B
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226)	LD-PA	B
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB (QL= 1 tab/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF-¢	B
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap (ACTIGALL equiv)	-	G
ursodiol tab (URSO (FORTE) equiv)	-	G
RELTONE CAP	-	NC
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn conc (GASTROCROM equiv)	-	G
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
AMITIZA CAP, LUBIPROSTONE CAP	-	NC
GASTROINTESTINAL STIMULANTS		
metoclopramide soln (REGLAN equiv)	-	G
metoclopramide tab (REGLAN equiv)	-	G
GIMOTI NASAL SPRAY	-	NC
METZOLV ODT	-	NC
INFLAMMATORY BOWEL AGENTS		
CIMZIA INJ (QL= 2 inj/28 days)	LMSP-PA-QL	B
CIMZIA STARTER INJ KIT (QL= 1 kit/plan year)	LMSP-PA-QL	B
DIPENTUM CAP	-	B
RENFLEXIS INJ	MSP-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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
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
mesalamine DR cap (DELZICOL equiv)	-	NC
mesalamine tab (ASACOL equiv)	-	NC
PENTASA CAP	-	NC
REMICADE INJ	-	NC
ROWASA KIT	-	NC
INTESTINAL ACIDIFIERS		
lactulose soln	-	G
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron tab (LOTRONEX equiv)	-	G
LINZESS CAP	-	NC
VIBERZI TAB	-	NC
ZELNORM TAB	-	NC
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB	PA	B
SYMPROIC TAB	PA	B
alvimopan cap (ENTEREG equiv)	-	NC
ENTEREG CAP	-	NC
RELISTOR INJ	-	NC
RELISTOR INJ KIT	-	NC
RELISTOR TAB	-	NC
PHOSPHATE BINDER AGENTS		
AURYXIA TAB (Step Therapy requires trial of RENVELA and FOSRENOL)	ST	B
FOSRENOL CHEW TAB	-	B
FOSRENOL POWDER PACK	-	B
PHOSLYRA SOLN	-	B
REVELA TAB	-	B
calcium acetate cap (PHOSLO equiv)	-	G
lanthanum carbonate chew tab (FOSRENOL equiv)	-	G
sevelamer powder pak (REVELA equiv)	-	G
sevelamer tab (REVELA TAB equiv)	-	G
RENAGEL TAB	-	NC
RENAGEL TAB 800MG	-	NC
sevelamer hydrochloride tab (RENAGEL equiv)	-	NC
VELPHORO 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
GASTROINTESTINAL AGENTS - MISC. Cont.		
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		
CYTRA K CRYSTALS	-	G
CYTRA-3 SYRUP	-	G
ORACIT SOLN	-	G
potassium citrate CR tab (UROCIT-K TAB equiv)	-	G
potassium citrate/citric acid powder pack (POLYCITRA equiv)	-	G
potassium citrate/citric acid soln (POLYCITRA-K equiv)	-	G
sodium citrate/citric acid soln (BICITRA equiv)	-	G
tricitrates soln (POLYCITRA-LC equiv)	-	G
CYSTINOSIS AGENTS		
CYSTAGON CAP (Only available through CVS Specialty 800-238-7828)	LD	B
PROCYSBI CAP	-	NC
PROCYSBI GRANULES PACKET	-	NC
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP	-	B
PENTOSAN CAP	-	NC
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin SR tab (UROXATRAL equiv)	-	G
dutasteride cap (AVODART equiv)	-	G
finasteride tab (PROSCAR equiv)	-	G
tamsulosin cap (FLOMAX equiv)	-	G
CARDURA XL TAB	-	NC
dutasteride/tamsulosin cap (JALYN equiv)	-	NC
silodosin cap (RAPAFLO equiv)	-	NC
URINARY ANALGESICS		
phenazopyridine tab (PYRIDIDIUM equiv)	-	NC
URINARY STONE AGENTS		
LITHOSTAT TAB	-	B
THIOLA EC TAB	-	NC
THIOLA TAB	-	NC
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine/probenecid tab (COL-BENEMID equiv)	-	G
DUZALLO TAB	-	NC
GOUT AGENTS		
MITIGARE CAP	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
GOUT AGENTS Cont.		
allopurinol tab (ZYLOPRIM equiv)	-	G
febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol)	ST-¢	G
COLCHICINE CAP	-	NC
colchicine tab (COLCRYS equiv)	-	NC
COLCRYS TAB	-	NC
GLOPERBA SOLN	-	NC
ULORIC TAB	-	NC
ZURAMPIC TAB	-	NC
URICOSURICS		
probenecid tab (BENEMID equiv)	-	G

HEMATOLOGICAL AGENTS - MISC.

ANTIHEMOPHILIC PRODUCTS

ADVATE INJ	MSP-PA	B
ALPHANATE/HEMOPIL/KOATE INJ	MSP-PA	B
ALPHANINE SD/MONONINE INJ	MSP-PA	B
BEBULIN/PROFILNINE INJ	MSP-PA	B
BENEFIX INJ	MSP-PA	B
BENEFIX/RIXUBIS INJ	MSP-PA	B
FEIBA INJ	MSP-PA	B
HELIXATE/KOGENATE INJ	MSP-PA	B
HEMLIBRA INJ	LMSP-PA	B
HUMATE-P/WILATE INJ	MSP-PA	B
MONOCLATE-P INJ	MSP-PA	B
NOVOSEVEN INJ	MSP-PA	B
RECOMBINATE INJ	MSP-PA	B
RIASTAP INJ	MSP-PA	B
XYNTHA INJ	MSP-PA	B
AFSTYLA KIT	-	NC

BRADYKININ B2 RECEPTOR ANTAGONISTS

icatibant inj (FIRAZYR equiv)	LMSP-PA	B
FIRAZYR INJ	-	NC

COMPLEMENT INHIBITORS

BERINERT INJ (Only available through Walgreens 888-347-3416)	LD-PA	B
CINRYZE INJ (QL= 16 vials/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
HAEGARDA INJ	MSP-PA	B
RUCONEST INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B

HEMATAOLOGIC - TYROSINE KINASE INHIBITORS

TAVALISSE TAB (QL= 2 tab/day; Only available through Biologics 800-850-4306)	LD-PA-QL-SF	B
--	-------------	---

HEMATORHEOLOGIC AGENTS

pentoxifylline ER tab (TRENTAL equiv)	-	G
---------------------------------------	---	---

PLASMA KALLIKREIN INHIBITORS

TAKHZYRO INJ (QL= 2 inj/28 days; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B
ORLADEYO CAP	-	NC

PLATELET AGGREGATION INHIBITORS

BRILINTA 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
HEMATOLOGICAL AGENTS - MISC. Cont.		
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 (AGGRENEX equiv)	-	G
cilostazol tab (PLETAL equiv)	-	G
clopidogrel tab 75mg (PLAVIX equiv)	-	G
dipyridamole tab (PERSANTINE equiv)	-	G
prasugrel tab (EFFIENT equiv)	-	G
ticlopidine tab (TICLID equiv)	-	G
AGGRENEX CAP	-	NC
ASPIRIN/OMEPRAZOLE ER TAB	-	NC
CLOPIDOGREL THERAPY PACK	-	NC
PLAVIX TAB 300MG	-	NC
YOSPRALA TAB	-	NC

HEMATOPOIETIC AGENTS

AGENTS FOR GAUCHER DISEASE

CEREZYME INJ	MSP-PA	B
miglustat cap (ZAVESCA equiv) (Only available through Accredo 800-803-2523)	LD-PA	B
VPRIV INJ	MSP-PA	B
CERDELGA CAP	-	NC
ZAVESCA CAP	-	NC

AGENTS FOR SICKLE CELL ANEMIA

DROXIA CAP	-	B
SIKLOS TAB	-	NC

AGENTS FOR SICKLE CELL DISEASE

ENDARI POWDER PACK (QL= 6 packets/day)	LMSP-PA-QL	B
OXBRYTA TAB (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767)	LD-PA-QL	B

COBALAMINS

NASCOBAL NASAL SPRAY	-	B
cyanocobalamin inj	-	G
CALOMIST NASAL SPRAY	-	NC

FOLIC ACID/FOLATES

folic acid tab 1mg (Covered at \$0 for females only; All other members covered at generic copay)	-	\$0
folic acid tab 400mcg (Covered for females only)	OTC	\$0
folic acid tab 800mcg (Covered for females only)	OTC	\$0

HEMATOPOIETIC GROWTH FACTORS

DOPTELET TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
FULPHILA INJ	LMSP	B
NEUMEGA INJ	LMSP	B
NIVESTYM INJ	LMSP	B
NPLATE INJ	MSP-PA	B
PROMACTA POWDER	LMSP-PA	B
PROMACTA TAB	LMSP-PA	B
RETACRIT INJ	MSP	B
ZARXIO 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
HEMATOPOIETIC AGENTS Cont.		
ZIEXTENZO INJ	MSP	B
ARANESP INJ	-	NC
EPOGEN INJ	-	NC
GRANIX INJ	-	NC
LEUKINE INJ	-	NC
MIRCERA INJ	-	NC
MULPLETA TAB	-	NC
NEULASTA INJ	-	NC
NEUPOGEN INJ	-	NC
NYVEPRIA INJ	-	NC
PROCRIT INJ	-	NC
REBLOZYL INJ	-	NC
UDENYCA INJ	-	NC
HEMATOPOIETIC MIXTURES		

NEPHRON FA TAB	-	B
ferrex 150 forte cap	-	G
ferrex 150 forte cap (NIFEREX 150 FORTE equiv)	-	G
folbee tab	-	G
MULTIGEN FOLIC TAB	-	G
MULTIGEN PLUS TAB	-	G
MULTIGEN TAB	-	G
tricon cap (TRINSICON equiv)	-	G
BIFERARX TAB	-	NC
B-SERENE PAD	-	NC
CORVITE 150 TAB	-	NC
CYFOLEX CAP	-	NC
FEONYX TAB	-	NC
FOLITE TAB	-	NC
folvite-d tab (GENICIN VITA-D equiv)	-	NC
FOLVITE-FE TAB	-	NC
OVEEZA CAP	-	NC
PUREFOLIX TAB	-	NC

IRON

ferrous sulfate elixir (Covered for members 1 year or younger)	OTC	\$0
FERROUS SULFATE LIQUID (Covered for members 1 year or younger)	OTC	\$0
ferrous sulfate soln (Covered for members 1 year or younger)	OTC	\$0
ferrous sulfate syrup (FERROUS SULFATE equiv) (Covered for members 1 year or younger)	OTC	\$0
IRON SUSP (Covered for members 1 year or younger)	OTC	\$0

STEM CELL MOBILIZERS

MOZOBIL INJ	MSP-PA	B
-------------	--------	---

HEMOSTATICS

HEMOSTATICS - SYSTEMIC

AMICAR SYRUP	-	B
aminocaproic acid soln (AMICAR equiv)	-	G
aminocaproic acid syrup (AMICAR equiv)	-	G
aminocaproic acid tab (AMICAR 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
HEMOSTATICS Cont.		
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		
ANTIHISTAMINE HYPNOTICS		
diphenhydramine cap 50mg (BENADRYL equiv) (Only 50mg covered)	-	G
BARBITURATE HYPNOTICS		
BUTISOL ELIXIR	-	B
BUTISOL TAB	-	B
SECONAL CAP	-	B
phenobarbital elixir	-	G
phenobarbital tab	-	G
HYPNOTICS - TRICYCLIC AGENTS		
doxepin tab (SILENOR equiv)	-	NC
NON-BARBITURATE HYPNOTICS		
SOMNOTE CAP	-	B
estazolam tab (PROSOM equiv)	-	G
eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day)	QL	G
FLURAZEPAM CAP	-	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)	-	G
AMBIEN CR TAB	-	NC
DORAL TAB	-	NC
EDLUAR SL TAB	-	NC
INTERMEZZO SL TAB	-	NC
zolpidem ER tab (AMBIEN CR equiv)	-	NC
zolpidem tartrate SL tab (INTERMEZZO equiv)	-	NC
ZOLPIMIST SPRAY	-	NC
OREXIN RECEPTOR ANTAGONISTS		
DAYVIGO TAB	-	NC
SELECTIVE MELATONIN RECEPTOR AGONISTS		
HETLIOZ CAP	-	NC
ramelteon tab (ROZEREM equiv)	-	NC
ROZEREM TAB	-	NC
LAXATIVES		
LAXATIVE COMBINATIONS		

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
LAXATIVES Cont.		
GAVILYTE-C SOLN (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
peg 3350/electrolytes soln (COLYTE equiv) (Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay)	QL	\$0
trilyte soln (NULYTELY equiv) (Covered at \$0 for members 50-75 years, all other members covered at generic copay; Limited to 2 fills/calendar year)	QL	\$0
CLENPIQ SOLN	-	B
HALFLYTELY BOWEL PREP KIT	PA	B
MOVIPREP SOLN (Step Therapy requires trial of CLENPIQ)	ST	B
SUCLEAR KIT	PA	B
SUPREP SOLN	PA	B
GOLYTELY PACKET	PA	G
peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (Step Therapy requires trial of CLENPIQ)	ST	G
COLYTE SOLN	-	NC
gavilyte-h kit	-	NC
GOLYTELY SOLN	-	NC
PLENVU SOLN	-	NC
PREPOPIK PAK	-	NC
SUTAB TAB	-	NC
LAXATIVES - MISCELLANEOUS		
lactulose soln	-	G
polyethylene glycol 3350 powder (MIRALAX equiv)	-	G
GIALAX KIT	-	NC
KRISTALOSE PACK	-	NC
KRISTALOSE PACKET	-	NC
MIRALAX PACKET	-	NC
SALINE LAXATIVES		
VISICOL TAB	-	B
OSMOPREP TAB	-	NC
LOCAL ANESTHETICS-PARENTERAL		
LOCAL ANESTHETIC COMBINATIONS		
ROPIVICAIN/CLONIDINE/KETOROLAC INJ	-	NC
MACROLIDES		
AZITHROMYCIN		
ZITHROMAX POWDER PACK	-	B
ZMAX SUSP	-	B
azithromycin susp (ZITHROMAX equiv)	-	G
azithromycin tab (ZITHROMAX equiv)	-	G
CLARITHROMYCIN		
CLARITHROMYC SUSP	-	B
clarithromycin susp (BIAXIN equiv)	-	G
clarithromycin tab (BIAXIN equiv)	-	G
BIAXIN XL TAB	-	NC
clarithromycin ER tab (BIAXIN XL equiv)	-	NC
ERYTHROMYCINS		
ERYTHROMYCIN EC CAP (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
MACROLIDES Cont.		
erythromycin DR cap (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	ST	G
erythromycin ethylsuccinate susp (ERYPED equiv) (Step Therapy requires trial of azithromycin or clarithromycin)	ST	G
erythromycin stearate tab (Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg)	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 doxycycline hyclate 100mg)	ST	G
ERYPED SUSP	-	NC
ERYTHROMYCIN ETHYLSUCCINATE TAB	-	NC

FIDAXOMICIN

DIFICID SUSP (QL= 136 mL/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN)	QL-ST	B
DIFICID TAB (QL= 20 tabs/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN)	QL-ST	B

MEDICAL DEVICES AND SUPPLIES

CONTRACEPTIVES

CERVICAL CAP	-	\$0
DIAPHRAGM	-	\$0
FEMALE CONDOMS	OTC	\$0

DIABETIC SUPPLIES

FREESTYLE FREEDOM LITE METER	OTC	\$0
FREESTYLE LITE METER	OTC	\$0
FREESTYLE PRECISION NEO METER	OTC	\$0
ONETOUCH METER	OTC	\$0
PRECISION XTRA METER	OTC	\$0
ACCU-CHEK AVIVA PLUS METER	OTC-PA	B
ACCU-CHEK GUIDE CARE METER	OTC-PA	B
ACCU-CHEK GUIDE ME KIT	OTC-PA	B
ACCU-CHEK NANO METER	OTC-PA	B
DIABETIC METER (all other diabetic meters)	OTC-PA	B
OMNIPOD 5 PACK PODS (QL= 10 pods/month)	QL	B
OMNIPOD DASH PODS (QL= 10 pods/month)	QL	B
OMNIPOD STARTER KIT (QL= 1 kit/year)	QL	B
V-GO INJ KIT (QL= 1 kit/day)	QL	B
CALIBRATION LIQUID	OTC	G
DEXCOM G6 RECEIVER (QL= 1 receiver/year)	PA-QL	G
DEXCOM G6 SENSOR (QL= 3 sensors/28 days)	PA-QL	G
DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days)	PA-QL	G
FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year)	PA-QL	G
FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days)	PA-QL	G
FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year)	PA-QL	G
FREESTYLE LIBRE SENSOR (10-DAY) (QL= 3 sensors/30 days)	PA-QL	G
FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days)	PA-QL	G
LANCET KIT	OTC	G
LANCETS	OTC	G

MISC. DEVICES

ALCOHOL SWABS	OTC	NC
---------------	-----	----

ORAL HYGIENE PRODUCTS

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

MEDICAL DEVICES AND SUPPLIES Cont.

HURRISEAL MIS SNAP	-	NC
--------------------	---	----

PARENTERAL THERAPY SUPPLIES

NOVOPEN ECHO	-	B
B-D INSULIN SYRINGE	--OTC	G
B-D PEN NEEDLE	OTC	G
NOVOFINE PEN NEEDLE	OTC	G
NOVOTWIST PEN NEEDLE	OTC	G
NOVOTWIST/NOVOFINE PEN NEEDLE	OTC	G
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

NURTEC ODT (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B
AJOVY INJ	-	NC

MIGRAINE COMBINATIONS

ISOMETHEPTENE/CAFFEINE/ACETAMINOPHEN TAB	-	B
MIGERGOT SUPP (QL=20 tabs/30 days)	QL	B
ergotamine/caffeine tab (CAFERGOT equiv) (QL= 40 tabs/30 days)	QL	G
isometheptene/caffeine/acetaminophen tab (PRODRIN equiv)	-	G
ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP	-	NC
acetaminophen/isometheptene/dichloral cap (MIDRIN equiv)	-	NC
PRODRIN TAB	-	NC
SUMANSETRON PAK	-	NC
sumatriptan/naproxen tab (TREXIMET equiv)	-	NC
TREXIMET TAB	-	NC

MIGRAINE PRODUCTS

dihydroergotamine mesylate nasal spray (MIGRANAL equiv) (QL= 8 sprays/fill, 2 fills/30 days)	PA-QL	G
dihydroergotamine mesylate inj (D.H.E. equiv)	-	NC

MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES

AIMOVIG 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
UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year)	PA-QL	B
AJOVY INJ	-	NC

MIGRAINE PRODUCTS - NSAIDS

CAMBIA POWDER PACKET	-	NC
----------------------	---	----

SEROTONIN AGONISTS

REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year)	PA-QL	B
ZOLMITRIPTAN SPRAY, 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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
MIGRAINE PRODUCTS Cont.		
rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days)	QL	G
sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days)	QL	G
SUMATRIPTAN INJ 6MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days)	QL	G
sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 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= 5 inj/fill, 2 fills/30 days)	QL	G
zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G
zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days)	PA-QL	G
almotriptan tab (AXERT equiv)	-	NC
ALSUMA INJ, ZEMBRACE SYMTOUCH INJ	-	NC
AMERGE TAB	-	NC
AXERT TAB	-	NC
eletriptan tab (RELPAK equiv)	-	NC
FROVA TAB	-	NC
frovatriptan tab (FROVA equiv)	-	NC
IMITREX NASAL SPRAY, SUMATRIPTAN NASAL SPRAY	-	NC
IMITREX TAB	-	NC
MAXALT MLT TAB	-	NC
MAXALT TAB	-	NC
ONZETRA XSAIL	-	NC
RELPAK TAB	-	NC
SUMAVEL DOSEPRO INJ	-	NC
TOSYMRA SOLN	-	NC
ZECUITY PAD	-	NC
ZOMIG TAB	-	NC

MINERALS & ELECTROLYTES

FLUORIDE

FLUORABON SOLN (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand copay)	-	\$0
sodium fluoride chew tab (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE LOZENGE (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
sodium fluoride soln (LURIDE equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
SODIUM FLUORIDE TAB (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
FLUOR-A-DAY CHEW TAB	-	G

PHOSPHATE

K-PHOS TAB	-	B
phospha 250 neutral tab (K-PHOS NEUTRAL equiv)	-	G

POTASSIUM

KLOR-CON M15 TAB	-	B
KLOR-CON POWDER PACKET 25MEQ	-	B
K-TAB	-	G
POT/CHLORIDE EFFER TAB	-	G
potassium bicarbonate effer tab (K-LYTE equiv)	-	G
potassium chloride effer tab (K-LYTE/CL 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
MINERALS & ELECTROLYTES Cont.		
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
ZINC		
GALZIN CAP	-	B
zinc sulfate cap	-	G
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
trientine cap (SYPRINE equiv)	MSP-PA	B
penicillamine tab (DEPEN TITRATAB equiv)	-	G
penicillamine cap (CUPRIMINE equiv)	-	NC
IMMUNOSUPPRESSIVE AGENTS		
everolimus tab 0.25mg, 0.5mg, 0.75mg (ZORTRESS equiv)	PA	G
sirolimus soln (RAPAMUNE equiv)	-	G
ASTAGRAF XL CAP	-	NC
ENSPRYNG INJ	-	NC
PROGRAF PACKET	-	NC
POTASSIUM REMOVING AGENTS		
LOKELMA PAK	PA	B
SPS SUSP	-	G
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP	-	NC
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
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
FIRST MOUTHWASH BLM	-	B
LIDOCAINE ORAL SOLN 4%	-	B
lidocaine viscous soln	-	G
ANTIALLERGY AGENTS - MOUTH/THROAT		
APHTHASOL PASTE	-	B
ANTI-INFECTIVES - THROAT		
ORAVIG TAB	-	B
clotrimazole troches (MYCELEX TROCHES equiv)	-	G
nystatin susp	-	G
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln (PERIDEX equiv)	-	G
DENTAL PRODUCTS		
PREVIDENT 5000 PLUS CREAM (Covered at \$0 for members 5 years or younger; All other members covered at preferred brand 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.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
MOUTH/THROAT/DENTAL AGENTS Cont.		
sodium fluoride cream (PREVIDENT equiv) (Covered at \$0 for members 5 years or younger; All other members covered at generic copay)	-	\$0
PREVIDENT PASTE	-	B
PREVIDENT RINSE	-	B
sodium fluoride gel (PREVIDENT equiv)	-	G
sodium fluoride paste (PREVIDENT equiv)	-	G
sodium fluoride rinse (PREVIDENT equiv)	-	G
sodium fluoride/potassium nitrate paste (PREVIDENT equiv)	-	G
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
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
DIALYVITE TAB	-	G
dialyvite tab (NEPHRO-VITE equiv)	-	G
DIALYVITE/ZINC TAB	-	G
FOLBEE PLUS CZ TAB	-	G
renaphro cap (NEPHROCAP equiv)	-	G
FIBRIK CAP	-	NC
NEPHRO-VITE TAB	-	NC
MULTIPLE VITAMINS & FLUORIDE-FOLIC ACID		
MULTIVITAMIN/FLUORIDE CHEW TAB	-	NC
MULTIPLE VITAMINS W/ MINERALS		
multivitamin/minerals tab (STROVITE equiv)	-	G
MULTIVITAMIN/MINERALS TAB	-	NC
REMEDIENT CAP	-	NC
VITRECYL IRON TAB	-	NC
VITRECYL TAB	-	NC
MULTIVITAMINS		
FOLIKA-V TAB	-	NC
PED MULTI VITAMINS W/FL & FE		
pediatric multiple vitamins/fluoride/iron soln	-	G
PED MV W/ FLUORIDE		
FLORIVA PLUS DROPS	-	B
QUFLORA PEDIATRIC CHEW TAB	-	B
MULTIVITAMIN/FLUORIDE CHEW 0.25MG	-	G
MULTIVITAMIN/FLUORIDE CHEW 1MG	-	G
MULTIVITAMIN/FLUORIDE CHEW TAB	-	G
pediatric multiple vitamins/fluoride chew tab	-	G
pediatric multiple vitamins/fluoride soln	-	G
POLY-VI-FLOR 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
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
VINATE M	-	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
MYNATAL-Z TAB	-	NC
NATACHEW	-	NC
NEEVO DHA	-	NC
NESTABS ABC	-	NC
NESTABS DHA	-	NC
NESTABS ONE	-	NC
NEXA PLUS	-	NC
OB COMPLETE ONE	-	NC
OB COMPLETE PETITE	-	NC
OB COMPLETE PREMIER	-	NC
PREFERA OB	-	NC
PREFERA OB ONE	-	NC
PRENA1 CHEW	-	NC
PRENA1 PEARL, VITAPEARL	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
MULTIVITAMINS Cont.		
PRENA1 TRUE, VITATRUE	-	NC
PRENARA CAP	-	NC
PRENATE AM	-	NC
PRENATE CHEWABLE	-	NC
PRENATE DHA	-	NC
PRENATE ELITE	-	NC
PRENATE ESSENTIAL	-	NC
PRENATE MINI	-	NC
PRENATE MINI, TRISTART DHA	-	NC
PRENATE TAB	-	NC
PRIMACARE	-	NC
PROVIDA DHA	-	NC
PROVIDA OB	-	NC
SELECT OB + DHA	-	NC
THRIVITE RX	-	NC
TRICARE PRENATAL CHEWABLE	-	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

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)	PA	G
tizanidine tab (ZANAFLEX equiv)	-	G
BACLOFEN TAB 5MG	-	NC
carisoprodol tab 250mg (SOMA equiv)	-	NC
chlorzoxazone tab	-	NC
CHLORZOXAZONE TAB 250MG	-	NC
CHLORZOXAZONE TAB 250MG, LORZONE TAB	-	NC
CYCLOBENZAPRINE COMPOUND KIT	-	NC
cyclobenzaprine ER cap (AMRIX equiv)	-	NC
cyclobenzaprine tab 7.5mg (FEXMID equiv)	-	NC
FIRST BACLOFEN SUSP KIT	-	NC
metaxalone tab (SKELAXIN equiv)	-	NC
METAXALONE TAB 400MG	-	NC
OZOBAX SOLN	-	NC
SOMA TAB 250MG	-	NC

DIRECT MUSCLE RELAXANTS

dantrolene cap (DANTRIUM 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

MUSCULOSKELETAL THERAPY AGENTS Cont.

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
orphenadrine/aspirin/caffeine tab (NORGESIC FORTE equiv)	-	NC
TIZANIDINE COMFORT KIT	-	NC

VISCOSUPPLEMENTS

DUROLANE INJ	MSP-PA	B
EUFLEXXA/SUPARTZ INJ	MSP-PA	B
GELSYN-3 INJ	MSP-PA	B
SYNVISC INJ	MSP-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

NASAL AGENTS - MISC.

ALZAIR NASAL SPRAY	-	NC
TICANASE PAK	-	NC

NASAL ANESTHETICS

GOPRELTO 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 ANTI-INFECTIVES

BACTROBAN NASAL OINT (QL= 10 tubes/fill)	QL	B
--	----	---

NASAL STEROIDS

BECONASE AQ NASAL SPRAY	-	EXC
budesonide nasal spray (RHINOCORT AQUA equiv)	OTC	EXC
FLUNISOLIDE NASAL SPRAY (NASAREL equiv)	-	EXC
fluticasone nasal spray (FLONASE equiv)	-	EXC
mometasone nasal spray (NASONEX equiv)	-	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.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
NASAL AGENTS - SYSTEMIC AND TOPICAL Cont.		
NASACORT OTC NASAL SPRAY	OTC	EXC
OMNARIS NASAL SPRAY	-	EXC
QNASL NASAL SPRAY	-	EXC
SINUVA NASAL IMPLANT	-	EXC
triamcinolone OTC nasal spray (NASACORT equiv)	OTC	EXC
VERAMYST NASAL SPRAY	-	EXC
XHANCE NASAL EXHALER	-	EXC
ZETONNA NASAL SPRAY	-	EXC
SYMPATHOMIMETIC DECONGESTANTS		
epinephrine hcl nasal soln (ADRENALIN equiv)	-	NC
NEUROMUSCULAR AGENTS		
ALS AGENTS		
riluzole tab (RILUTEK equiv)	-	G
TIGLUTIK SUSP	-	NC
NEUROMUSCULAR BLOCKING AGENT - NEUROTOXINS		
BOTOX INJ	MSP-PA	B
DYSPOIN INJ	MSP-PA	B
XEOMIN INJ	MSP-PA	B
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
EVRYSDI SOLN	-	NC
NUTRIENTS		
LIPIDS		
DOJOLVI ORAL LIQUID	-	NC
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT OPHTH INSERT	-	NC
BETA-BLOCKERS - OPHTHALMIC		
BETIMOL OPHTH SOLN	-	B
BETOPTIC-S OPHTH SOLN	-	B
COMBIGAN OPHTH SOLN	-	B
DORZOLAMIDE/TIMOLOL OPHTH SOLN	-	B
ISTALOL OPHTH SOLN	-	B
METIPRANOLOL OPHTH SOLN	-	B
TIMOLOL OPHTH GEL SOLN	-	B
TIMOPTIC OCULOSE OPHTH SOLN 0.25%	-	B
betaxolol ophth soln (BETOPTIC-S 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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
CYCLOPLEGIC MYDRIATICS		
CYCLOMYDRIL OPHTH SOLN	-	B
HOMATROPINE OPHTH SOLN	-	B
ISOPTO HYOSCINE OPHTH SOLN	-	B
atropine ophth oint	-	G
atropine ophth soln (ISOPTO ATROPINE equiv)	-	G
cyclopentolate ophth soln (CYCLOGYL equiv)	-	G
homatropine ophth soln (ISOPTO HOMATROPINE equiv)	-	G
phenylephrine ophth soln (MYDFRIN equiv)	-	G
tropicamide ophth soln (MYDRIACYL equiv)	-	G
TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN	-	NC
MIOTICS		
ISOPTO CARBACHOL OPHTH SOLN	-	B
PHOSPHOLINE OPHTH SOLN	-	B
PILOPINE HS OPHTH GEL	-	B
pilocarpine ophth soln (ISOPTO CARPINE equiv)	-	G
OPHTHALMIC - ANGIOGENESIS INHIBITORS		
LUCENTIS INJ	MSP-PA	B
MACUGEN INJ	MSP-PA	B
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P OPHTH SOLN 0.1%	-	B
IOPIDINE OPHTH SOLN 1%	-	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
ALPHAGAN P OPHTH SOLN 0.15%	-	NC
LUMIFY OPHTH SOLN 0.25%	-	NC
OPHTHALMIC ANTI-INFECTIVES		
AZASITE SOLN	-	B
BACITRACIN OPHTH OINT	-	B
CILOXAN OPHTH OINT	-	B
TOBREX OPHTH OINT	-	B
ZIRGAN OPHTH GEL	-	B
bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv)	-	G
bacitracin/polymyxin b ophth oint (POLYSPORIN equiv)	-	G
ciprofloxacin ophth soln (CILOXAN equiv)	-	G
erythromycin ophth oint	-	G
gatifloxacin ophth soln (ZYMAXID equiv)	-	G
GENTAK OPHTH OINT	-	G
gentamicin ophth oint (GARAMYCIN equiv)	-	G
gentamicin ophth soln (GARAMYCIN equiv)	-	G
levofloxacin ophth soln (QUIXIN equiv)	-	G
moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv)	-	G
NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN	-	G
ofloxacin ophth soln (OCUFLOX 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
polymyxin b/trimethoprim ophth soln (POLYTRIM equiv)	-	G
sulfacetamide sodium ophth soln (BLEPH-10 equiv)	-	G
tobramycin ophth soln (TOBREX equiv)	-	G
TRIFLURIDINE OPHTH SOLN	-	G
trifluridine ophth soln (VIROPTIC equiv)	-	G
BESIVANCE OPHTH SUSP	-	NC
MOXEZA OPHTH SOLN	-	NC
moxifloxacin hcl ophth soln 0.5% (MOXEZA equiv)	-	NC
MOXIFLOXACIN SOLN	-	NC
VANCOMYCIN SOLN	-	NC
VIGAMOX OPHTH SOLN	-	NC
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS OPHTH EMULSION	PA	B
CEQUA (PF) OPHTH SOLN	-	NC
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA OPHTH SOLN	PA	B
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA OPHTH SOLN	-	NC
ROCKLATAN OPHTH SOLN	-	NC
OPHTHALMIC LOCAL ANESTHETICS		
proparacaine ophth soln (ALCAINE equiv)	-	G
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
OPHTHALMIC STEROIDS		
ALREX OPHTH SUSP	-	B
BLEPHAMIDE OPHTH SOLN	-	B
BLEPHAMIDE S.O.P. OPHTH OINT	-	B
DUREZOL OPHTH EMULSION	-	B
FLAREX OPHTH SUSP	-	B
FML FORTE OPHTH SUSP	-	B
FML S.O.P. OPHTH OINT	-	B
LOTEMAX OPHTH GEL	-	B
LOTEMAX OPHTH OINT	-	B
MAXIDEX OPHTH SOLN	-	B
PRED FORTE OPHTH SUSP	-	B
PRED MILD OPHTH SOLN	-	B
PRED-G OPHTH SOLN	-	B
TOBRADEX OPHTH OINT	-	B
TOBRADEX ST OPHTH SUSP	-	B
VEXOL OPHTH SUSP	-	B
ZYLET OPHTH SUSP (QL= 5ml/fill (10ml bottle is Not Covered))	QL	B
bacitracin/polymyxin/neomycin/hydrocortisone ophth oint (CORTISPORIN 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
dexamethasone ophth soln	-	G
fluorometholone ophth soln (FML LIQUIFILM equiv)	-	G
loteprednol ophth susp (LOTEMAX equiv)	-	G
neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv)	-	G
neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv)	-	G
NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN	-	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
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
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
OPHTHALMICS - MISC.		
ACUVAIL OPHTH SOLN	-	B
ALAMAST OPHTH SOLN	-	B
ALOCRILOPHTH SOLN	-	B
ALOMIDE 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
PROLENSA OPHTH SOLN	-	B
ketotifen ophth soln (ZADITOR equiv)	OTC	EXC
azelastine ophth soln (OPTIVAR equiv)	-	G
bromfenac ophth soln (BROMDAY equiv)	-	G
cromolyn ophth soln (CROLOM equiv)	-	G
diclofenac sodium ophth soln (VOLTAREN equiv)	-	G
dorzolamide ophth soln (TRUSOPT equiv)	-	G
epinastine ophth soln (ELESTAT equiv)	-	G
FLURBIPROFEN OPHTH SOLN	-	G
flurbiprofen ophth soln (OCUFEN equiv)	-	G
ketorolac ophth soln (ACULAR (LS) equiv)	-	G
olopatadine ophth soln 0.1% (PATANOL 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.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
OPHTHALMIC AGENTS Cont.		
olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%)	QL-ST	G
BEPREVE OPHTH SOLN	-	NC
BROMSITE OPHTH SOLN	-	NC
EMADINE OPHTH SOLN	-	NC
LASTACFT OPHTH SOLN	-	NC
PAZEO OPHTH SOLN 0.7%	-	NC
UPNEEQ SOLN	-	NC
ZADITOR OPHTH SOLN	OTC	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
LUMIGAN OPHTH SOLN	-	NC
VYZULTA SOLN	-	NC
XELPROS OPHTH EMULSION	-	NC
ZIOPTAN OPHTH SOLN	-	NC
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln (VOSOL equiv)	-	G
ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	-	G
OTIC ANTI-INFECTIVES		
CIPROFLOXACIN OTIC SOLN	-	B
ofloxacin otic soln (FLOXIN equiv)	-	G
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
neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv)	-	G
neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv)	-	G
antipyrine/benzocaine otic soln (AURALGAN equiv)	-	NC
CORTANE-B AQUEOUS OTIC SOLN	-	NC
CORTANE-B OTIC SOLN	-	NC
otomax-HC otic soln (CORTANE-B equiv)	-	NC
OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN	-	NC
OTOZIN OTIC DROPS	-	NC
pramoxine-HC AQ otic soln (CORTANE-B AQUEOUS equiv)	-	NC
OTIC STEROIDS		
ACETASOL HC OTIC SOLN	-	B
acetic acid/hydrocortisone otic soln (VOSOL HC equiv)	-	G
fluocinolone otic oil (DERMOTIC equiv)	-	G
OXYTOCICS		
OXYTOCICS		
methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days)	QL	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
PASSIVE IMMUNIZING AGENTS		
IMMUNE SERUMS		
CARIMUNE INJ	MSP-PA	B
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	MSP-PA	B
GAMASTAN S/D 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		
HIZENTRA INJ	MSP-PA	B
XEMBIFY INJ (Only available through CVS Specialty 800-237-2767)	LD-PA	B
CUTAQUIG INJ	-	NC

PENICILLINS

AMINOPENICILLINS		
amoxicillin cap (TRIMOX equiv)	-	G
AMOXICILLIN CHEW TAB	-	G
amoxicillin susp (TRIMOX equiv)	-	G
amoxicillin tab (AMOXIL equiv)	-	G
ampicillin cap (PRINCIPEN equiv)	-	G
ampicillin susp (PRINCIPEN equiv)	-	G
MOXATAG TAB	-	NC
MOXATAG TAB 775MG	-	NC

NATURAL PENICILLINS		
penicillin vk soln (VEETIDS equiv)	-	G
penicillin vk tab (VEETIDS equiv)	-	G

PENICILLIN COMBINATIONS		
AMOXICILLIN/CLAVULANATE ER TAB	-	B
amoxicillin/clavulanate chew tab (AUGMENTIN equiv)	-	G
amoxicillin/clavulanate ER tab (AUGMENTIN XR equiv)	-	G
amoxicillin/clavulanate susp (AUGMENTIN ES equiv)	-	G
amoxicillin/clavulanate tab (AUGMENTIN equiv)	-	G

PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin cap (DYNAPEN equiv)	-	G

PHARMACEUTICAL ADJUVANTS

SEMI SOLID VEHICLES		
POLYETHYLENE GLYCOL 8000 GRANULES	-	B

PROGESTINS

PROGESTINS		
medroxyprogesterone tab (PROVERA equiv)	-	G
megestrol ES susp (MEGACE ES equiv)	-	G
norethindrone tab (AYGESTIN equiv)	-	G
progesterone cap (PROMETRIUM 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

PROGESTINS Cont.

progesterone oil inj	-	G
----------------------	---	---

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

AGENTS FOR CHEMICAL DEPENDENCY

LUCEMYRA TAB (QL= 84 tabs/7 days)	PA-QL	B
acamprosate calcium DR tab (CAMPRAL equiv)	-	G
DISULFIRAM TAB	-	G
disulfiram tab (ANTABUSE equiv)	-	G

ANTI-CATAPLECTIC AGENTS

XYREM SOLN (QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 314-587-4050)	LD-PA-QL	B
XYWAV SOLN	-	NC

ANTIDEMENTIA AGENTS

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
rivastigmine cap (EXELON equiv)	-	G
rivastigmine patch (EXELON equiv)	-	G
memantine ER cap (NAMENDA XR equiv)	-	NC
NAMENDA XR CAP	-	NC
NAMENDA XR TITRATION PACK	-	NC
NAMZARIC CAP	-	NC
NAMZARIC STARTER PACK	-	NC

COMBINATION PSYCHOTHERAPEUTICS

CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB	-	G
olanzapine/fluoxetine cap (SYMBYAX equiv)	-	G
PERPHENAZINE/ AMITRIPTYLINE TAB	-	G

FIBROMYALGIA AGENTS

SAVELLA PAK	-	B
SAVELLA TAB (QL= 2 tabs/day)	QL	B

HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS

ADDYI TAB	-	NC
VYLEESI INJ	-	NC

MOVEMENT DISORDER DRUG THERAPY

AUSTEDO TAB (QL= 4 tabs/day)	LMSP-PA-QL	B
INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479)	LD-PA-QL	B
tetrabenazine tab (XENAZINE equiv)	LMSP-PA	B
INGREZZA PACK 40-80MG	-	NC
XENAZINE TAB	-	NC

MULTIPLE SCLEROSIS AGENTS

AUBAGIO TAB	LMSP-PA	B
AVONEX 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.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.		
dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day)	LMSP-PA-QL	B
dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv)	LMSP	B
EXTAVIA INJ	LMSP-PA	B
GILENYA CAP	LMSP-PA	B
glatiramer inj (COPAXONE equiv)	LMSP-PA	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	LMSP-PA	B
ZEPOSIA STARTER PACK	LMSP-PA	B
dimethyl fumarate DR cap (TECFIDERA equiv)	LMSP	G
BAFIERTAM CAP	-	NC
BETASERON INJ	-	NC
MAVENCLAD PAK	-	NC
TECFIDERA CAP	-	NC
TECFIDERA STARTER PACK	-	NC
VUMERITY CAP	-	NC
ZINBRYTA INJ	-	NC
POSTHERPETIC NEURALGIA (PHN) AGENTS		
GRALISE TAB	-	NC
LYRICA CR TAB	-	NC
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
LIDOTIN PAK	-	NC
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
FLUOXETINE CAP (PMDD)	-	NC
SARAFEM TAB	-	NC
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUEDEXTA CAP (QL= 2 caps/day)	PA-QL	B
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
PIMOZIDE TAB	-	B
ERGOLOID MESYLATES TAB	-	NC
ergoloid mesylates tab (HYDERGINE equiv)	-	NC
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB	-	NC
SMOKING DETERRENENTS		
bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX PAK (Limited to 180 days/plan year)	QL-SMKG	\$0
CHANTIX TAB (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

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

** OTC drugs are not a covered benefit.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont.

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

TRANSTHYRETIN AMYLOIDOSIS AGENTS

TEGSEDI INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523)	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	MSP-PA	B
GLASSIA INJ	MSP-PA	B

CYSTIC FIBROSIS AGENTS

KALYDECO PAK (QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B
KALYDECO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B
ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B
ORKAMBI TAB (QL= 4 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B
PULMOZYME INH SOLN	LMSP	B
SYMDEKO TAB (QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL-SF	B
TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416)	LD-PA-QL	B

PULMONARY FIBROSIS AGENTS

ESBRIET CAP (QL= 9 caps/day)	LMSP-PA-QL-SF	B
ESBRIET TAB 267MG (QL= 9 tabs/day)	LMSP-PA-QL-SF	B
ESBRIET TAB 801MG (QL= 3 tabs/day)	LMSP-PA-QL-SF	B
OFEV CAP (QL= 2 caps/day; Only available through Walgreens 888-347-3416)	LD-PA-QL-SF	B

SULFONAMIDES

SULFONAMIDES

SULFADIAZINE TAB	-	G
------------------	---	---

TETRACYCLINES

AMINOMETHYLCYCLINES

NUZYRA TAB (QL= 2 tabs/day, 30 tabs/180 days; Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416)	LD-QL-RS	B
--	----------	---

TETRACYCLINES

ORAXYL CAP	-	B
VIBRAMYCIN SYRUP	-	B
doxycycline hyclate cap (VIBRAMYCIN equiv)	-	G
doxycycline hyclate DR tab (DORYX equiv)	PA	G
doxycycline hyclate tab (VIBRATAB equiv)	-	G
doxycycline monohydrate cap (MONODOX equiv)	-	G
doxycycline monohydrate tab (ADOXA equiv)	-	G
doxycycline susp (VIBRAMYCIN equiv)	-	G
minocycline cap (MINOCIN 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
TETRACYCLINES Cont.		
minocycline tab (DYNACIN equiv) (Step therapy requires trial of minocycline caps)	ST	G
ACTICLATE TAB 75MG, 150MG	-	NC
ADOXA CAP 150MG	-	NC
ADOXA TAB 150MG	-	NC
ADOXA TAB 75MG	-	NC
demeclocycline tab (DECLOMYCIN equiv)	-	NC
DORYX MPC TAB	-	NC
doxycycline hyclate tab 75mg, 150mg	-	NC
doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv)	-	NC
doxycycline monohydrate cap 150mg (ADOXA equiv)	-	NC
doxycycline monohydrate cap 75mg (MONODOX equiv)	-	NC
doxycycline monohydrate tab 150mg (ADOXA equiv)	-	NC
doxycycline monohydrate tab 75mg (ADOXA equiv)	-	NC
MINOCYCLINE ER CAP	-	NC
minocycline ER tab (SOLODYN equiv)	-	NC
MONODOX CAP 75MG	-	NC
SEYSARA TAB	-	NC
TARGADOX TAB	-	NC
tetracycline cap	-	NC

THYROID AGENTS

ANTITHYROID AGENTS		
methimazole tab (TAPAZOLE equiv)	-	G
propylthiouracil tab	-	G

THYROID HORMONES		
THYROLAR TAB	-	B
ARMOUR THYROID TAB, NATURE THROID TAB	-	G
liothyronine tab (CYTOMEL equiv)	-	G
np thyroid tab (ARMOUR THYROID, NATURE THROID equiv)	-	G
SYNTHROID TAB	-	G
levothyroxine tab (SYNTHROID equiv)	-	NC
THYQUIDITY SOLN	-	NC
TIROSINT CAP	-	NC
TIROSINT-SOL	-	NC

TOXOIDS

TOXOID COMBINATIONS		
ADACEL/BOOSTRIX INJ	VAC	\$0
TETANUS-DIPHThERIA TOXOID INJ	VAC	\$0
VAXELIS INJ	-	NC

ULCER DRUGS

ANTISPASMODICS		
BELLADONNA ALKALOID/OPIUM SUPP	-	B
CANTIL TAB	-	B
CUVPOSA SOLN	-	B
PROPANTHELINE TAB	-	B
SYMAX DUOTAB	-	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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
ULCER DRUGS Cont.		
chlordiazepoxide/clidinium cap (LIBRAX equiv)	-	G
dicyclomine cap (BENTYL equiv)	-	G
dicyclomine soln (BENTYL equiv)	-	G
dicyclomine tab (BENTYL equiv)	-	G
glycopyrrolate tab (ROBINUL equiv)	-	G
hyoscyamine sulfate CR tab (LEVBID equiv)	-	G
hyoscyamine sulfate elixir (LEVSIN equiv)	-	G
hyoscyamine sulfate ODT (ANASPAZ equiv)	-	G
hyoscyamine sulfate SL tab (LEVSIN equiv)	-	G
hyoscyamine sulfate soln (LEVSIN equiv)	-	G
hyoscyamine sulfate SR cap (LEVSINEX equiv)	-	G
hyoscyamine tab (LEVSIN equiv)	-	G
methscopolamine tab (PAMINE equiv)	-	G
b-donna tab (DONNATAL equiv)	-	NC
DONNATAL EXTENTABS	-	NC
DONNATAL TAB	-	NC
GLYCATE TAB	-	NC
pb-belladonna elixir (DONNATAL equiv)	-	NC
H-2 ANTAGONISTS		
CIMETIDINE SOLN	-	G
cimetidine tab (TAGAMET equiv)	-	G
famotidine susp (PEPCID equiv)	-	G
famotidine tab (PEPCID equiv)	-	G
nizatidine cap (AXID equiv)	-	G
ranitidine cap (ZANTAC equiv)	-	NC
ranitidine syrup (ZANTAC equiv)	-	NC
ranitidine tab (Rx Only) (ZANTAC equiv)	-	NC
ZANTAC EFFER TAB	-	NC
MISC. ANTI-ULCER		
sucralfate tab (CARAFATE equiv)	-	G
PROTON PUMP INHIBITORS		
FIRST OMEPRAZOLE SUSP	PA	B
LANSOPRAZOLE SUSP	PA	B
PREVACID OTC CAP	OTC	EXC
esomeprazole cap	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
DEXILANT CAP	-	NC
ESOMEPRAZOLE STRONTIUM CAP	-	NC
NEXIUM 24HR TAB	-	NC
NEXIUM CAP	-	NC
NEXIUM GRANULE PACK	-	NC
PRILOSEC 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
----------	--------------	------

ULCER DRUGS Cont.

PRILOSEC OTC DR TAB	OTC	NC
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab (CYTOTEC equiv)	-	G
ULCER THERAPY COMBINATIONS		
PYLERA CAP	-	B
ZEGERID CAP OTC	OTC	EXC
lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv)	-	G
omeprazole/sodium bicarbonate cap (ZEGERID equiv)	-	NC
omeprazole/sodium bicarbonate powder pack (ZEGERID equiv)	-	NC
ZEGERID CAP	-	NC
ZEGERID POWDER PACK	-	NC

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS

ANTISPASMODICS

GLYCATE TAB, GLYCOPYRROLATE TAB	-	NC
hyoscyamine inj (LEVSIN equiv)	-	NC

H-2 ANTAGONISTS

NIZATIDINE CAP	-	G
PEPCID SUSP	-	NC

MISC. ANTI-ULCER

sucralfate susp (CARAFATE equiv)	PA	G
----------------------------------	----	---

PROTON PUMP INHIBITORS

ACIPHEX SPRINKLE CAP 10MG, RABEPRAZOLE SPRINKLE CAP 10MG	-	NC
esomeprazole DR granule pack (NEXIUM equiv)	-	NC
lansoprazole odt (PREVACID SOLUTAB equiv)	-	NC
omeprazole magnesium DR tab 20mg (PRILOSEC equiv)	OTC	NC
omeprazole tab	OTC	NC
pantoprazole sodium packet (PROTONIX equiv)	-	NC

ULCER THERAPY COMBINATIONS

HELIDAC PACK	-	NC
TALICIA CAP	-	NC

URINARY ANTI-INFECTIVES

URINARY ANTI-INFECTIVE COMBINATIONS

UROQID #2 TAB	-	B
PROSED DS TAB	-	NC

URINARY ANTISPASMODICS

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW)

tropium chloride SR cap (SANCTURA XR equiv)	-	G
---	---	---

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)

OXYTROL PATCH (OTC)	OTC	EXC
oxybutynin ER tab (DITROPAN XL equiv)	-	G
oxybutynin syrup	-	G
oxybutynin tab (DITROPAN equiv)	-	G
solifenacin tab (VESICARE equiv)	-	G
tolterodine SR cap (DETROL LA 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.

EXC	NC =Not Covered	INF	generic =small letters	LD	BRANDS =CAPITAL LETTERS
LMSP	Plan Exclusion	MSP	Infertility	OTC	Limited Distribution
PA	Lumicera Mandatory Specialty Pharmacy Program	QL	Mandatory Specialty Pharmacy Program	RS	Over-the-Counter
SF	Prior Authorization	SMKG	Quantity Limit	ST	Restricted to Specialist
VAC	Limited to two 15 day fills per month for first 3 months	¢	Smoking Cessation		Step Therapy
	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
URINARY ANTISPASMODICS Cont.		
tolterodine tab (DETROL equiv)	¢	G
tropium tab (SANCTURA equiv)	-	G
darifenacin SR tab (ENABLEX equiv)	-	NC
DETROL LA CAP	-	NC
GELNIQUE	-	NC
TOVIAZ TAB	-	NC
VESICARE TAB	-	NC
URINARY ANTISPASMODICS		
hyoscyamine tab (LEVSIN equiv)	-	G
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB	-	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		
BXSERO INJ	VAC	\$0
MENACTRA INJ	VAC	\$0
MENHIBRIX INJ	VAC	\$0
MENOMUNE INJ	VAC	\$0
MENVEO INJ	VAC	\$0
PNEUMOVAX INJ	VAC	\$0
PREVNAR 13 INJ	VAC	\$0
TRUMENBA INJ	VAC	\$0
VAXCHORA SUSP	VAC	\$0
VIVOTIF BERNA CAP (QL= 4 caps/fill)	QL-VAC	\$0
VIRAL VACCINES		
AFLURIA INJ	VAC	\$0
AFLURIA INJ, FLUZONE INJ	VAC	\$0
CERVARIX INJ	VAC	\$0
COVID-19 VACCINE INJ (MODERNA) (QL= 1 dose/24 days; limit 2 fills/12 months)	QL	\$0
COVID-19 VACCINE INJ (PFIZER) (QL= 1 dose/17 days; limit 2 fills/12 months)	QL	\$0
ENGERIX-B INJ	VAC	\$0
ENGERIX-B/RECOMBIVAX-HB INJ	VAC	\$0
FLUAD INJ	VAC	\$0
FLUAD QUAD INJ	VAC	\$0
FLUBLOK INJ	VAC	\$0
FLUBLOK QUAD PF INJ	VAC	\$0
FLUCELVAX INJ	VAC	\$0
FLUCELVAX QUAD INJ	VAC	\$0
FLULAVAL QUAD INJ, FLUZONE QUAD INJ	VAC	\$0
FLUMIST QUADRIVALENT NASAL SUSP	VAC	\$0
FLUVIRIN 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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
VACCINES Cont.		
FLUVIRIN PF INJ	VAC	\$0
FLUZONE HD PF INJ	VAC	\$0
FLUZONE HIGH DOSE PF INJ	VAC	\$0
FLUZONE INTRADERMAL INJ	VAC	\$0
FLUZONE QUADRIVALENT INJ	VAC	\$0
FLUZONE/FLUARIX QUAD INJ	VAC	\$0
GARDASIL 9 INJ	VAC	\$0
GARDASIL INJ	VAC	\$0
HAVRIX INJ, VAQTA INJ	VAC	\$0
HEPLISAV-B INJ	VAC	\$0
M-M-R II INJ	VAC	\$0
SHINGRIX INJ (Covered for members age 50 or older)	VAC	\$0
TWINRIX INJ	VAC	\$0
VARIVAX INJ	VAC	\$0
ZOSTAVAX INJ (Covered for members age 50 or older)	VAC	\$0
STAMARIL INJ	-	NC

VAGINAL AND RELATED PRODUCTS

VAGINAL CONTRACEPTIVE - PH MODULATORS

PHEXXI GEL	-	NC
------------	---	----

VAGINAL PRODUCTS

MISCELLANEOUS VAGINAL PRODUCTS

ACIDIC VAGINAL JELLY	-	B
FEM PH GEL	-	B
INTRAROSA SUPP	-	NC

SPERMICIDES

CONTRACEPTIVE FOAM	OTC	\$0
CONTRACEPTIVE GEL	OTC	\$0
CONTRACEPTIVE SUPP	OTC	\$0
TODAY SPONGE	OTC	\$0

VAGINAL ANTI-INFECTIVES

AVC VAGINAL CREAM	-	B
CLEOCIN VAGINAL SUPP	-	B
CLINDESSE VAGINAL CREAM	-	B
clindamycin vaginal cream (CLEOCIN equiv)	-	G
metronidazole vaginal gel (METROGEL equiv)	-	G
NYSTATIN VAGINAL TAB	-	G
terconazole cream (TERAZOL equiv)	-	G
TERCONAZOLE CREAM 0.8%	-	G
terconazole supp (TERAZOL equiv)	-	G

VAGINAL ESTROGENS

ESTRING (3 copays per Rx)	-	B
FEMRING (3 copays per Rx)	-	B
estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill)	QL	G
ESTRACE VAGINAL CREAM	-	NC
estradiol cream (ESTRACE 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.

EXC	Plan Exclusion	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	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
Category/Class**

Last Updated* 2/1/2021

DrugName	Special Code	Tier
VAGINAL PRODUCTS Cont.		
IMVEXXY SUPP	-	NC
PREMARIN VAGINAL CREAM	-	NC
VAGINAL PROGESTINS		
CRINONE GEL	PA	B
ENDOMETRIN INSERT	PA	B
PROGESTERONE SUPP	PA	B
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill)	QL	G
SYMJEPI INJ (QL= 2 inj/fill)	QL	G
ADRENALIN INJ, EPINEPHRINE INJ	-	NC
AUVI-Q INJ	-	NC
EPIPEN (JR) INJ	-	NC
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
NORTHERA CAP	-	NC
VASOPRESSORS		
midodrine tab (PROAMATINE equiv)	-	G
VITAMINS		
OIL SOLUBLE VITAMINS		
phytonadione tab (MEPHYTON equiv)	-	G
vitamin D cap (RX strength only)	-	G
ERGOAL 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		
POTABA POWDER PACKET	-	B
POTABA TAB	-	B
niacin cap	OTC	EXC
niacin CR tab (SLO-NIACIN equiv)	OTC	EXC
niacin tab	OTC	EXC
NIACIN TR TAB	OTC	EXC
niacinamide tab	OTC	EXC
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.

EXC	NC =Not Covered Plan Exclusion	INF	generic =small letters Infertility	LD	BRANDS =CAPITAL LETTERS Limited Distribution
LMSP	Lumicera Mandatory Specialty Pharmacy Program	MSP	Mandatory Specialty Pharmacy Program	OTC	Over-the-Counter
PA	Prior Authorization	QL	Quantity Limit	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* 2/1/2021**

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)
ABSTRAL SL TAB	B
ACCU-CHEK AVIVA PLUS METER	B
ACCU-CHEK AVIVA PLUS TEST STRIP	B
ACCU-CHEK GUIDE CARE METER	B
ACCU-CHEK GUIDE ME KIT	B
ACCU-CHEK GUIDE TEST STRIP	B
ACCU-CHEK NANO METER	B
ACCU-CHEK SMARTVIEW TEST STRIP	B
ACCU-CHEK TEST STRIP	B
ACTEMRA ACTPEN INJ	B
ACTEMRA IV INJ	B
ACTEMRA SC INJ	B
ACTIMMUNE INJ	B
acyclovir cream	G
ADAGEN INJ	B
ADEMPAS TAB	B
ADMELOG INJ, INSULIN LISPRO INJ	B
ADMELOG SOLOSTAR INJ, INSULIN LISPRO KWIKPEN INJ (JUNIOR)	B
ADVATE INJ	B
AFINITOR DISPERZ	B
AFINITOR TAB 10MG	B
AIMOVIG INJ	B
ALDURAZYME INJ	B
ALECENSA CAP	B
ALINIA SUSP	B
ALPHANATE/HEMOFIL/KOATE INJ	B
ALPHANINE SD/MONONINE INJ	B
ALUNBRIG TAB 30MG	B
ALUNBRIG TAB 90MG, 180MG	B
ANDRODERM PATCH	B
APIDRA INJ	B
APIDRA SOLOSTAR INJ	B
ARALAST/PROLASTIN/ZEMAIRA INJ	B
ARCALYST INJ	B
ARIKAYCE SUSP	B
armodafinil tab	G
ARZERRA INJ	B
AUBAGIO TAB	B
AUSTEDO TAB	B
AVASTIN INJ	B
AVONEX 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.

SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 2/1/2021

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)
AYVAKIT TAB	B
BALVERSA TAB 3MG	B
BALVERSA TAB 4MG	B
BALVERSA TAB 5MG	B
BANZEL SUSP	B
BANZEL TAB	B
BEBULIN/PROFILNINE INJ	B
BENEFIX INJ	B
BENEFIX/RIXUBIS INJ	B
BENLYSTA AUTO-INJECTOR	B
BENLYSTA INJ	B
BENZNIDAZOLE TAB	B
BERINERT INJ	B
bexarotene cap	B
BOSULIF TAB	B
BOTOX INJ	B
BRAFTOVI CAP 75MG	B
BRUKINSA CAP	B
budesonide ER tab	G
butalbital/acetaminophen tab 50-325mg	G
butalbital/acetaminophen/caffeine tab	G
butalbital/aspirin/caffeine cap	G
CABLIVI INJ KIT	B
CABOMETYX TAB	B
CALQUENCE CAP	B
CAPRELSA TAB	B
CARIMUNE INJ	B
CAYSTON INH SOLN	B
CEREZYME INJ	B
CHOLBAM CAP	B
CIMZIA INJ	B
CIMZIA STARTER INJ KIT	B
CINRYZE INJ	B
clobazam tab	G
clobetasol foam	G
clobetasol lotion	G
COMETRIQ KIT	B
COPIKTRA CAP	B
CORLANOR SOLN	B
CORLANOR TAB	B
COTELLIC TAB	B
CRINONE GEL	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* 2/1/2021

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)
CYSTADANE POWDER	B
dalfampridine ER tab	B
deferiprone tab	B
DESCOVY TAB	B
DEXCOM G6 RECEIVER	G
DEXCOM G6 SENSOR	G
DEXCOM G6 TRANSMITTER	G
DIABETIC METER	B
DIACOMIT CAP	B
DIACOMIT POWDER PACK	B
dihydroergotamine mesylate nasal spray	G
DOPTELET TAB	B
doxycycline hyclate DR tab	G
dronabinol cap	G
DUPIXENT INJ	B
DUPIXENT PEN INJ	B
DUROLANE INJ	B
DYSPORT INJ	B
ELAPRASE INJ	B
EMGALITY INJ	B
EMGALITY INJ 100MG/ML	B
ENBREL INJ 25MG	B
ENBREL INJ 50MG	B
ENBREL MINI INJ	B
ENBREL SURECLICK INJ 50MG	B
ENDARI POWDER PACK	B
ENDOMETRIN INSERT	B
ENTRESTO TAB	B
EPANED PREMIXED SOLN	B
EPANED SOLN	B
EPIDIOLEX SOLN	B
EPIDUO FORTE GEL	B
ERIVEDGE CAP	B
ERLEADA TAB	B
erlotinib tab	B
ESBRIET CAP	B
ESBRIET TAB 267MG	B
ESBRIET TAB 801MG	B
esomeprazole cap	G
EUFLEXXA/SUPARTZ INJ	B
everolimus tab	B
everolimus tab 0.25mg, 0.5mg, 0.75mg	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.

**SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 2/1/2021**

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)
EXTAVIA INJ	B
FABRAZYME INJ	B
FARYDAK CAP	B
FASENRA PEN INJ	B
FEIBA INJ	B
fentanyl citrate lollipop	G
FENTORA TAB, FENTANYL BUCCAL TAB	B
FERRIPROX SOLN	B
FERRIPROX TAB	B
FIRST OMEPRAZOLE SUSP	B
FLEBOGAMMA/GAMMAPLEX/OCTAGAM/PRIVIGEN INJ	B
FREESTYLE LIBRE 2 RECEIVER	G
FREESTYLE LIBRE 2 SENSOR	G
FREESTYLE LIBRE RECEIVER	G
FREESTYLE LIBRE SENSOR (10-DAY)	G
FREESTYLE LIBRE SENSOR (14-DAY)	G
GALAFOLD CAP	B
GAMASTAN S/D INJ	B
GAMUNEX INJ	B
GELSYN-3 INJ	B
GENOTROPIN INJ	B
GILENYA CAP	B
GILOTRIF TAB	B
GLASSIA INJ	B
glatiramer inj	B
GOLYTELY PACKET	G
HAEGARDA INJ	B
HALFLYTELY BOWEL PREP KIT	B
HELIXATE/KOGENATE INJ	B
HEMLIBRA INJ	B
HERCEPTIN INJ	B
HIZENTRA INJ	B
HUMALOG INJ	B
HUMALOG KWIKPEN INJ	B
HUMALOG MIX INJ	B
HUMALOG MIX KWIKPEN INJ, INSULIN LISPRO PROTAMINE INJ	B
HUMATE-P/WILATE INJ	B
HUMIRA INJ 10MG	B
HUMIRA INJ 20MG	B
HUMIRA INJ 40MG	B
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	B
HUMIRA INJ PEDIATRIC CROHNS 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.

**SISC - Book of Business Drug List cont.
 Prior Authorization Drug List
 Last Updated* 2/1/2021**

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)
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	B
HUMIRA PEN INJ 40MG	B
HUMULIN MIX INJ	B
HUMULIN MIX PEN INJ	B
HUMULIN N INJ	B
HUMULIN N PEN INJ	B
HUMULIN R INJ	B
HYCAMTIN CAP	B
HYQVIA INJ	B
IBRANCE CAP	B
IBRANCE TAB	B
icatibant inj	B
ICLUSIG TAB	B
IDHIFA TAB	B
IMBRUVICA CAP 140MG	B
IMBRUVICA CAP 70MG	B
IMBRUVICA TAB	B
INBRIJA INH POWDER	B
INGREZZA CAP	B
INLYTA TAB	B
IRESSA TAB	B
ISTURISA TAB 10MG	B
ISTURISA TAB 1MG	B
ISTURISA TAB 5MG	B
itraconazole cap	G
itraconazole soln	G
ivermectin lotion	G
JAKAFI TAB	B
JYNARQUE PAK	B
JYNARQUE TAB	B
KALYDECO PAK	B
KALYDECO TAB	B
KESIMPTA INJ	B
KEVZARA INJ	B
KINERET INJ	B
KORLYM TAB	B
KOSELUGO CAP	B
LANSOPRAZOLE SUSP	B
lapatinib ditosylate tab	B
LAZANDA NASAL SPRAY	B
LEDIPASVIR/SOFOSBUVIR TAB	B
LENVIMA 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* 2/1/2021**

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)
lidocaine patch	G
LOKELMA PAK	B
LONSURF TAB	B
LORBRENA TAB 100MG	B
LORBRENA TAB 25MG	B
LUCEMYRA TAB	B
LUCENTIS INJ	B
LUMIZYME/MYOZYME INJ	B
LYNPARZA CAP	B
LYNPARZA TAB	B
MACUGEN INJ	B
MAVYRET TAB	B
MAYZENT TAB	B
MAYZENT TAB STARTER PACK	B
MEKINIST TAB 0.5MG	B
MEKINIST TAB 2MG	B
MEKTOVI TAB	B
METHYLTESTOSTERONE CAP	B
miglustat cap	B
modafinil tab	G
MONOCLATE-P INJ	B
MOTEGRITY TAB	B
MOVANTIK TAB	B
MOZOBIL INJ	B
NAGLAZYME INJ	B
naproxen susp	G
NATPARA INJ	B
NERLYNX TAB	B
NEUPRO PATCH	B
NEXAVAR TAB	B
NINLARO CAP	B
nitazoxanide tab	G
NOVOSEVEN INJ	B
NOXAFIL SUSP	B
NPLATE INJ	B
NUBEQA TAB	B
NUCALA INJ	B
NUEDEXTA CAP	B
NURTEC ODT	B
OCALIVA TAB	B
ODOMZO CAP	B
OFEV 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* 2/1/2021**

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)
OLUMIANT TAB	B
OPSUMIT TAB	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
ORIAHNN CAP	B
ORILISSA TAB 150MG	B
ORILISSA TAB 200MG	B
ORKAMBI GRANULES PACKET	B
ORKAMBI TAB	B
OTEZLA STARTER PACK	B
OTEZLA TAB	B
OXBRYTA TAB	B
OXERVATE OPHTH SOLN	B
PALFORZIA POWDER SOLN	B
PALFORZIA SPRINKLE CAP	B
PALYNZIQ INJ	B
PEMAZYRE TAB	B
phentermine cap	G
phentermine tab	G
PIQRAY TAB	B
PLEGRIDY INJ	B
PLEGRIDY PEN INJ	B
POMALYST CAP	B
posaconazole DR tab	G
PRALUENT INJ	B
PROGESTERONE SUPP	B
PROMACTA POWDER	B
PROMACTA TAB	B
pyrimethamine tab	B
QBRELIS SOLN	B
QINLOCK TAB	B
rabeprazole EC tab	G
REBIF INJ	B
RECOMBINATE INJ	B
RENFLEXIS INJ	B
REPATHA INJ	B
REPATHA PUSHTRONEX INJ	B
RESTASIS OPHTH EMULSION	B
RETEVMO CAP	B
RETIN-A CREAM	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* 2/1/2021**

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)
RETIN-A GEL	B
REYVOW TAB	B
RIASTAP INJ	B
RINVOQ ER TAB	B
RIOMET ER SUSP	B
RITUXAN INJ	B
ROZLYTREK CAP	B
RUBRACA TAB	B
RUCONEST INJ	B
rufinamide susp	G
RUZURGI TAB	B
RYDAPT CAP	B
sapropterin dihydrochloride powder packet	B
sapropterin dihydrochloride soluble tab	B
SIGNIFOR INJ	B
sildenafil tab 20mg	G
SKLICE LOTION	B
SKYRIZI INJ	B
SOFOBUVIR/VELPATASVIR TAB	B
SOLIQUA INJ	B
SOMATULINE INJ	B
SOMAVERT INJ	B
SPORANOX SOLN	B
SPRIX NASAL SPRAY	B
SPRYCEL TAB	B
STELARA INJ	B
STIVARGA TAB	B
STRENSIQ INJ	B
SUCLEAR KIT	B
sucralfate susp	G
SUNOSI TAB	B
SUPPRELIN LA INJ	B
SUPREP SOLN	B
SUTENT CAP	B
SYMDEKO TAB	B
SYMLINPEN INJ	B
SYMPROIC TAB	B
SYNVISC INJ	B
TABRECTA TAB	B
tadalafil tab (PAH)	B
tadalafil tab 5mg	G
TAFINLAR 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* 2/1/2021**

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)
TAGRISO TAB	B
TAKHZYRO INJ	B
TALTZ INJ	B
TALZENNA CAP 0.25MG	B
TALZENNA CAP 1MG	B
TARGRETIN GEL	B
TASIGNA CAP	B
TAVALISSE TAB	B
tazarotene cream 0.1%	G
TAZORAC CREAM 0.05%	B
TAZVERIK TAB	B
TEGSEDI INJ	B
temsirolimus inj	B
TEST STRIP (all other test strips)	B
testosterone gel pump 1.62%	G
testosterone soln	G
tetrabenazine tab	B
THALOMID CAP	B
TIBSOVO TAB	B
tizanidine cap	G
TOBI PODHALER	B
TORISEL INJ	B
TRACLEER TAB 32MG	B
TREMFYA INJ	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	B
TRIKAFTA TAB	B
TRINTELLIX TAB	B
TROKENDI XR CAP	B
TRULANCE TAB	B
TUKYSA TAB	B
TURALIO CAP	B
TYSABRI INJ	B
TYVASO INH SOLN	B
UBRELVY TAB	B
UPTRAVI TAB	B
VALCHLOR GEL	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* 2/1/2021**

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)
VASCEPA CAP 0.5GM	B
VASCEPA CAP 1GM	G
VELCADE INJ	B
VELTASSA POWDER	B
VENCLEXTA STARTER PACK	B
VENCLEXTA TAB	B
VENTAVIS INH SOLN	B
VERZENIO TAB	B
vigabatrin powder pack	B
vigabatrin tab	B
VITRAKVI CAP 100MG	B
VITRAKVI CAP 25MG	B
VITRAKVI SOLN	B
VIZIMPRO TAB	B
VOSEVI TAB	B
VOTRIENT TAB	B
VPRIV INJ	B
VYNDAMAX CAP	B
VYNDAQEL CAP	B
WAKIX TAB	B
XADAGO TAB	B
XALKORI CAP	B
XELJANZ TAB	B
XELJANZ XR TAB	B
XEMBIFY INJ	B
XEOMIN INJ	B
XIAFLEX INJ	B
XIFAXAN TAB 200MG	B
XIFAXAN TAB 550MG	B
XIIDRA OPTH SOLN	B
XOLAIR INJ	B
XOSPATA TAB	B
XPOVIO PAK	B
XULTOPHY INJ	B
XYNTHA INJ	B
XYREM SOLN	B
ZEJULA CAP	B
ZELBORAF TAB	B
ZEPOSIA CAP	B
ZEPOSIA STARTER PACK	B
ZOLINZA CAP	B
zolmitriptan ODT	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.

SISC - Book of Business Drug List cont.
Prior Authorization Drug List
Last Updated* 2/1/2021

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)
zolmitriptan tab	G
ZORTRESS TAB 1MG	B
ZYDELIG TAB	B
ZYKADIA CAP	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* 2/1/2021
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

aliskiren tab	BYSTOLIC TAB	eplerenone tab	febuxostat tab
galantamine tab	JANUVIA TAB	LATUDA TAB	OCALIVA TAB
rasagiline tab	tolterodine 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* 2/1/2021
Over-the-Counter (OTC)**

- The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

ACCU-CHEK AVIVA PLUS METER	ACCU-CHEK AVIVA PLUS TEST STRIP	ACCU-CHEK GUIDE CARE METER	ACCU-CHEK GUIDE ME KIT
ACCU-CHEK GUIDE TEST STRIP	ACCU-CHEK NANO METER	ACCU-CHEK SMARTVIEW TEST STRIP	ACCU-CHEK TEST STRIP
AEROCHAMBER aspirin tab 325mg	aspirin chew tab 81mg aspirin tab 81mg	aspirin ec tab 325mg	aspirin ec tab 81mg
CALIBRATION LIQUID	CLINISTIX TEST STRIP	B-D INSULIN SYRINGE	B-D PEN NEEDLE
CONTRACEPTIVE SUPP	DIABETIC METER	CONTRACEPTIVE FOAM	CONTRACEPTIVE GEL
FERROUS SULFATE LIQUIII	ferrous sulfate soln	FEMALE CONDOMS	ferrous sulfate elixir
folic acid tab 800mcg	FREESTYLE FREEDOM LITE METER	ferrous sulfate syrup	folic acid tab 400mcg
FREESTYLE LITE TEST STRIP	FREESTYLE PRECISION NEO METER	FREESTYLE INSULINX TEST STRIP	FREESTYLE LITE METER
GUAIFENESIN/CODEINE SYRUP	HUMULIN MIX INJ	FREESTYLE PRECISION NEO TEST STRIP	FREESTYLE TEST STRIP
HUMULIN N PEN INJ	HUMULIN R INJ	HUMULIN MIX PEN INJ	HUMULIN N INJ
KETOSTIX	LANCET KIT	IRON SUSP	KETO-DIASTIX TEST STRIF
nicotine gum	NICOTINE KIT	LANCETS	levonorgestrel tab
NOVOFINE PEN NEEDLE	NOVOLIN 70/30 FLEXPEN INJ	nicotine lozenge	nicotine patch
NOVOLIN N INJ	NOVOLIN R FLEXPEN INJ	NOVOLIN 70/30 INJ	NOVOLIN N FLEXPEN INJ
NOVOTWIST/NOVOFINE PEN NEEDLE	ONETOUCH METER	NOVOLIN R INJ	NOVOTWIST PEN NEEDLE
PEAK FLOW METER	PLAN B TAB	ONETOUCH TEST STRIP	ONETOUCH VERIO TEST STRIP
PRECISION XTRA TEST STRIP	TEST STRIP (all other test strips)	PRECISION XTRA KETONE TEST STRIP	PRECISION XTRA METER
		TODAY SPONGE	

** 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* 2/1/2021
Mandatory Specialty Pharmacy (MSP)

- 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 ACTPEN INJ	ACTEMRA IV INJ	ACTEMRA SC INJ
ACTIMMUNE INJ	ADAGEN INJ	ADEMPAS TAB	ADVATE INJ
AFINITOR DISPERZ	AFINITOR TAB 10MG	ALDURAZYME INJ	ALECENSA CAP
ALFERON-N INJ	ALPHANATE/HEMOFIL/KO/ TE INJ	ALPHANINE SD/MONONINE INJ	ALUNBRIG TAB 30MG
ALUNBRIG TAB 90MG, 180MG	ambrisentan tab	ARALAST/PROLASTIN/ZEM	ARCALYST INJ
ARIKAYCE SUSP	ARZERRA INJ	AIRA INJ	AUSTEDO TAB
AVASTIN INJ	AVONEX INJ	AUBAGIO TAB	azacitidine inj
BALVERSA TAB 3MG	BALVERSA TAB 4MG	AYVAKIT TAB	BEBULIN/PROFILNINE INJ
BENEFIX INJ	BENEFIX/RIXUBIS INJ	BALVERSA TAB 5MG	BENLYSTA INJ
BERINERT INJ	bexarotene cap	BENLYSTA	AUTO-INJECTOR
BOTOX INJ	BRAFTOVI CAP 75MG	bosentan tab	BOSULIF TAB
CABOMETYX TAB	CALCITRIOL INJ	BRUKINSA CAP	CABLIVI INJ KIT
CAPRELSA TAB	CARIMUNE INJ	CALQUENCE CAP	capecitabine tab
CHOLBAM CAP	CIMZIA INJ	CAYSTON INH SOLN	CEREZYME INJ
colistimethate inj	COMETRIQ KIT	CIMZIA STARTER INJ KIT	CINRYZE INJ
CYSTADANE POWDER	CYSTADROPS SOLN	COPIKTRA CAP	COTELLIC TAB
dalfampridine ER tab	deferasirox granules packet	CYSTAGON CAP	CYSTARAN OPHTH SOLN
deferiprone tab	DIACOMIT CAP	deferasirox tab	deferasirox tab 90mg, 360mg
dimethyl fumarate DR starter pack	DOPTELET TAB	DIACOMIT POWDER PACK	dimethyl fumarate DR cap
DUROLANE INJ	DYSPORT INJ	DUPIXENT INJ	DUPIXENT PEN INJ
ENBREL INJ 50MG	ENBREL MINI INJ	ELAPRASE INJ	ENBREL INJ 25MG
EPIDIOLEX SOLN	ERIVEDGE CAP	ENBREL SURECLICK INJ	ENDARI POWDER PACK
ESBRIET CAP	ESBRIET TAB 267MG	50MG	erlotinib tab
EUFLEXXA/SUPARTZ INJ	everolimus tab	ERLEADA TAB	ETOPOSIDE CAP
FARYDAK CAP	FASENRA PEN INJ	ESBRIET TAB 801MG	FABRAZYME INJ
FERRIPROX TAB	FIRMAGON INJ	EXTAVIA INJ	FERRIPROX SOLN
FULPHILA INJ	FUZEON INJ	FEIBA INJ	FORTEO INJ
GAMUNEX INJ	ganciclovir inj	FLEBOGAMMA/GAMMAPL EX/OCTAGAM/PRIVIGEN INJ	GAMASTAN S/D INJ
GENOTROPIN INJ	GILENYA CAP	GALAFOLD CAP	GELSYN-3 INJ
glatiramer inj	HAEGARDA INJ	ganirelix ac inj	GLASSIA INJ
HERCEPTIN INJ	HIZENTRA INJ	GILOTRIF TAB	HEMLIBRA INJ
		HELIXATE/KOGENATE INJ	HUMIRA INJ 10MG
		HUMATE-P/WILATE 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.

HUMIRA INJ 20MG	HUMIRA INJ 40MG	HUMIRA INJ CROHNS/UC/HIDRADENITI STARTER PACK	HUMIRA INJ PEDIATRIC CROHNS STARTER PACK
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	HUMIRA PEN INJ 40MG	HYCANTIN CAP	HYQVIA INJ
IBRANCE TAB	IBRANCE TAB	icatibant inj	ICLUSIG TAB
IDHIFA TAB	imatinib tab	IMBRUVICA CAP 140MG	IMBRUVICA CAP 70MG
IMBRUVICA TAB	INCRELEX INJ	INGREZZA CAP	INLYTA TAB
INTRON-A INJ	IRESSA TAB	ISTURISA TAB 10MG	ISTURISA TAB 1MG
ISTURISA TAB 5MG	JAKAFI TAB	JYNARQUE PAK	JYNARQUE TAB
KALYDECO PAK	KALYDECO TAB	KESIMPTA INJ	KEVZARA INJ
KINERET INJ	KORLYM TAB	KOSELUGO CAP	lapatinib ditosylate tab
LEDIPASVIR/SOFOSBUVIR TAB	LENVIMA CAP	LONSURF TAB	LORBRENA TAB 100MG
LORBRENA TAB 25MG	LUCENTIS INJ	LUMIZYME/MYOZYME INJ	LUPRON DEPOT PED INJ
LUPRON DEPOT-PED INJ	LYNPARZA CAP	LYNPARZA TAB	LYSODREN TAB
MACUGEN INJ	MAVYRET TAB	MAYZENT TAB	MAYZENT TAB STARTER PACK
MEKINIST TAB 0.5MG	MEKINIST TAB 2MG	MEKTOVI TAB	MESNEX TAB
MIACALCIN INJ	miglustat cap	MONOCLATE-P INJ	MOZOBIL INJ
MYLERAN TAB	NAGLAZYME INJ	NATPARA INJ	NERLYNX TAB
NEUMEGA INJ	NEXAVAR TAB	nilutamide tab	NINLARO CAP
NIVESTYM INJ	NOVOSEVEN INJ	NPLATE INJ	NUBEQA TAB
NUCALA INJ	NUZYRA TAB	OCALIVA TAB	octreotide inj
ODOMZO CAP	OFEV CAP	OLUMIANT TAB	OPSUMIT TAB
ORENCIA CLICK INJ	ORENCIA SC INJ 125MG/ML	ORENCIA SC INJ 50MG/0.4ML	ORENCIA SC INJ 87.5MG/0.7ML
ORKAMBI GRANULES PACKET	ORKAMBI TAB	OTEZLA STARTER PACK	OTEZLA TAB
ORBRYTA TAB	OXERVATE OPHTH SOLN	PALFORZIA POWDER PACK	PALFORZIA SPRINKLE CAP
PALYNZIQ INJ	PEGASYS INJ	PEG-INTRON INJ	PEMAZYRE TAB
PIQRAY TAB	PLEGRIDY INJ	PLEGRIDY PEN INJ	POMALYST CAP
PROLIA INJ	PROMACTA POWDER	PROMACTA TAB	PULMOZYME INH SOLN
pyrimethamine tab	QINLOCK TAB	REBETOL SOLN	REBIF INJ
RECOMBINATE INJ	RENFLIXIS INJ	RETACRIT INJ	RETEVMO CAP
REVLIMID CAP	RIASTAP INJ	ribavirin cap	ribavirin tab
RINVOQ ER TAB	RITUXAN INJ	ROZLYTREK CAP	RUBRACA TAB
RUCONEST INJ	RUZURGI TAB	RYDAPT CAP	sapropterin dihydrochloride powder packet
sapropterin dihydrochloride soluble tab	SIGNIFOR INJ	SKYRIZI INJ	SOFOSBUVIR/VELPATASVI R TAB
SOMATULINE INJ	SOMAVERT INJ	SPRYCEL TAB	STELARA INJ
STIVARGA TAB	STRENSIQ INJ	SUPPRELIN LA INJ	SUTENT CAP
SYMDEKO TAB	SYNVISC INJ	TABRECTA TAB	tadalafil tab (PAH)
TAFINLAR CAP	TAGRISSO TAB	TAKHZYRO INJ	TALTZ INJ
TALZENNA CAP 0.25MG	TALZENNA CAP 1MG	TARGRETIN GEL	TASIGNA CAP
TAVALISSE TAB	TAZVERIK TAB	TEGSEDI INJ	temozolomide cap
temsirolimus inj	tetrabenazine tab	THALOMID CAP	TIBSOVO TAB
TOBI PODHALER	tobramycin neb soln	TORISEL INJ	TRACLEER TAB 32MG

** 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.

TREMFYA INJ	treprostinil inj 10mg/ml	treprostinil inj 1mg/ml	treprostinil inj 2.5mg/ml
treprostinil inj 5mg/ml	tretinoin cap	trientine cap	TRIKAFTA TAB
TUKYSA TAB	TURALIO CAP	TYMLOS INJ	TYSABRI INJ
TYVASO INH SOLN	UPTRAVI TAB	VALCHLOR GEL	VELCADE INJ
VENCLEXTA STARTER PACK	VENCLEXTA TAB	VENTAVIS INH SOLN	VERZENIO TAB
vigabatrin powder pack	vigabatrin tab	VITRAKVI CAP 100MG	VITRAKVI CAP 25MG
VITRAKVI SOLN	VIVITROL INJ	VIZIMPRO TAB	VOSEVI TAB
VOTRIENT TAB	VPRIV INJ	VYNDAMAX CAP	VYNDAQEL CAP
WAKIX TAB	XALKORI CAP	XELJANZ TAB	XELJANZ XR TAB
XEMBIFY INJ	XEOMIN INJ	XGEVA INJ	XIAFLEX INJ
XOLAIR INJ	XOSPATA TAB	XPOVIO PAK	XYNTHA INJ
XYREM SOLN	ZARXIO INJ	ZEJULA CAP	ZELBORAF TAB
ZEPOSIA CAP	ZEPOSIA STARTER PACK	ZIEXTENZO INJ	ZOLADEX INJ
ZOLINZA CAP	ZYDELIG TAB	ZYKADIA CAP	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.

SISC - Book of Business Drug List
Last Updated* 2/1/2021
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
aliskiren tab	Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan
AMTURNIDE TAB	Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan
asenapine maleate SL tab	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
ASTEPRO NASAL SPRAY	Step therapy requires trial of azelastine nasal spray 0.1%
AURYXIA TAB	Step Therapy requires trial of RENEVA and FOSRENOL
azelastine nasal spray 0.15%	Step therapy requires trial of azelastine nasal spray 0.1%
BROVANA NEB SOLN	Step Therapy requires trial of PERFOROMIST
BYETTA INJ	Step Therapy requires trial of VICTOZA or BYDUREON
CAVERJECT INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
ciclopirox shampoo	Step Therapy requires trial of ketoconazole shampoo
CIPRO HC OTIC SUSP	Step Therapy requires trial of CIPRODEX
DICLOFENAC PATCH, FLECTOR PATCH	QL= 30 patches/fill; Step Therapy requires trial of celecoxib
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN
EDEX INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
erythromycin DR cap	Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg
ERYTHROMYCIN EC CAP	Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg
erythromycin ethylsuccinate susp	Step Therapy requires trial of azithromycin or clarithromycin
erythromycin stearate tab	Step Therapy requires trial of azithromycin, clarithromycin, or doxycycline hyclate 100mg
erythromycin tab	Step Therapy requires trial of azithromycin, clarithromycin or doxycycline hyclate 100mg
FANAPT TAB	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
FANAPT TITRATION PACK	QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER
febuxostat tab	Step Therapy requires trial of allopurinol
flvoxamine ER cap	Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine
FOSAMAX+D TAB	Step Therapy requires trial of ACTONEL
LATUDA TAB	QL= 1 tab/day; Step Therapy requires trial of quetiapine
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
MECLOFENAMATE CAP	Step Therapy requires trial of two: diclofenac potassium tab, ketoprofen cap, ibuprofen, or naproxen
METHITEST TAB	Step Therapy requires trial of ANDROGEL or ANDRODERM
metronidazole gel 1%	Step Therapy requires trial of metronidazole gel 0.75%
minocycline tab	Step therapy requires trial of minocycline caps

** 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.
Last Updated* 2/1/2021
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

Drug Name	Step Therapy Requirements
MOVIPREP SOLN	Step Therapy requires trial of CLENPIQ
MUSE SUPP	QL= 6 supp/30 days; Step therapy requires trial of sildenafil
nevirapine ER tab	Step Therapy requires trial of nevirapine
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%
paliperidone ER tab	Step Therapy requires trial of ABILIFY or quetiapine ER
peg 3350 soln (100 gram Moviprep equiv)	Step Therapy requires trial of CLENPIQ
risedronate DR tab	Step Therapy requires trial of alendronate
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASON/SALMETEROL
TEKAMLO TAB	Step Therapy requires trial of valsartan
TEKTURNA HCT TAB	Step Therapy requires trial of valsartan/hctz
travoprost ophth soln	QL= 5ml/30 days; Step Therapy requires trial of latanoprost
VALTURNA TAB	Step Therapy requires trial of one: candesartan, valsartan, irbesartan, OR losartan
ZOLMITRIPTAN 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* 2/1/2021**

Drug Name	Tier # for Drug Copay
bupropion SR tab(Limited to 180 days/plan year)	\$0
CHANTIX PAK(Limited to 180 days/plan year)	\$0
CHANTIX TAB(Limited to 180 days/plan year)	\$0
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

** 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* 2/1/2021**

Drug Name	Tier # for Drug Copay
CLOMIPHENE CITRATE TAB	G
ganirelix ac 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.

SISC - Book of Business Drug List
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
ABILIFY DISCMELT	QL= 2 tabs/day
abiraterone tab 250mg	QL= 4 tabs/day
ABSTRAL SL TAB	QL= 120 tabs/30 days
ACTEMRA ACTPEN INJ	QL= 2 inj/28 days
ACTEMRA SC INJ	QL= 2 inj/28 days
ADEMPAS TAB	QL= 3 tabs/day; Only available through Accredo 800-803-2523
AFINITOR DISPERZ	QL= 1 tab/day
AFINITOR TAB 10MG	QL= 1 tab/day
AIMOVIJ INJ	QL= 1 pack/28 days
AKYNZEO CAP	QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist
ALECENSA CAP	QL= 8 caps/day
ALINIA SUSP	QL= 60ml/3 days
ALUNBRIG TAB 30MG	QL= 4 tabs/day; Only available through Biologics 800-850-4306
ALUNBRIG TAB 90MG, 180MG	QL= 1 tab/day; Only available through Biologics 800-850-4306
ambrisentan tab	QL= 1 tab/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Lumicera 855-847-3553 or Walgreens 888-347-3416
ANDRODERM PATCH	QL= 1 patch/day
ANZEMET TAB	QL= 9 tabs/fill
aprepitant cap	QL= 3 caps/fill
aprepitant pak	QL= 3 caps/fill
ARIKAYCE SUSP	QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046
aripiprazole ODT	QL= 2 tabs/day
armodafinil tab	QL= 1 tab/day
asenapine maleate SL tab	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
AUSTEDO TAB	QL= 4 tabs/day
AYVAKIT TAB	QL= 1 tab/day; Only available through Biologics 800-850-4306
BACTROBAN NASAL OINT	QL= 10 tubes/fill
BALVERSA TAB 3MG	QL= 3 tabs/day; Only available through US Bioservices 888-518-7246
BALVERSA TAB 4MG	QL= 2 tabs/day; Only available through US Bioservices 888-518-7246
BALVERSA TAB 5MG	QL= 1 tab/day; Only available through US Bioservices 888-518-7246
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
bosentan tab	QL= 2 tabs/day; Restricted to Cardiology or Pulmonology Specialist; Only available through Walgreens 888-347-3416
BRAFTOVI CAP 75MG	QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118
BRUKINSA CAP	QL= 4 caps/day; Only available through Biologics 800-850-4306
budesonide ER tab	QL=1 tab/day
buprenorphine patch	QL= 4 patches/28 days
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

** 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.
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
butalbital/aspirin/caffeine cap	QL= 60 tabs/30 days
butorphanol nasal spray	QL= 1 bottle/fill, 2 fills/30 days
BYDUREON BCISE AUTO INJ	QL= 4 inj/28 days
BYDUREON INJ	QL= 4 inj/28 days
BYDUREON PEN INJ	QL= 4 inj/28 days
CABLIVI INJ KIT	QL= 1 vial/day; Only available through Biologics 800-850-4306
CABOMETYX TAB	QL= 1 tab/day
CALQUENCE CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
carisoprodol tab	QL= 90 tabs/90 days
CAVERJECT INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
celecoxib cap	QL= 2 caps/day
CHANTIX PAK	Limited to 180 days/plan year
CHANTIX TAB	Limited to 180 days/plan year
CIMZIA INJ	QL= 2 inj/28 days
CIMZIA STARTER INJ KIT	QL= 1 kit/plan year
CINRYZE INJ	QL= 16 vials/28 days; Only available through CVS Specialty 800-237-2767
COPIKTRA CAP	QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118
COTELLIC TAB	QL= 3 tabs/day
COVID-19 VACCINE INJ (MODERNA)	QL= 1 dose/24 days; limit 2 fills/12 months
COVID-19 VACCINE INJ (PFIZER)	QL= 1 dose/17 days; limit 2 fills/12 months
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
DEPO-PROVERA SC INJ 104MG	QL= 1 inj/90 days
DEXCOM G6 RECEIVER	QL= 1 receiver/year
DEXCOM G6 SENSOR	QL= 3 sensors/28 days
DEXCOM G6 TRANSMITTER	QL= 1 transmitter/90 days
DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL	QL= 2 packs/fill
diclofenac gel 1%	QL= 5 tubes/fill
DICLOFENAC PATCH, FLECTOR PATCH	QL= 30 patches/fill; Step Therapy requires trial of celecoxib
DIFICID SUSP	QL= 136 mL/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN
DIFICID TAB	QL= 20 tabs/fill; Step Therapy requires trial of vancomycin soln or FIRVANQ SOLN
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 TAB	QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479
DUPIXENT INJ	QL= 2 inj/ 28 days
DUPIXENT PEN INJ	QL= 2 inj/28 days
econazole cream	QL= 30gm/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.

SISC - Book of Business Drug List Cont.
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
EDEX INJ	QL= 6 inj/30 days; Step therapy requires trial of sildenafil
EMGALITY INJ	QL= 1 inj/28 days
EMGALITY INJ 100MG/ML	QL= 3 inj/fill, 6 fills/year
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
ENDARI POWDER PACK	QL= 6 packets/day
enoxaparin inj	QL= 17 days supply
entecavir tab	QL= 1 tab/day
ENTRESTO TAB	QL= 2 tabs/day
epinephrine pen inj 0.15mg, 0.3mg	QL= 2 inj/fill
ergotamine/cafeine tab	QL= 40 tabs/30 days
ERLEADA TAB	QL= 4 tabs/day
ESBRIET CAP	QL= 9 caps/day
ESBRIET TAB 267MG	QL= 9 tabs/day
ESBRIET TAB 801MG	QL= 3 tabs/day
estradiol vaginal tab, yuvafem vaginal tab	QL= 8 tabs/28 days, 18 tabs on first fill
eszopiclone tab	QL= 1 tab/day
everolimus tab	QL= 1 tab/day
FANAPT TAB	QL= 2 tabs/day; Step Therapy requires trial of ABILIFY or quetiapine ER
FANAPT TITRATION PACK	QL= 1 pack/plan year; Step Therapy requires trial of ABILIFY or quetiapine ER
FARXIGA TAB	QL= 1 tab/day
FARYDAK CAP	QL= 6 caps/21 days
FASENRA PEN INJ	QL= 1 inj/56 days
fentanyl citrate lollipop	QL= 120 lozenges/30 days
FENTORA TAB, FENTANYL BUCCAL TAB	QL= 120 tabs/30 days
FREESTYLE LIBRE 2 RECEIVER	QL= 1 receiver/year
FREESTYLE LIBRE 2 SENSOR	QL= 2 sensors/28 days
FREESTYLE LIBRE RECEIVER	QL= 1 receiver/year
FREESTYLE LIBRE SENSOR (10-DAY)	QL= 3 sensors/30 days
FREESTYLE LIBRE SENSOR (14-DAY)	QL= 2 sensors/28 days
GALAFOLD CAP	QL= 15 caps/30 days; Only available through Walgreens 888-347-3416
GAVILYTE-C SOLN	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
GILOTRIF TAB	QL= 1 tab/day; Only available through Accredo 800-803-2523
GLUCAGEN HYPOKIT INJ	QL= 2 inj/fill
glucagon (rdna) for inj kit	QL= 2 inj/fill
GLUCAGON EMR INJ	QL= 2 inj/fill
GLUCAGON KIT	QL= 2 inj/fill
GLYXAMBI TAB	QL= 1 tab/day
granisetron tab	QL= 9 tabs/fill
GRANISOL SOLN	QL= 60ml/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.

SISC - Book of Business Drug List Cont.
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
guaifenesin/codeine syrup	QL= 240ml/fill
GVOKE INJ	QL= 2 inj/fill
GVOKE PFS INJ	QL= 2 inj/fill
HUMIRA INJ 10MG	QL= 2 syringes/28 days
HUMIRA INJ 20MG	QL= 2 syringes/28 days
HUMIRA INJ 40MG	QL= 2 syringes/28 days
HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PEDIATRIC CROHNS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK	QL= 1 pack/fill, 1 fill/plan year
HUMIRA PEN INJ 40MG	QL= 2 pens/28 days
hydrocodone/chlorpheniramine CR susp	QL= 120ml/fill; 2 fills/30 days
HYDROCODONE/CHLORPHENIRAMINE/I SEUDOEPHEDRINE LIQUID	QL= 120ml/fill, 2 fills/month
HYSINGLA ER TAB	QL= 1 tab/day
ibandronate tab 150mg	QL= 1 tab/30 days
IBRANCE CAP	QL= 21 caps/28 days
IBRANCE TAB	QL= 21 caps/28 days
IDHIFA TAB	QL= 1 tab/day
IMBRUVICA CAP 140MG	QL= 3 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 TAB	QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118
INBRIJA INH POWDER	QL= 10 caps/day
INGREZZA CAP	QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479
INLYTA TAB	QL= 8 tabs/day
ISTURISA TAB 10MG	QL= 6 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007
ISTURISA TAB 1MG	QL= 8 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007
ISTURISA TAB 5MG	QL= 2 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007
ivermectin lotion	QL= 1 tube/fill
JAKAFI TAB	QL= 2 tabs/day
JANUMET TAB	QL= 2 tabs/day
JANUMET XR TAB	QL= 2 tabs/day
JANUVIA TAB	QL= 1 tab/day
JARDIANCE TAB	QL= 1 tab/day
JENTADUETO TAB	QL= 2 tabs/day
JENTADUETO XR TAB	QL= 2 tabs/day
JYNARQUE PAK	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
JYNARQUE TAB	QL= 2 tabs/day; Only available through Walgreens 888-347-3416
KALYDECO PAK	QL= 2 packets/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416

** 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.
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
KALYDECO TAB	QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
ketorolac tab	QL= 20 tabs/5 days
KEVZARA INJ	QL= 2 inj/28 days
KINERET INJ	QL= 1 inj/day; Only available through Biologics 800-850-4306
KOSELUGO CAP	QL= 4 caps/day; Only available through Onco360 877-662-6633
latanoprost ophth soln	QL= 2.5ml/30 days
LATUDA TAB	QL= 1 tab/day; Step Therapy requires trial of quetiapine
LAZANDA NASAL SPRAY	QL= 15 bottles/30 days
LEDIPASVIR/SOFOSBUVIR TAB	QL= 1 tab/ day
LENVIMA CAP	QL= 3 caps/day; Only available through Accredo 800-803-2523
LEVALBUTEROL INHALER, XOPENEX HFA INHALER	QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA
lidocaine oint	QL= 36gm/fill
lidocaine patch	QL= 3 patches/day
LORBRENA TAB 100MG	QL= 1 tab/day
LORBRENA TAB 25MG	QL= 3 tabs/day
LUCEMYRA TAB	QL= 84 tabs/7 days
LYNPARZA CAP	Only available through Biologics 800-850-4306, QL= 16 caps/day
LYNPARZA TAB	Only available through Biologics 800-850-4306, QL= 4 tabs/day
malathion lotion	QL= 2 bottles/fill
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; Only available through Diplomat Pharmacy 877-977-9118
methylegonovine tab	QL= 28 tabs/fill, 1 fill/365 days
MIGERGOT SUPP	QL=20 tabs/30 days
modafinil tab	QL= 2 tabs/day
MUSE SUPP	QL= 6 supp/30 days; Step therapy requires trial of sildenafil
NALOXONE PREFILLED INJ	QL= 2 inj/fill
naratriptan tab	QL= 9 tabs/fill, 2 fills/30 days
NARCAN NASAL SPRAY	QL= 2 sprays/fill
NATROBA SUSP	QL= 1 bottle/fill
NAYZILAM SPRAY	QL= 2 packs/fill; Restricted to Neurology Specialist
NERLYNX TAB	QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
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
NICOTROL INHALER	Limited to 180 days/plan year
NICOTROL NASAL SPRAY	Limited to 180 days/plan year
nitazoxanide tab	QL= 6 tabs/3 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.

SISC - Book of Business Drug List Cont.
Last Updated* 2/1/2021
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
NOXAFIL SUSP	QL= 525ml/26 days
NUBEQA TAB	QL= 4 tabs/day
NUCALA INJ	QL= 1 inj/28 days
NUCYNTA ER TAB	QL= 2 tabs/day
NUDEXTA CAP	QL= 2 caps/day
NURTEC ODT	QL= 8 tabs/30 days, 6 fills/year
NUZYRA TAB	QL= 2 tabs/day, 30 tabs/180 days; Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416
OCALIVA TAB	QL= 1 tab/day; Only available through Walgreens 888-347-3416
OFEV CAP	QL= 2 caps/day; Only available through Walgreens 888-347-3416
olopatadine ophth soln 0.2%	QL= 2.5ml/30 days; Step therapy requires trial of olopatadine ophth soln 0.1%
OLUMIANT TAB	QL= 1 tab/day
OMNIPOD 5 PACK PODS	QL= 10 pods/month
OMNIPOD DASH PODS	QL= 10 pods/month
OMNIPOD STARTER KIT	QL= 1 kit/year
OPSUMIT TAB	QL= 1 tab/day; Only available through CVS Specialty 800-237-2767
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
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 Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
ORKAMBI TAB	QL= 4 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
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
OXBRYTA TAB	QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767
OXERVATE OPHTH SOLN	QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523
OZEMPIC INJ	QL= 1 pack/28 days
PALYNZIQ INJ	QL= 1 inj/day; Only available through Diplomat Pharmacy 877-977-9118
peg 3350/electrolytes soln	Covered at \$0 for members 50-75 years-Limited to 2 fills/calendar year; All other members covered at generic copay
PEMAZYRE TAB	QL= 14 tabs/21 days; Only available through Biologics 800-850-4306
phentermine cap	QL= 1 cap/day
phentermine tab	QL= 1 tab/day
PICATO GEL	QL= 1 box/fill
POMALYST CAP	QL= 21 caps/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.

SISC - Book of Business Drug List Cont.
Last Updated* 2/1/2021
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
posaconazole DR tab	QL= 93 tabs/30 days
POTIGA TAB	QL= 3 tabs/day
PRALUENT INJ	QL= 2 inj/28 days
PRETOMANID TAB	QL= 1 tab/day; Restricted to Infectious Disease Specialist
PROLIA INJ	QL= 1 fill/6 months
pyrimethamine tab	QL= 3 tabs/day; Only available through Walgreens 888-347-3416
QINLOCK TAB	QL= 3 tabs/day; Only available through Biologics 800-850-4306
REGRANEX GEL	QL= 30gm/fill
RELENZA DISKHALER	QL= 1 inhaler/calendar year
REPATHA INJ	QL= 2 inj/28 days
REPATHA PUSHTRONEX INJ	QL= 1 inj/28 days
RETEVMO CAP	QL= 4 caps/day
RETIN-A CREAM	QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization
RETIN-A GEL	QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization
REVLIMID CAP	QL= 1 cap/day; Restricted to Oncology or Hematology Specialist
REYVOW TAB	QL= 8 tabs/30 days, 6 fills/year
RINVOQ ER TAB	QL= 1 tab/day
rizatriptan ODT	QL= 12 tabs/fill, 3 fills/60 days
rizatriptan tab	QL= 12 tabs/fill, 3 fills/60 days
rosuvastatin tab 10mg	QL= 1 tab/day
rosuvastatin tab 5mg	QL= 1 tab/day
ROZLYTREK CAP	QL= 3 caps/day
RUBRACA TAB	QL= 4 tabs/day; Only available through Avella Pharmacy (877) 546-5779
RYBELSUS TAB	QL=1 tab/day
SANCUSO PATCH	QL= 4 patches/fill
SANTYL OINT	QL= 90gm/30 days
SAVELLA TAB	QL= 2 tabs/day
SIGNIFOR INJ	QL= 2 vials/day; Only available through Accredo 800-803-2523
sildenafil tab	QL=6 tabs/30 days
SIVEXTRO TAB	QL= 6 tabs/fill; Restricted to Infectious Disease Specialist
SKLICE LOTION	QL= 1 tube/fill
SKYRIZI INJ	QL= 2 inj/84 days
SOFOSBUVIR/VELPATASVIR TAB	QL= 1 tab/ day
SOLIQUA INJ	QL= 15ml/25 days
SPINOSAD SUSP	QL= 1 bottle/fill
SPIRIVA RESPIMAT INHALER 1.25MCG/ACT	QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR, BREO, DULERA, or FLUTICASONE/SALMETEROL
STELARA INJ	QL= 1 inj/84 days
STIVARGA TAB	QL= 4 tabs/day
STRIVERDI RESPIMAT INHALER	QL= 1 inhaler/30 days
sumatriptan inj	QL= 4 inj/fill, 2 fills/30 days
SUMATRIPTAN INJ 6MG/0.5ML	QL= 4 inj/fill, 2 fills/30 days
sumatriptan nasal spray	QL= 6 sprays/fill, 2 fills/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.

SISC - Book of Business Drug List Cont.
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
sumatriptan tab	QL= 9 tabs/fill, 2 fills/30 days
sumatriptan vial inj	QL= 5 inj/fill, 2 fills/30 days
SUNOSI TAB	QL= 1 tab/day
SYMDEKO TAB	QL= 2 tabs/day; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
SYMJEPI INJ	QL= 2 inj/fill
SYNJARDY TAB	QL= 2 tabs/day
SYNJARDY XR TAB 10-1000MG, 25-1000MG	QL= 1 tab/day
SYNJARDY XR TAB 5-1000MG, 12.5-1000MG	QL= 2 tabs/day
TABRECTA TAB	QL= 4 tabs/day
tadalafil tab 2.5mg	QL= 1 tab/day
tadalafil tab 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 CVS Specialty 800-237-2767
TALTZ INJ	QL= 1 inj/28 days
TALZENNA CAP 0.25MG	QL= 3 caps/day
TALZENNA CAP 1MG	QL= 1 cap/day
TAVALISSE TAB	QL= 2 tab/day; Only available through Biologics 800-850-4306
TAZVERIK TAB	QL= 8 tabs/day; Only available through Onco360 877-662-6633
TEGSEDI INJ	QL= 4 inj/28 days; Only available through Accredo 800-803-2523
testosterone gel pump 1.62%	QL= 2 bottles/30 days
testosterone soln	QL= 2 bottles/30 days
TIBSOVO TAB	QL= 2 tabs/day; Only available through Diplomat Pharmacy 877-977-9118
TRACLEER TAB 32MG	QL=4 tabs/day; Only available through Walgreens 888-347-3416
TRADJENTA TAB	QL= 1 tab/day
travoprost ophth soln	QL= 5ml/30 days; Step Therapy requires trial of latanoprost
TREMFYA INJ	QL= 1 inj/56 days
tretinoin cream	QL= 20gm/fill; Acne Only – members age 35 or older require Prior Authorization
tretinoin gel	QL= 15gm/fill. Acne Only – members age 35 or older require Prior Authorization
TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG	QL= 1 tab/day
TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG	QL= 2 tabs/day
TRIKAFTA TAB	QL= 84 tabs/28 days; Only available through Maxor Pharmacy 800-658-6046 or Walgreens 888-347-3416
trilyte soln	Covered at \$0 for members 50-75 years, all other members covered at generic copay Limited to 2 fills/calendar year
TRINTELLIX TAB	QL= 1 tab/day
TRULICITY INJ	QL= 4 pens/28 days
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

** 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.
Last Updated* 2/1/2021
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
TYVASO INH SOLN	QL= 1 ampule/day; Only available through Accredo 800-803-2523
UBRELVY TAB	QL= 10 tabs/30 days, 6 fills/year
ULESFIA LOTION	QL= 4 bottles/fill
UPTRAVI TAB	QL= 2 tabs/day; Only available through Accredo 800-803-2523
VALCHLOR GEL	QL= 4 tubes/30 days; Only available through Avella (877) 546-5779
VALTOCO NASAL SPRAY	QL= 2 packs/fill; Restricted to Neurology Specialist
vancomycin cap	QL= 56 caps/fill
VARUBI TAB	QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist
VASCEPA CAP 0.5GM	QL= 4 caps/day
VASCEPA CAP 1GM	QL= 4 caps/day
VENTAVIS INH SOLN	QL= 9 ampules/day; Only available through Accredo 800-803-2523
VENTOLIN HFA INHALER	QL= 2 inhalers/30 days
VERZENIO TAB	QL= 2 tabs/day
V-GO INJ KIT	QL= 1 kit/day
VICTOZA INJ	QL= 9ml/30 days
VIMPAT TAB	QL= 2 tabs/day
VITRAKVI CAP 100MG	QL= 2 caps/day; Only available through US Bioservices 888-518-7246
VITRAKVI CAP 25MG	QL= 6 caps/day; Only available through US Bioservices 888-518-7246
VITRAKVI SOLN	QL= 10ml/day; Only available through US Bioservices 888-518-7246
VIVOTIF BERNA CAP	QL= 4 caps/fill
VIZIMPRO TAB	QL= 1 tab/day
VOSEVI TAB	QL= 1 tab/day
VYNDAMAX CAP	QL= 1 cap/day
VYNDAQEL CAP	QL= 4 caps/day
WAKIX TAB	QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479
XADAGO TAB	QL= 1 tab/day
XALKORI CAP	QL= 2 caps/day
XCOPRI PAK 150-200MG	QL= 2 tabs/day
XCOPRI PAK 50-200MG	QL= 2 tabs/day
XCOPRI TAB 150MG, 200MG	QL= 2 tabs/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
XELJANZ TAB	QL= 2 tabs/day
XELJANZ XR TAB	QL= 1 tab/day
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 2.5-1000MG, 5-1000MG	QL= 2 tabs/day
XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG	QL= 1 tab/day
XOSPATA TAB	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.

SISC - Book of Business Drug List Cont.
Last Updated* 2/1/2021
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

Drug Name	Quantity Limit
XPOVIO PAK	QL= 32 tabs/28 days; Only available through Biologics 800-850-4306
XTAMPZA ER CAP	QL= 120 caps/30 days
XULTOPHY INJ	QL= 15ml/30 days
XYREM SOLN	QL= 540ml/30 days; Only available through Xyrem Central Pharmacy 314-587-4050
ZEJULA CAP	QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118
ZELBORAF TAB	QL= 8 tabs/day
zolmitriptan ODT	QL= 9 tabs/fill, 2 fills/30 days
ZOLMITRIPTAN SPRAY, ZOMIG 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
ZYKADIA CAP	QL= 3 caps/day
ZYKADIA TAB	QL= 3 tabs/day
ZYLET OPHTH SUSP	QL= 5ml/fill (10ml bottle is Not Covered)

** 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.