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Medicare Plus BlueSM Group PPO
Prescription BlueSM Group PDP

2021 Group Enhanced Comprehensive Formulary

(List of Covered Drugs)

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

This formulary was updated on September 1, 2021. For more recent information or other questions, please contact us, **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** Customer Service, at 1-866-684-8216 or, for TTY users 711, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m. Eastern time, seven days a week, or visit www.bcbsm.com/medicare.



When visiting your doctor(s), please bring your personal drug list and this 2021 Blue Cross Drug List with you.

Updated: 09/01/2021
Formulary 21363, Version 15
www.bcbsm.com/medicare



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Medicare Advantage Plans

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Blue Cross Blue Shield of Michigan. When it refers to “plan” or “our plan,” it means **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP**.

This document includes a list of the drugs (formulary) for our plan which is current as of September 1, 2021. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2022, and from time to time during the year.

What is the Medicare Plus Blue Group PPO and Prescription Blue Group PDP Group Enhanced Formulary?

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

Can the Formulary (drug list) change?

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

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

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes

based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, or quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 31-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP Group Enhanced Formulary?**"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of September 1, 2021. To get updated information about the drugs covered by **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP**, please contact us. Our contact information appears on the front and back cover pages. In the event of a mid-year non-maintenance formulary change, we will send out an errata sheet to notify you of this change.

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page Index 1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Medicare Plus Blue Group PPO and **Prescription Blue Group PDP** cover both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization: Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** before you fill your prescriptions. If you don't get approval, **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** may not cover the drug.
- **Quantity Limits:** For certain drugs, **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** limit the amount of the drug that **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** will cover. For example, **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** provides 31 tablets per prescription for *pioglitazone*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** may not cover Drug B unless you try Drug A first. If Drug A does not work for you, **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** will then cover Drug B.

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

You can ask **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** formulary?” on page iii for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** pays for certain OTC drugs. **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** will provide these OTC drugs at no cost to you. The cost to **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** of these OTC drugs will not count toward your total Part D drug costs (that is, the cost of the OTC drugs does not count for the coverage gap).

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of drugs), you should first contact Customer Service and ask if your drug is covered.

If you learn that **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** do not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP**. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP**.
- You can ask **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Medicare Plus Blue Group PPO and Prescription Blue Group PDP Group Enhanced Formulary?

You can ask **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP** limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31-day supply of medication. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

If you move into (or out of) a long-term care facility, a skilled nursing facility or if you are discharged from a hospital, you will continue to have access to your medications during the transition. If needed, limits on early prescription refills will be waived to assure that your medications are available through a new pharmacy provider when you are moving to or from a long-term care facility. Contact Customer Service if you require assistance in your transition. For more detailed information about our Transition Policy, refer to your *Evidence of Coverage* or visit our website at www.bcbsm.com/medicare/help/forms-documents.html.

We will send you a letter within three business days of your filling a temporary transition supply, notifying you that this was a temporary supply and explaining your options.

For more information

For more detailed information about your **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP**, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

Medicare Plus Blue Group PPO and Prescription Blue Group PDP Group Enhanced Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by **Medicare Plus Blue Group PPO** and **Prescription Blue Group PDP**. If you have trouble finding your drug in the list, turn to the Index that begins on page Index 1.

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

The information in the Requirements/Limits column tells you if **Medicare Plus Blue Group PPO** or **Prescription Blue Group PDP** have any special requirements for coverage of your drug.

Tier Descriptions

Medicare Plus Blue Group PPO and Prescription Blue Group PDP Drug Tier Costs							
Tier	Drug Description	Up to a 31-day supply				Up to a 90-day supply*	
		Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)	Long-term care (LTC) cost sharing	Out-of network cost sharing	Standard retail and standard mail-order cost sharing (in-network)	Preferred retail and preferred mail-order cost sharing (in-network)
Tier 1	Preferred Generic	See your <i>Evidence of Coverage</i> Chart for member cost-share details					
Tier 2	Generic						
Tier 3	Preferred Brand						
Tier 4	Non-Preferred Drug						
Tier 5	Specialty Tier	See your Medical or Prescription Benefits Chart for member cost-share details				90-day supply is not available	

Out-of-network pharmacy coverage is limited to certain situations. Consult your *Evidence of Coverage* for details.

*Most pharmacies will fill a 90-day supply of medication. Check with your pharmacist.

Drug Notes Code Definitions

Symbol	Definition
HRM	High Risk Medication. Medicine that may be unsafe in patients greater than 65 years of age. Our formulary does include coverage for some of these drugs, but alternatives may be found on the formulary. Please discuss with your doctor if there are alternatives to these medications that would be appropriate for you to use.
B/D	This prescription drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
EX	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count toward your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
LA	Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, call Medicare Plus Blue Group PPO and Prescription Blue Group PDP Customer Service at 1-866-684-8216, Monday through Friday, 8:30 a.m. to 5:00 p.m. Eastern time. From October 1 through March 31, hours are from 8 a.m. to 9 p.m. Eastern time, seven days a week. TTY users should call 711.
PA	Prior Authorization. The plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don't get approval, we may not cover the drug.
QL	Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.
ST	Step Therapy. In some cases, the plan requires you to first try a certain drug to treat your condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
NEDS	Non-Extended Day Supply. These drugs are not offered at a 90-day supply. They are offered up to a 31-day supply.

Drug Name	Drug Tier	Requirements /Limits
ANALGESICS		
ANALGESICS, OTHER		
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	4	
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	2	
<i>butalbital-acetaminophen-caff oral capsule</i>	2	
<i>butalbital-acetaminophen-caff oral tablet</i>	2	
<i>butalbital-aspirin-caffeine oral capsule</i>	2	
<i>butalbital-aspirin-caffeine oral tablet</i>	2	
<i>tencon oral tablet</i>	2	QL (1080 per 90 days)
<i>zebutal oral capsule</i>	2	
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
<i>cataflam oral tablet</i>	2	HRM
<i>celecoxib oral capsule 100 mg</i>	2	QL (270 per 90 days)
<i>celecoxib oral capsule 200 mg, 400 mg</i>	2	QL (180 per 90 days)
<i>celecoxib oral capsule 50 mg</i>	2	QL (540 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>choline,magnesium salicylate oral liquid</i>	2	EX
DICLOFENAC EPOLAMINE TRANSDERMAL PATCH 12 HOUR	4	PA; HRM
<i>diclofenac potassium oral tablet</i>	2	HRM
<i>diclofenac sodium oral tablet extended release 24 hr</i>	2	HRM
<i>diclofenac sodium oral tablet,delayed release (dr/ec)</i>	2	HRM
<i>diclofenac sodium topical gel 1 %</i>	2	HRM; QL (1000 per 31 days)
<i>diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic</i>	2	
<i>diflunisal oral tablet</i>	2	HRM
<i>ec-naproxen oral tablet,delayed release (dr/ec)</i>	2	HRM
<i>etodolac oral capsule</i>	2	HRM
<i>etodolac oral tablet</i>	2	HRM
<i>etodolac oral tablet extended release 24 hr</i>	2	HRM
<i>fenoprofen oral tablet</i>	2	HRM

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
Brand-name drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
FLECTOR TRANSDERMAL PATCH 12 HOUR	4	PA; HRM
<i>flurbiprofen oral tablet 100 mg</i>	2	
<i>ibu oral tablet 400 mg</i>	2	HRM
<i>ibu oral tablet 600 mg, 800 mg</i>	1	HRM
<i>ibuprofen oral suspension</i>	2	HRM
<i>ibuprofen oral tablet 400 mg</i>	2	HRM
<i>ibuprofen oral tablet 600 mg, 800 mg</i>	1	HRM
INDOCIN ORAL SUSPENSION	4	HRM
<i>indomethacin oral capsule</i>	2	HRM
<i>indomethacin oral capsule, extended release</i>	2	HRM
<i>indomethacin sodium intravenous recon soln</i>	4	HRM
<i>ketoprofen oral capsule</i>	2	HRM
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	2	HRM; QL (90 per 90 days)
<i>ketorolac injection cartridge 30 mg/ml</i>	4	HRM
<i>ketorolac injection syringe 15 mg/ml</i>	4	HRM

Drug Name	Drug Tier	Requirements /Limits
<i>ketorolac intramuscular solution</i>	4	HRM
<i>ketorolac oral tablet</i>	2	HRM; QL (360 per 90 days)
<i>meclofenamate oral capsule</i>	4	HRM
<i>mefenamic acid oral capsule</i>	4	HRM
<i>meloxicam oral tablet</i>	1	HRM
<i>nabumetone oral tablet</i>	2	HRM
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 750 MG	4	HRM
<i>naproxen oral suspension</i>	2	HRM
<i>naproxen oral tablet</i>	2	HRM
<i>naproxen oral tablet, delayed release (dr/ec)</i>	2	HRM
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	HRM
<i>oxaprozin oral tablet</i>	2	HRM
<i>piroxicam oral capsule</i>	2	HRM
<i>salsalate oral tablet 750 mg</i>	2	
<i>sulindac oral tablet</i>	2	HRM
<i>tolmetin oral capsule</i>	2	HRM

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>tolmetin oral tablet 600 mg</i>	2	HRM
OPIOID ANALGESICS, LONG-ACTING		
<i>buprenorphine transdermal patch weekly</i>	4	QL (12 per 84 days)
BUTRANS TRANSDERMAL PATCH WEEKLY 7.5 MCG/HOUR	4	QL (12 per 84 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	2	QL (45 per 90 days)
<i>levorphanol tartrate oral tablet</i>	2	
<i>methadone oral solution</i>	2	
<i>methadone oral tablet</i>	2	
<i>morphine intravenous syringe 2 mg/ml</i>	4	
<i>morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	4	QL (180 per 90 days)
<i>morphine oral capsule, extend. release pellets 40 mg</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>morphine oral tablet extended release 100 mg, 15 mg, 30 mg, 60 mg</i>	4	QL (270 per 90 days)
<i>morphine oral tablet extended release 200 mg</i>	4	QL (90 per 90 days)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR	4	
OXYCODONE ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR	4	
OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR	4	
<i>oxymorphone oral tablet extended release 12 hr</i>	4	QL (180 per 90 days)
<i>tramadol oral tablet extended release 24 hr</i>	2	QL (90 per 90 days)
<i>tramadol oral tablet, er multiphase 24 hr</i>	2	QL (90 per 90 days)
OPIOID ANALGESICS, SHORT-ACTING		

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
Brand-name drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>acetaminophen-codeine oral solution 120 mg-12 mg /5 ml (5 ml), 120-12 mg/5 ml, 300 mg-30 mg /12.5 ml</i>	2	QL (5167 per 31 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	2	QL (1080 per 90 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	2	QL (540 per 90 days)
<i>ascomp with codeine oral capsule</i>	2	
<i>belladonna alkaloids-opium rectal suppository</i>	2	EX
<i>butalbital compound w/codeine oral capsule</i>	2	
<i>butalbital-acetaminop-caf-cod oral capsule</i>	2	
<i>butorphanol nasal spray,non-aerosol</i>	2	QL (15 per 90 days)
<i>codeine sulfate oral tablet 15 mg, 60 mg</i>	2	QL (540 per 90 days)
<i>codeine sulfate oral tablet 30 mg</i>	2	QL (1080 per 90 days)
<i>codeine-bitalbital-asa-caff oral capsule</i>	2	
DEMEROL (PF) INJECTION SOLUTION 100 MG/2 ML	4	HRM

Drug Name	Drug Tier	Requirements /Limits
DEMEROL (PF) INJECTION SYRINGE	4	HRM
DEMEROL INJECTION SOLUTION 50 MG/ML	4	HRM
<i>duramorph (pf) injection solution 0.5 mg/ml</i>	4	QL (4133 per 31 days)
<i>duramorph (pf) injection solution 1 mg/ml</i>	4	QL (6000 per 90 days)
<i>endocet oral tablet</i>	2	QL (1080 per 90 days)
<i>fentanyl citrate (pf) injection solution</i>	2	
<i>fentanyl citrate buccal lozenge on a handle</i>	5	PA; NEDS
FENTANYL CITRATE BUCCAL TABLET, EFFERVESCENT	5	PA; NEDS
FENTORA BUCCAL TABLET, EFFERVESCENT	5	PA; NEDS
<i>hydrocodone-acetaminophen oral solution</i>	2	QL (5735 per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	2	QL (1080 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
Brand-name drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocodone-ibuprofen oral tablet</i>	2	QL (450 per 90 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	4	
<i>hydromorphone injection solution 1 mg/ml</i>	4	
<i>hydromorphone injection solution 2 mg/ml</i>	2	
<i>hydromorphone injection syringe 1 mg/ml, 2 mg/ml, 4 mg/ml</i>	4	
<i>hydromorphone oral liquid</i>	2	
<i>hydromorphone oral tablet</i>	2	
<i>hydromorphone rectal suppository</i>	2	EX
LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY	5	PA; NEDS
LORTAB ELIXIR ORAL SOLUTION	4	QL (6000 per 30 days)
<i>morphine (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	4	
<i>morphine concentrate oral solution</i>	2	

Drug Name	Drug Tier	Requirements /Limits
MORPHINE INJECTION SOLUTION 2 MG/ML, 4 MG/ML	4	
<i>morphine injection solution 8 mg/ml</i>	4	
<i>morphine injection syringe 8 mg/ml</i>	4	
MORPHINE INTRAVENOUS SOLUTION 4 MG/ML, 8 MG/ML	4	
MORPHINE INTRAVENOUS SYRINGE 8 MG/ML	4	
<i>morphine oral solution</i>	2	
<i>morphine oral tablet</i>	2	
<i>nalbuphine injection solution 10 mg/ml</i>	2	QL (600 per 90 days)
<i>nalbuphine injection solution 20 mg/ml</i>	2	QL (300 per 90 days)
NUCYNTA ORAL TABLET 100 MG	4	QL (543 per 90 days)
NUCYNTA ORAL TABLET 50 MG	4	QL (1086 per 90 days)
NUCYNTA ORAL TABLET 75 MG	4	QL (726 per 90 days)
<i>oxycodone oral capsule</i>	2	
<i>oxycodone oral concentrate</i>	4	
<i>oxycodone oral solution</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>oxycodone oral tablet</i>	2	
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (1080 per 90 days)
<i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i>	2	
<i>oxymorphone oral tablet</i>	4	
<i>pentazocine-naloxone oral tablet</i>	2	
PRIMLEV ORAL TABLET	4	QL (1170 per 90 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 1,200 MCG (600 MCG/SPRAY X 2), 1,600 MCG (800 MCG/SPRAY X 2)	5	PA; QL (124 per 31 days); NEDS
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY	5	PA; NEDS
<i>tramadol oral tablet 50 mg</i>	2	QL (720 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>tramadol-acetaminophen oral tablet</i>	2	QL (1080 per 90 days)
ANESTHETICS		
LOCAL ANESTHETICS		
CETACAINE TOPICAL AEROSOL, SPRAY	4	EX
<i>lidocaine (pf) in d7.5w intrathecal solution</i>	4	
<i>lidocaine hcl injection solution 10 mg/ml (1 %)</i>	4	
<i>lidocaine hcl topical cream 3 %</i>	2	EX
<i>lidocaine hcl-hydrocortison ac rectal cream</i>	2	EX
<i>lidocaine hcl-hydrocortison ac rectal kit 3-0.5 %, 3-1 % (7 gram)</i>	2	EX
<i>lidocaine hcl-hydrocortison ac topical cream</i>	2	EX
<i>lidocaine in 5 % dextrose (pf) intravenous parenteral solution 8 mg/ml (0.8 %)</i>	4	
<i>lidocaine topical adhesive patch, medicated 5 %</i>	3	PA; QL (270 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>lidocaine-epinephrine (pf) injection solution 2 %-1:200,000</i>	4	
<i>lidocaine-epinephrine injection solution</i>	4	
<i>lidocaine-hydrocortisone-aloe rectal gel</i>	2	EX
<i>lidocaine-prilocaine topical cream</i>	4	
<i>lidocort topical cream</i>	2	EX
<i>lidopin topical cream 3 %</i>	2	EX
PAIN EASE MEDIUM STREAM SPRAY TOPICAL AEROSOL,SPRAY	4	EX
PAIN EASE MIST SPRAY TOPICAL AEROSOL,SPRAY	4	EX
PLIAGLIS TOPICAL CREAM	4	
SPRAY AND STRETCH TOPICAL AEROSOL,SPRAY	4	EX
SYNERA TOPICAL PATCH, MEDICATED SELF-HEATING	4	

Drug Name	Drug Tier	Requirements /Limits
XYLOCAINE-MPF INJECTION SOLUTION 10 MG/ML (1 %), 20 MG/ML (2 %)	4	
XYLOCAINE-MPF/EPINEPHRINE INJECTION SOLUTION	4	
<i>zionodil topical lotion</i>	2	EX
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
<i>acamprosate oral tablet,delayed release (dr/ec)</i>	2	
<i>disulfiram oral tablet</i>	2	
OPIOID DEPENDENCE TREATMENTS		
BUNAVAIL BUCCAL FILM 4.2-0.7 MG	4	
OPIOID DEPENDENCE		
<i>buprenorphine hcl sublingual tablet</i>	1	
<i>buprenorphine-naloxone sublingual film</i>	1	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>buprenorphine-naloxone sublingual tablet</i>	1	
LUCEMYRA ORAL TABLET	5	NEDS
<i>naltrexone oral tablet</i>	1	
ZUBSOLV SUBLINGUAL TABLET	4	
OPIOID REVERSAL AGENTS		
KLOXXADO NASAL SPRAY, NON-AEROSOL	3	
<i>naloxone injection solution</i>	1	
<i>naloxone injection syringe 0.4 mg/ml</i>	2	
<i>naloxone injection syringe 1 mg/ml</i>	1	
NARCAN NASAL SPRAY, NON-AEROSOL	3	
SMOKING CESSATION AGENTS		
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr</i>	2	
CHANTIX CONTINUING MONTH BOX ORAL TABLET	3	
CHANTIX ORAL TABLET	3	

Drug Name	Drug Tier	Requirements /Limits
CHANTIX STARTING MONTH BOX ORAL TABLETS, DOSE PACK	3	
NICOTROL INHALATION CARTRIDGE	4	
NICOTROL NS NASAL SPRAY, NON-AEROSOL	4	
VARENICLINE ORAL TABLET	3	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
<i>amikacin injection solution 500 mg/2 ml</i>	4	
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION	5	PA; NEDS
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	4	
<i>gentamicin injection solution 40 mg/ml</i>	4	
<i>gentamicin sulfate (ped) (pf) injection solution</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>gentamicin topical cream</i>	2	
<i>gentamicin topical ointment</i>	2	
<i>neomycin oral tablet</i>	2	
<i>paromomycin oral capsule</i>	2	
<i>tobramycin sulfate injection recon soln</i>	4	
<i>tobramycin sulfate injection solution</i>	4	
ANTIBACTERIALS, OTHER		
<i>acetic acid otic (ear) solution</i>	2	
<i>aztreonam injection recon soln 1 gram</i>	4	
<i>bacitracin intramuscular recon soln</i>	4	
<i>clindamycin hcl oral capsule</i>	2	
CLINDAMYCIN IN 0.9 % SOD CHLOR INTRAVENOUS PIGGYBACK	4	
<i>clindamycin in 5 % dextrose intravenous piggyback</i>	4	
<i>clindamycin pediatric oral recon soln</i>	4	
<i>clindamycin phosphate injection solution</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	4	
CLINDAMYCIN PHOSPHATE TOPICAL GEL, ONCE DAILY	2	
<i>colistin (colistimethate na) injection recon soln</i>	4	
<i>daptomycin intravenous recon soln 500 mg</i>	5	NEDS
FIRVANQ ORAL RECON SOLN	4	
<i>fosfomycin tromethamine oral packet</i>	4	
<i>linezolid in dextrose 5% intravenous piggyback</i>	5	NEDS
<i>linezolid oral suspension for reconstitution</i>	2	QL (1680 per 28 days)
<i>linezolid oral tablet</i>	4	QL (56 per 28 days)
<i>linezolid-0.9% sodium chloride intravenous parenteral solution</i>	5	NEDS
<i>methenamine hippurate oral tablet</i>	2	
<i>metro i.v. intravenous piggyback</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
<i>metronidazole in nacl (iso-os) intravenous piggyback</i>	4	
<i>metronidazole oral capsule</i>	2	
<i>metronidazole oral tablet</i>	2	
<i>metronidazole topical cream</i>	2	
<i>metronidazole topical gel</i>	2	
<i>metronidazole topical gel with pump</i>	2	
<i>metronidazole topical lotion</i>	2	
<i>metronidazole vaginal gel</i>	2	
MONUROL ORAL PACKET	4	
<i>neomycin-polymyxin b gu irrigation solution</i>	4	
<i>nitrofurantoin macrocrystal oral capsule</i>	2	HRM
<i>nitrofurantoin monohyd/m-cryst oral capsule</i>	2	HRM
<i>nitrofurantoin oral suspension</i>	2	HRM
NUVESSA VAGINAL GEL	4	

Drug Name	Drug Tier	Requirements /Limits
<i>phenazopyridine oral tablet 100 mg, 200 mg</i>	2	EX
<i>polymyxin b sulfate injection recon soln</i>	4	
<i>rosadan topical cream</i>	2	
<i>rosadan topical gel</i>	2	
SIVEXTRO INTRAVENOUS RECON SOLN	5	NEDS
SIVEXTRO ORAL TABLET	5	NEDS
<i>tinidazole oral tablet</i>	2	
<i>trimethoprim oral tablet</i>	2	
VANCOMYCIN (BULK) POWDER	4	EX
VANCOMYCIN IN DEXTROSE 5 % INTRAVENOUS PIGGYBACK 1 GRAM/200 ML	4	
VANCOMYCIN INJECTION RECON SOLN	4	
<i>vancomycin intravenous recon soln 1,000 mg, 1.5 gram, 10 gram, 500 mg, 750 mg</i>	4	
<i>vancomycin oral capsule</i>	4	
<i>vancomycin oral recon soln</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
<i>vandazole vaginal gel</i>	2	
XENLETA ORAL TABLET	5	NEDS
XIFAXAN ORAL TABLET 550 MG	4	QL (270 per 90 days)
BETA-LACTAM, CEPHALOSPORINS		
<i>cefaclor oral capsule</i>	2	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	2	
<i>cefaclor oral tablet extended release 12 hr</i>	2	
<i>cefadroxil oral capsule</i>	2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	2	
<i>cefadroxil oral tablet</i>	2	
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml</i>	4	
<i>cefazolin injection recon soln 1 gram, 10 gram, 100 gram, 300 g, 500 mg</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>cefazolin intravenous recon soln</i>	4	
<i>cefdinir oral capsule</i>	2	
<i>cefdinir oral suspension for reconstitution</i>	2	
CEFEPIME IN DEXTROSE 5 % INTRAVENOUS PIGGYBACK 1 GRAM/50 ML	4	
<i>cefepime in dextrose, iso-osm intravenous piggyback 1 gram/50 ml</i>	4	
<i>cefepime injection recon soln 1 gram</i>	4	
<i>cefixime oral capsule</i>	2	
<i>cefixime oral suspension for reconstitution</i>	2	
<i>cefoxitin in dextrose, iso-osm intravenous piggyback</i>	4	
<i>cefoxitin intravenous recon soln</i>	4	
<i>cefpodoxime oral suspension for reconstitution</i>	2	
<i>cefpodoxime oral tablet</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>cefprozil oral suspension for reconstitution</i>	2	
<i>cefprozil oral tablet</i>	2	
CEFTAZIDIME IN D5W INTRAVENOUS PIGGYBACK	4	
<i>ceftazidime injection recon soln</i>	4	
<i>ceftriaxone in dextrose,iso-os intravenous piggyback</i>	4	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	4	
CEFTRIAZONE INJECTION RECON SOLN 100 GRAM	4	
<i>ceftriaxone intravenous recon soln</i>	4	
<i>cefuroxime axetil oral tablet</i>	2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	4	
<i>cefuroxime sodium intravenous recon soln</i>	4	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>cephalexin oral suspension for reconstitution</i>	1	
<i>cephalexin oral tablet</i>	1	
FETROJA INTRAVENOUS RECON SOLN	5	NEDS
SUPRAX ORAL CAPSULE	4	
<i>tazicef injection recon soln 1 gram, 2 gram</i>	4	
<i>tazicef intravenous recon soln</i>	4	
TEFLARO INTRAVENOUS RECON SOLN	4	
BETA-LACTAM, PENICILLINS		
<i>amoxicillin oral capsule</i>	1	
<i>amoxicillin oral suspension for reconstitution</i>	1	
<i>amoxicillin oral tablet</i>	1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>amoxicillin-pot clavulanate oral tablet</i>	2	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	2	
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	2	
<i>ampicillin oral capsule 500 mg</i>	2	
<i>ampicillin sodium injection recon soln 1 gram, 125 mg, 250 mg, 500 mg</i>	4	
<i>ampicillin sodium intravenous recon soln</i>	4	
<i>ampicillin-sulbactam injection recon soln</i>	4	
<i>ampicillin-sulbactam intravenous recon soln</i>	4	
BICILLIN C-R INTRAMUSCULAR SYRINGE	4	
BICILLIN L-A INTRAMUSCULAR SYRINGE	4	
<i>dicloxacillin oral capsule</i>	2	
<i>nafcillin in dextrose iso-osm intravenous piggyback</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>nafcillin injection recon soln</i>	4	
<i>nafcillin intravenous recon soln</i>	4	
<i>oxacillin in dextrose(iso-osm) intravenous piggyback</i>	4	
<i>oxacillin injection recon soln</i>	4	
<i>penicillin g potassium injection recon soln</i>	4	
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	4	
<i>penicillin g sodium injection recon soln</i>	4	
<i>penicillin v potassium oral recon soln</i>	1	
<i>penicillin v potassium oral tablet</i>	1	
PIPERACILLIN-TAZOBACTAM INTRAVENOUS RECON SOLN 13.5 GRAM	4	
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	4	

CARBAPENEMS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

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Drug Name	Drug Tier	Requirements /Limits
<i>ertapenem injection recon soln</i>	4	
<i>imipenem-cilastatin intravenous recon soln</i>	4	
<i>meropenem intravenous recon soln</i>	4	
MEROPENEM-0.9% SODIUM CHLORIDE INTRAVENOUS PIGGYBACK	4	
MACROLIDES		
<i>azithromycin intravenous recon soln</i>	4	
<i>azithromycin oral packet</i>	2	
<i>azithromycin oral suspension for reconstitution</i>	2	
<i>azithromycin oral tablet</i>	2	
<i>clarithromycin oral suspension for reconstitution</i>	2	
<i>clarithromycin oral tablet</i>	2	
<i>clarithromycin oral tablet extended release 24 hr</i>	2	

Drug Name	Drug Tier	Requirements /Limits
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	5	QL (136 per 10 days); NEDS
DIFICID ORAL TABLET	5	QL (20 per 10 days); NEDS
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	4	
<i>erythrocin (as stearate) oral tablet 250 mg</i>	2	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	4	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	2	
<i>erythromycin ethylsuccinate oral tablet</i>	2	
<i>erythromycin oral capsule, delayed release(dr/ec)</i>	2	
<i>erythromycin oral tablet</i>	2	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	2	
QUINOLONES		

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Drug Name	Drug Tier	Requirements /Limits
BAXDELA INTRAVENOUS RECON SOLN	5	NEDS
BAXDELA ORAL TABLET	5	NEDS
<i>ciprofloxacin hcl oral tablet 100 mg, 750 mg</i>	2	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg</i>	1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	4	
<i>levofloxacin in d5w intravenous piggyback</i>	4	
<i>levofloxacin intravenous solution</i>	4	
<i>levofloxacin oral solution</i>	2	
<i>levofloxacin oral tablet</i>	2	
<i>moxifloxacin ophthalmic (eye) drops, viscous</i>	2	
<i>moxifloxacin oral tablet</i>	2	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	2	
SULFONAMIDES		
OVACE PLUS TOPICAL SHAMPOO	4	EX

Drug Name	Drug Tier	Requirements /Limits
<i>sulfacetamide sodium (acne) topical suspension</i>	2	
<i>sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 10-5 % (w/w)</i>	2	EX
<i>sulfacetamide sod-sulfur-urea topical cleanser</i>	2	EX
<i>sulfadiazine oral tablet</i>	2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1	
TETRACYCLINES		
<i>demeclocycline oral tablet</i>	4	
<i>doxy-100 intravenous recon soln</i>	4	
<i>doxycycline hyclate intravenous recon soln</i>	4	
<i>doxycycline hyclate oral capsule</i>	2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 200 mg, 50 mg</i>	2	
DOXYCYCLINE MONOHYDRATE ORAL CAPSULE, IR - DELAY REL, BIPHASE	4	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	2	
<i>doxycycline monohydrate oral tablet</i>	2	
<i>minocycline oral capsule</i>	2	
<i>minocycline oral tablet</i>	2	
<i>minocycline oral tablet extended release 24 hr 115 mg, 65 mg</i>	4	QL (90 per 90 days)
<i>minocycline oral tablet extended release 24 hr 135 mg, 45 mg, 90 mg</i>	2	QL (90 per 90 days)
<i>morgidox oral capsule 100 mg</i>	2	
ORACEA ORAL CAPSULE, IR - DELAY REL, BIPHASE	4	

Drug Name	Drug Tier	Requirements /Limits
<i>tetracycline oral capsule</i>	2	
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT ORAL SOLUTION	5	PA; QL (620 per 31 days); NEDS
BRIVIACT ORAL TABLET	5	PA; QL (62 per 31 days); NEDS
DIACOMIT ORAL CAPSULE	5	PA; NEDS
DIACOMIT ORAL POWDER IN PACKET	5	PA; NEDS
<i>divalproex oral capsule, delayed rel sprinkle</i>	2	
<i>divalproex oral tablet extended release 24 hr</i>	2	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	2	
EPIDIOLEX ORAL SOLUTION	5	PA; NEDS
<i>felbamate oral suspension</i>	4	
<i>felbamate oral tablet</i>	4	
FINTEPLA ORAL SOLUTION	5	PA; NEDS
FYCOMPA ORAL SUSPENSION	4	

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Drug Name	Drug Tier	Requirements /Limits
FYCOMPA ORAL TABLET	4	
<i>lamotrigine oral tablet</i>	2	
<i>lamotrigine oral tablet extended release 24hr</i>	4	
<i>lamotrigine oral tablet, chewable dispersible</i>	2	
<i>lamotrigine oral tablet, disintegrating</i>	4	
<i>lamotrigine oral tablets, dose pack</i>	2	
<i>levetiracetam oral solution</i>	2	
<i>levetiracetam oral tablet</i>	2	
<i>levetiracetam oral tablet extended release 24 hr</i>	2	
QUDEXY XR ORAL CAPSULE, SPRINKLE, ER 24HR	4	
<i>roweepra oral tablet</i>	2	
SPRITAM ORAL TABLET FOR SUSPENSION	4	
<i>subvenite oral tablet</i>	4	
<i>subvenite starter (blue) kit oral tablets, dose pack</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>subvenite starter (green) kit oral tablets, dose pack</i>	2	
<i>subvenite starter (orange) kit oral tablets, dose pack</i>	2	
<i>topiramate oral capsule, sprinkle</i>	2	
<i>topiramate oral capsule, sprinkle, er 24hr</i>	4	
<i>topiramate oral tablet</i>	2	
<i>valproic acid (as sodium salt) oral solution</i>	2	
<i>valproic acid oral capsule</i>	2	
XCOPRI MAINTENANCE PACK ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 250MG/DAY(150 MG X1-100MG X1)	4	PA; QL (168 per 84 days)
XCOPRI MAINTENANCE PACK ORAL TABLET 350 MG/DAY (200 MG X1-150MG X1)	5	PA; QL (56 per 28 days); NEDS
XCOPRI ORAL TABLET 100 MG, 50 MG	5	PA; QL (31 per 31 days); NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
XCOPRI ORAL TABLET 150 MG, 200 MG	5	PA; QL (62 per 31 days); NEDS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	PA; QL (84 per 84 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	PA; QL (28 per 28 days); NEDS

CALCIUM CHANNEL MODIFYING AGENTS

CELONTIN ORAL CAPSULE 300 MG	3	
<i>ethosuximide oral capsule</i>	2	
<i>ethosuximide oral solution</i>	2	

GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS

<i>clobazam oral suspension</i>	4	QL (1440 per 90 days)
<i>clobazam oral tablet 10 mg</i>	4	QL (180 per 90 days)
<i>clobazam oral tablet 20 mg</i>	3	QL (62 per 31 days)

Drug Name	Drug Tier	Requirements /Limits
DIASTAT ACUDIAL RECTAL KIT	4	HRM
DIASTAT RECTAL KIT	4	HRM
<i>diazepam rectal kit</i>	4	HRM
<i>gabapentin oral capsule</i>	2	QL (810 per 90 days)
<i>gabapentin oral solution</i>	2	QL (6480 per 90 days)
<i>gabapentin oral tablet 600 mg</i>	2	QL (540 per 90 days)
<i>gabapentin oral tablet 800 mg</i>	2	QL (360 per 90 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR	4	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	4	QL (270 per 90 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	4	QL (180 per 90 days)
LYRICA ORAL CAPSULE 25 MG, 75 MG	4	QL (360 per 90 days)
LYRICA ORAL SOLUTION	4	QL (2700 per 90 days)
NAYZILAM NASAL SPRAY, NON- AEROSOL	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>phenobarbital oral elixir</i>	2	HRM
<i>phenobarbital oral tablet</i>	2	HRM
<i>phenobarbital sodium injection solution</i>	4	HRM
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 50 mg</i>	4	QL (270 per 90 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	4	QL (180 per 90 days)
<i>pregabalin oral capsule 25 mg, 75 mg</i>	4	QL (360 per 90 days)
<i>pregabalin oral solution</i>	4	QL (2700 per 90 days)
<i>pregabalin oral tablet extended release 24 hr</i>	4	
<i>primidone oral tablet</i>	2	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	NEDS
SYMPAZAN ORAL FILM 5 MG	4	
<i>tiagabine oral tablet</i>	4	
VALTOCO NASAL SPRAY, NON-AEROSOL	4	HRM
<i>vigabatrin oral powder in packet</i>	5	LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>vigabatrin oral tablet</i>	5	NEDS
<i>vigadrone oral powder in packet</i>	5	NEDS
SODIUM CHANNEL AGENTS		
APTOM ORAL TABLET	5	NEDS
BANZEL ORAL SUSPENSION	5	NEDS
BANZEL ORAL TABLET 200 MG	3	
BANZEL ORAL TABLET 400 MG	5	NEDS
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	2	
<i>carbamazepine oral suspension 100 mg/5 ml, 200 mg/10 ml</i>	2	
<i>carbamazepine oral tablet</i>	2	
<i>carbamazepine oral tablet extended release 12 hr</i>	2	
<i>carbamazepine oral tablet, chewable</i>	2	
DILANTIN 30 MG ORAL CAPSULE	3	
<i>epitol oral tablet</i>	2	
<i>fosphenytoin injection solution 500 mg pe/10 ml</i>	2	
<i>oxcarbazepine oral suspension</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>oxcarbazepine oral tablet</i>	2	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG	4	ST
<i>phenytoin oral suspension</i>	2	
<i>phenytoin oral tablet, chewable</i>	2	
<i>phenytoin sodium extended oral capsule</i>	2	
<i>rufinamide oral suspension</i>	5	NEDS
<i>rufinamide oral tablet 200 mg</i>	3	
<i>rufinamide oral tablet 400 mg</i>	5	NEDS
VIMPAT ORAL SOLUTION	4	QL (3600 per 90 days)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	4	QL (180 per 90 days)
VIMPAT ORAL TABLET 50 MG	4	QL (360 per 90 days)
<i>zonisamide oral capsule</i>	2	
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
<i>ergoloid oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK	3	
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR	3	
CHOLINESTERASE INHIBITORS		
<i>donepezil oral tablet 10 mg, 5 mg</i>	2	QL (90 per 90 days)
<i>donepezil oral tablet 23 mg</i>	4	QL (90 per 90 days)
<i>donepezil oral tablet, disintegrating</i>	4	QL (90 per 90 days)
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	2	QL (90 per 90 days)
<i>galantamine oral solution</i>	2	
<i>galantamine oral tablet</i>	2	
<i>rivastigmine tartrate oral capsule</i>	2	
<i>rivastigmine transdermal patch 24 hour</i>	4	QL (90 per 90 days)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
<i>memantine oral capsule, sprinkle, er 24hr</i>	4	QL (90 per 90 days)
<i>memantine oral solution</i>	2	QL (1080 per 90 days)
<i>memantine oral tablet</i>	2	QL (180 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
MEMANTINE ORAL TABLETS,DOSE PACK	3	QL (147 per 84 days)
NAMENDA TITRATION PAK ORAL TABLETS,DOSE PACK	3	QL (147 per 84 days)
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK	4	QL (84 per 84 days)

ANTIDEPRESSANTS

ANTIDEPRESSANTS, OTHER

<i>amitriptyline-chlordiazepoxide oral tablet</i>	2	
<i>bupropion hcl oral tablet</i>	2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg</i>	2	
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	2	
<i>maprotiline oral tablet</i>	2	
<i>mirtazapine oral tablet</i>	2	
<i>mirtazapine oral tablet,disintegrating</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>olanzapine-fluoxetine oral capsule</i>	4	

<i>perphenazine-amitriptyline oral tablet</i>	2	
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MONOAMINE OXIDASE INHIBITORS

EMSAM TRANSDERMAL PATCH 24 HOUR	5	NEDS
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MARPLAN ORAL TABLET	4	
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<i>phenelzine oral tablet</i>	2	
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<i>tranylcypromine oral tablet</i>	4	
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SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS

<i>citalopram oral solution</i>	2	
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<i>citalopram oral tablet</i>	1	
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DESVENLAFAXIN E ORAL TABLET EXTENDED RELEASE 24 HR	4	ST
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<i>desvenlafaxine succinate oral tablet extended release 24 hr</i>	3	
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Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE	4	
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	QL (180 per 90 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	2	
<i>escitalopram oxalate oral solution</i>	2	
<i>escitalopram oxalate oral tablet</i>	2	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	4	ST
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	4	ST
<i>fluoxetine (padded) oral tablet</i>	4	
<i>fluoxetine oral capsule</i>	2	
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	2	
<i>fluoxetine oral solution</i>	4	
<i>fluoxetine oral tablet</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>fluvoxamine oral capsule, extended release 24hr</i>	2	
<i>fluvoxamine oral tablet</i>	2	
<i>nefazodone oral tablet</i>	2	
<i>paroxetine hcl oral tablet</i>	2	HRM
<i>paroxetine hcl oral tablet extended release 24 hr</i>	2	HRM
<i>paroxetine mesylate(menop.sym) oral capsule</i>	2	HRM
PAXIL ORAL SUSPENSION	4	HRM
<i>sertraline oral concentrate</i>	2	
<i>sertraline oral tablet</i>	1	
<i>trazodone oral tablet</i>	1	
TRINTELLIX ORAL TABLET	4	ST
<i>venlafaxine oral capsule, extended release 24hr</i>	2	
<i>venlafaxine oral tablet</i>	2	
<i>venlafaxine oral tablet extended release 24hr 225 mg</i>	2	
VIIBRYD ORAL TABLET	4	ST

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	4	ST
TRICYCLICS		
<i>amitriptyline oral tablet</i>	2	HRM
<i>amoxapine oral tablet</i>	2	HRM
<i>clomipramine oral capsule</i>	4	HRM
<i>desipramine oral tablet</i>	4	HRM
<i>doxepin oral capsule</i>	2	HRM
<i>doxepin oral concentrate</i>	2	HRM
<i>doxepin oral tablet 6 mg</i>	4	HRM; QL (90 per 90 days)
<i>imipramine hcl oral tablet</i>	2	HRM
<i>imipramine pamoate oral capsule</i>	2	HRM
<i>nortriptyline oral capsule</i>	2	HRM
<i>nortriptyline oral solution</i>	2	HRM
<i>protriptyline oral tablet</i>	2	HRM
SILENOR ORAL TABLET 6 MG	4	HRM; QL (90 per 90 days)
<i>trimipramine oral capsule</i>	2	HRM

ANTIEMETICS

Drug Name	Drug Tier	Requirements /Limits
ANTIEMETICS, OTHER		
<i>compro rectal suppository</i>	2	
<i>dimenhydrinate injection solution</i>	4	HRM
<i>droperidol injection solution</i>	2	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	HRM
PHENERGAN INJECTION SOLUTION	4	
<i>prochlorperazine maleate oral tablet</i>	2	
<i>prochlorperazine rectal suppository</i>	2	
<i>promethazine oral syrup</i>	2	
<i>promethazine oral tablet</i>	2	
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	2	
<i>promethegan rectal suppository</i>	2	
<i>scopolamine base transdermal patch 3 day</i>	4	HRM
<i>trimethobenzamide oral capsule</i>	2	
EMETOGENIC THERAPY ADJUNCTS		
<i>aprepitant oral capsule</i>	4	B/D PA

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
<i>aprepitant oral capsule,dose pack</i>	4	B/D PA
<i>dronabinol oral capsule</i>	4	B/D PA
EMEND ORAL SUSPENSION FOR RECONSTITUTION	4	B/D PA
<i>granisetron hcl oral tablet</i>	2	B/D PA
<i>ondansetron hcl oral solution</i>	4	B/D PA
<i>ondansetron hcl oral tablet</i>	2	B/D PA
<i>ondansetron oral tablet,disintegrating</i>	2	B/D PA

ANTIFUNGALS

ANTIFUNGALS		
ABELCET INTRAVENOUS SUSPENSION	5	B/D PA; NEDS
AMBISOME INTRAVENOUS SUSPENSION FOR RECONSTITUTION	5	B/D PA; NEDS
<i>amphotericin b injection recon soln</i>	4	B/D PA
<i>caspofungin intravenous recon soln</i>	4	B/D PA
<i>ciclopirox topical cream</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>ciclopirox topical suspension</i>	2	
<i>clotrimazole mucous membrane troche</i>	2	
<i>clotrimazole topical cream</i>	2	
<i>clotrimazole topical solution</i>	2	
<i>econazole topical cream</i>	3	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN	4	
EXODERM TOPICAL LOTION	4	EX
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	4	
<i>fluconazole oral suspension for reconstitution</i>	2	
<i>fluconazole oral tablet</i>	2	
<i>flucytosine oral capsule</i>	2	
<i>griseofulvin microsize oral suspension</i>	2	
<i>griseofulvin microsize oral tablet</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
<i>griseofulvin ultramicrosize oral tablet</i>	2	
<i>itraconazole oral capsule</i>	4	
<i>itraconazole oral solution</i>	3	
<i>ketoconazole oral tablet</i>	2	
<i>ketoconazole topical cream</i>	2	
<i>ketoconazole topical foam</i>	2	
<i>ketoconazole topical shampoo</i>	2	
<i>ketodan topical foam</i>	2	
LULICONAZOLE TOPICAL CREAM	4	
MENTAX TOPICAL CREAM	4	
<i>miconazole-3 vaginal suppository</i>	2	
<i>naftifine topical cream</i>	2	
NOXAFIL ORAL SUSPENSION	5	NEDS
NOXAFIL ORAL TABLET, DELAYED RELEASE (DR/EC)	5	QL (93 per 31 days); NEDS
<i>nyamyc topical powder</i>	2	
<i>nystatin oral suspension</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>nystatin oral tablet</i>	2	
<i>nystatin topical cream</i>	2	
<i>nystatin topical ointment</i>	2	
<i>nystatin topical powder</i>	2	
<i>nystop topical powder</i>	2	
<i>oxiconazole topical cream</i>	2	
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	5	QL (93 per 31 days); NEDS
<i>terbinafine hcl oral tablet</i>	2	
<i>terconazole vaginal cream</i>	2	
<i>terconazole vaginal suppository</i>	2	
<i>voriconazole intravenous recon soln</i>	5	NEDS
<i>voriconazole oral suspension for reconstitution</i>	5	NEDS
<i>voriconazole oral tablet</i>	3	

ANTIGOUT AGENTS

ANTIGOUT AGENTS

<i>allopurinol oral tablet</i>	1	
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Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>colchicine oral tablet</i>	4	QL (360 per 90 days)
<i>febuxostat oral tablet</i>	3	ST; QL (90 per 90 days)
<i>probenecid oral tablet</i>	2	
<i>probenecid-colchicine oral tablet</i>	2	
ULORIC ORAL TABLET	3	ST; QL (90 per 90 days)

ANTIMIGRAINE AGENTS

ERGOT ALKALOIDS

<i>dihydroergotamine nasal spray,non-aerosol</i>	4	QL (24 per 90 days)
<i>migergot rectal suppository</i>	2	

PROPHYLACTIC

AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	4	
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	3	
AJOVY SYRINGE SUBCUTANEOUS SYRINGE	3	

SEROTONIN (5-HT) RECEPTOR AGONISTS

<i>almotriptan malate oral tablet</i>	4	QL (36 per 90 days)
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Drug Name	Drug Tier	Requirements /Limits
<i>eletriptan oral tablet</i>	3	QL (18 per 90 days)
<i>frovatriptan oral tablet</i>	4	QL (36 per 90 days)
<i>naratriptan oral tablet</i>	2	QL (54 per 90 days)
<i>rizatriptan oral tablet</i>	2	QL (36 per 90 days)
<i>rizatriptan oral tablet,disintegrating</i>	2	QL (36 per 90 days)
<i>sumatriptan nasal spray,non-aerosol</i>	4	QL (36 per 90 days)
<i>sumatriptan succinate oral tablet</i>	2	
<i>sumatriptan succinate subcutaneous cartridge</i>	4	
<i>sumatriptan succinate subcutaneous pen injector</i>	4	
<i>sumatriptan succinate subcutaneous solution</i>	4	
<i>zolmitriptan oral tablet</i>	2	QL (18 per 90 days)
<i>zolmitriptan oral tablet,disintegrating</i>	2	QL (18 per 90 days)

ANTIMYASTHENIC AGENTS

PARASYMPATHOMIMETICS

<i>pyridostigmine bromide oral syrup</i>	2	
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Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>pyridostigmine bromide oral tablet 60 mg</i>	2	
<i>pyridostigmine bromide oral tablet extended release</i>	2	
<i>regonol injection solution</i>	4	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
<i>dapsone oral tablet</i>	2	
<i>rifabutin oral capsule</i>	4	
ANTITUBERCULARS		
<i>ethambutol oral tablet</i>	2	
<i>isoniazid oral solution</i>	2	
<i>isoniazid oral tablet</i>	2	
PASER ORAL GRANULES DR FOR SUSP IN PACKET	4	
PRETOMANID ORAL TABLET	4	
PRIFTIN ORAL TABLET	4	
<i>pyrazinamide oral tablet</i>	2	
<i>rifampin intravenous recon soln</i>	4	
<i>rifampin oral capsule</i>	2	

Drug Name	Drug Tier	Requirements /Limits
SIRTURO ORAL TABLET	5	PA; NEDS
TRECTOR ORAL TABLET	4	
ANTINEOPLASTICS, OTHER		
ANTINEOPLASTICS, OTHER		
LIBTAYO INTRAVENOUS SOLUTION	5	PA; NEDS
ANTINEOPLASTICS		
ALKYLATING AGENTS		
<i>cyclophosphamide oral capsule</i>	3	B/D PA
IFEX INTRAVENOUS RECON SOLN 3 GRAM	4	B/D PA
LEUKERAN ORAL TABLET	4	
MATULANE ORAL CAPSULE	5	LA; NEDS
<i>melphalan oral tablet</i>	4	B/D PA
PEPAXTO INTRAVENOUS RECON SOLN	5	PA; NEDS
VALCHLOR TOPICAL GEL	5	NEDS
ZEPZELCA INTRAVENOUS RECON SOLN	5	PA; NEDS
ANTIANDROGENS		

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>abiraterone oral tablet 250 mg</i>	5	PA; QL (124 per 31 days); NEDS
<i>abiraterone oral tablet 500 mg</i>	5	PA; QL (62 per 31 days); NEDS
<i>bicalutamide oral tablet</i>	2	
ERLEADA ORAL TABLET	5	PA; LA; NEDS
<i>flutamide oral capsule</i>	2	
<i>nilutamide oral tablet</i>	5	NEDS
NUBEQA ORAL TABLET	5	PA; NEDS
<i>toremifene oral tablet</i>	4	
XTANDI ORAL CAPSULE	5	PA; QL (124 per 31 days); NEDS
XTANDI ORAL TABLET 40 MG	5	PA; LA; QL (124 per 31 days); NEDS
XTANDI ORAL TABLET 80 MG	5	PA; LA; QL (62 per 31 days); NEDS
YONSA ORAL TABLET	5	PA; NEDS
ZYTIGA ORAL TABLET 250 MG	5	PA; NEDS
ZYTIGA ORAL TABLET 500 MG	5	PA; QL (62 per 31 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
ANTIANGIOGENIC AGENTS		
POMALYST ORAL CAPSULE	5	PA; LA; QL (31 per 31 days); NEDS
REVLIMID ORAL CAPSULE	5	PA; LA; QL (31 per 31 days); NEDS
THALOMID ORAL CAPSULE	5	PA; LA; NEDS
ANTIESTROGENS/MODIFIERS		
EMCYT ORAL CAPSULE	5	NEDS
SOLTAMOX ORAL SOLUTION	4	
<i>tamoxifen oral tablet</i>	2	
ANTIMETABOLITES		
DROXIA ORAL CAPSULE	4	
FOLOTYN INTRAVENOUS SOLUTION 20 MG/ML (1 ML)	5	NEDS
<i>gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml)</i>	5	NEDS
GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML	3	
<i>hydroxyurea oral capsule</i>	2	
<i>mercaptopurine oral tablet</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
ONUREG ORAL TABLET	5	PA; QL (14 per 28 days); NEDS
PURIXAN ORAL SUSPENSION	5	LA; NEDS
TABLOID ORAL TABLET	3	
ANTINEOPLASTICS, OTHER		
<i>adriamycin intravenous recon soln 10 mg</i>	4	B/D PA
ADRIAMYCIN INTRAVENOUS RECON SOLN 50 MG	3	B/D PA
<i>bleomycin injection recon soln 15 unit</i>	2	B/D PA
<i>dexrazoxane hcl intravenous recon soln 500 mg</i>	2	
ENHERTU INTRAVENOUS RECON SOLN	5	PA; NEDS
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION	5	NEDS
IDHIFA ORAL TABLET	5	PA; LA; NEDS
INQOVI ORAL TABLET	5	PA; QL (5 per 28 days); NEDS
<i>irinotecan intravenous solution 40 mg/2 ml</i>	2	

Drug Name	Drug Tier	Requirements /Limits
KISQALI FEMARA CO-PACK ORAL TABLET	5	PA; NEDS
<i>leucovorin calcium injection recon soln 50 mg, 500 mg</i>	4	
<i>leucovorin calcium oral tablet</i>	2	
LONSURF ORAL TABLET	5	PA; LA; NEDS
LUMOXITI INTRAVENOUS RECON SOLN	5	PA; NEDS
MARQIBO INTRAVENOUS KIT	4	
NINLARO ORAL CAPSULE	5	PA; NEDS
<i>oxaliplatin intravenous solution 50 mg/10 ml (5 mg/ml)</i>	5	NEDS
PADCEV INTRAVENOUS RECON SOLN	5	PA; NEDS
POLIVY INTRAVENOUS RECON SOLN	5	PA; NEDS
RYBREVANT INTRAVENOUS SOLUTION	5	PA; NEDS
SYNRIBO SUBCUTANEOUS RECON SOLN	5	NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
<i>valrubicin intravesical solution</i>	3	
VELCADE INJECTION RECON SOLN	4	
<i>vincasar pfs intravenous solution 2 mg/2 ml</i>	2	B/D PA
XPOVIO ORAL TABLET	5	PA; NEDS
ZOLINZA ORAL CAPSULE	5	PA; NEDS
AROMATASE INHIBITORS, 3RD GENERATION		
<i>anastrozole oral tablet</i>	2	
<i>exemestane oral tablet</i>	2	
<i>letrozole oral tablet</i>	2	
MOLECULAR TARGET INHIBITORS		
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION	5	PA; NEDS
AFINITOR ORAL TABLET	5	PA; NEDS
ALECENSA ORAL CAPSULE	5	PA; LA; NEDS
ALUNBRIG ORAL TABLET	5	PA; LA; NEDS
ALUNBRIG ORAL TABLETS,DOSE PACK	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
AYVAKIT ORAL TABLET	5	PA; NEDS
BALVERSA ORAL TABLET	5	PA; NEDS
BOSULIF ORAL TABLET	5	PA; LA; NEDS
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; NEDS
BRUKINSA ORAL CAPSULE	5	PA; NEDS
CABOMETYX ORAL TABLET	5	PA; LA; NEDS
CALQUENCE ORAL CAPSULE	5	PA; LA; NEDS
CAPRELSA ORAL TABLET	5	LA; NEDS
COMETRIQ ORAL CAPSULE	5	PA; LA; NEDS
COPIKTRA ORAL CAPSULE	5	PA; NEDS
COTELLIC ORAL TABLET	5	PA; LA; NEDS
DAURISMO ORAL TABLET	5	PA; NEDS
ERIVEDGE ORAL CAPSULE	5	PA; LA; NEDS
<i>erlotinib oral tablet</i>	5	PA; NEDS
<i>everolimus (antineoplastic) oral tablet</i>	5	PA; NEDS
FARYDAK ORAL CAPSULE	5	PA; LA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
FOTIVDA ORAL CAPSULE	5	PA; QL (21 per 28 days); NEDS
GAVRETO ORAL CAPSULE	5	PA; LA; QL (124 per 31 days); NEDS
GILOTRIF ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
IBRANCE ORAL CAPSULE	5	PA; LA; QL (21 per 28 days); NEDS
IBRANCE ORAL TABLET	5	PA; LA; QL (21 per 28 days); NEDS
ICLUSIG ORAL TABLET	5	PA; LA; NEDS
<i>imatinib oral tablet 100 mg</i>	5	PA; QL (186 per 31 days); NEDS
<i>imatinib oral tablet 400 mg</i>	5	PA; QL (62 per 31 days); NEDS
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; LA; QL (124 per 31 days); NEDS
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; LA; QL (31 per 31 days); NEDS
IMBRUVICA ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
INLYTA ORAL TABLET	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
INREBIC ORAL CAPSULE	5	PA; NEDS
IRESSA ORAL TABLET	5	LA; NEDS
JAKAFI ORAL TABLET	5	PA; LA; QL (62 per 31 days); NEDS
KISQALI ORAL TABLET	5	PA; NEDS
KOSELUGO ORAL CAPSULE	5	PA; NEDS
<i>lapatinib oral tablet</i>	5	NEDS
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 14 MG/DAY (10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X 2), 20 MG/DAY (10 MG X 2), 24 MG/DAY (10 MG X 2-4 MG X 1), 8 MG/DAY (4 MG X 2)	5	PA; LA; NEDS
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 4 MG	5	PA; NEDS
LORBRENA ORAL TABLET	5	PA; NEDS
LUMAKRAS ORAL TABLET	5	PA; LA; QL (240 per 30 days); NEDS
LYNPARZA ORAL TABLET	5	PA; LA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
MEKINIST ORAL TABLET	5	PA; NEDS
MEKTOVI ORAL TABLET	5	PA; NEDS
NERLYNX ORAL TABLET	5	PA; LA; NEDS
NEXAVAR ORAL TABLET	5	PA; LA; NEDS
ODOMZO ORAL CAPSULE	5	PA; LA; NEDS
PEMAZYRE ORAL TABLET	5	PA; NEDS
PIQRAY ORAL TABLET	5	PA; NEDS
QINLOCK ORAL TABLET	5	PA; QL (90 per 30 days); NEDS
RETEVMO ORAL CAPSULE 40 MG	5	PA; QL (186 per 31 days); NEDS
RETEVMO ORAL CAPSULE 80 MG	5	PA; QL (124 per 31 days); NEDS
ROZLYTREK ORAL CAPSULE	5	PA; NEDS
RUBRACA ORAL TABLET	5	PA; LA; NEDS
RYDAPT ORAL CAPSULE	5	PA; NEDS
SPRYCEL ORAL TABLET	5	PA; NEDS
STIVARGA ORAL TABLET	5	LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
SUTENT ORAL CAPSULE	5	PA; LA; NEDS
TABRECTA ORAL TABLET	5	PA; QL (112 per 28 days); NEDS
TAFINLAR ORAL CAPSULE	5	PA; NEDS
TAGRISSE ORAL TABLET	5	PA; LA; NEDS
TALZENNA ORAL CAPSULE	5	PA; NEDS
TASIGNA ORAL CAPSULE	5	PA; NEDS
TAZVERIK ORAL TABLET	5	PA; LA; NEDS
TEPMETKO ORAL TABLET	5	PA; LA; QL (62 per 31 days); NEDS
TIBSOVO ORAL TABLET	5	PA; NEDS
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)	5	PA; LA; QL (21 per 28 days); NEDS
TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)	5	PA; LA; QL (42 per 28 days); NEDS
TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)	5	PA; LA; QL (63 per 28 days); NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
TUKYSA ORAL TABLET 150 MG	5	PA; QL (120 per 30 days); NEDS
TUKYSA ORAL TABLET 50 MG	5	PA; QL (300 per 30 days); NEDS
TURALIO ORAL CAPSULE	5	PA; NEDS
TYKERB ORAL TABLET	5	NEDS
UKONIQ ORAL TABLET	5	PA; LA; QL (120 per 30 days); NEDS
VENCLEXTA ORAL TABLET 10 MG, 50 MG	3	PA; LA
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA; NEDS
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK	5	PA; LA; NEDS
VERZENIO ORAL TABLET	5	PA; LA; NEDS
VITRAKVI ORAL CAPSULE	5	PA; NEDS
VITRAKVI ORAL SOLUTION	5	PA; NEDS
VIZIMPRO ORAL TABLET	5	PA; NEDS
VOTRIENT ORAL TABLET	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
XALKORI ORAL CAPSULE	5	PA; LA; QL (62 per 31 days); NEDS
XOSPATA ORAL TABLET	5	PA; NEDS
ZEJULA ORAL CAPSULE	5	PA; LA; NEDS
ZELBORAF ORAL TABLET	5	PA; LA; QL (248 per 31 days); NEDS
ZYDELIG ORAL TABLET	5	PA; LA; NEDS
ZYKADIA ORAL TABLET	5	PA; NEDS
MONOCLONAL ANTIBODIES/ANTIBODY-DRUG CONJUGATE		
BLENREP INTRAVENOUS RECON SOLN	5	PA; NEDS
DANYELZA INTRAVENOUS SOLUTION	5	PA; NEDS
JEMPERLI INTRAVENOUS SOLUTION	5	PA; NEDS
MONJUVI INTRAVENOUS RECON SOLN	5	PA; NEDS
SARCLISA INTRAVENOUS SOLUTION	5	PA; NEDS
TRODELVY INTRAVENOUS RECON SOLN	5	PA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
ZYNLONTA INTRAVENOUS RECON SOLN	5	PA; LA; NEDS
RETINOIDS		
<i>bexarotene oral capsule</i>	5	PA; NEDS
PANRETIN TOPICAL GEL	3	
TARGRETIN TOPICAL GEL	5	PA; NEDS
<i>tretinoin (antineoplastic) oral capsule</i>	5	NEDS
TREATMENT ADJUNCTS		
MESNEX ORAL TABLET	4	
ANTI-OBESITY AGENTS		
ANTI-OBESITY AGENTS		
ADIPEX-P ORAL CAPSULE	4	EX
ADIPEX-P ORAL TABLET	4	EX
<i>benzphetamine oral tablet 50 mg</i>	2	EX
<i>diethylpropion oral tablet</i>	2	EX
<i>diethylpropion oral tablet extended release</i>	2	EX
<i>phendimetrazine tartrate oral capsule, extended release</i>	2	EX

Drug Name	Drug Tier	Requirements /Limits
<i>phentermine oral capsule</i>	2	EX
<i>phentermine oral tablet</i>	2	EX
ANTIPARASITICS		
ANTHELMINTHICS		
<i>albendazole oral tablet</i>	5	NEDS
<i>ivermectin oral tablet</i>	2	
<i>praziquantel oral tablet</i>	2	
ANTIPROTOZOALS		
<i>atovaquone oral suspension</i>	5	NEDS
<i>atovaquone-proguanil oral tablet</i>	2	
BENZNIDAZOLE ORAL TABLET	4	
<i>chloroquine phosphate oral tablet</i>	2	
COARTEM ORAL TABLET	3	
DARAPRIM ORAL TABLET	5	NEDS
<i>hydroxychloroquine oral tablet</i>	1	
<i>mefloquine oral tablet</i>	2	
NEBUPENT INHALATION RECON SOLN	4	B/D PA

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>nitazoxanide oral tablet</i>	5	NEDS
PENTAM INJECTION RECON SOLN	4	
<i>pentamidine injection recon soln</i>	4	
PRIMAQUINE ORAL TABLET	3	
<i>pyrimethamine oral tablet</i>	5	NEDS
<i>quinine sulfate oral capsule</i>	2	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
<i>benztropine injection solution</i>	4	HRM
<i>benztropine oral tablet</i>	2	HRM
<i>trihexyphenidyl oral elixir</i>	2	HRM
<i>trihexyphenidyl oral tablet</i>	2	HRM
ANTIPARKINSON AGENTS, OTHER		
<i>amantadine hcl oral capsule</i>	2	
<i>amantadine hcl oral solution</i>	2	
<i>amantadine hcl oral tablet</i>	2	
<i>carbidopa-levodopa-entacapone oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>entacapone oral tablet</i>	2	
<i>tolcapone oral tablet</i>	4	
DOPAMINE AGONISTS		
APOKYN SUBCUTANEOUS CARTRIDGE	5	LA; NEDS
<i>bromocriptine oral capsule</i>	2	
<i>bromocriptine oral tablet</i>	2	
NEUPRO TRANSDERMAL PATCH 24 HOUR	4	
<i>pramipexole oral tablet</i>	2	
<i>pramipexole oral tablet extended release 24 hr</i>	4	
<i>ropinirole oral tablet</i>	2	
<i>ropinirole oral tablet extended release 24 hr</i>	2	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
<i>carbidopa oral tablet</i>	2	
<i>carbidopa-levodopa oral tablet</i>	2	
<i>carbidopa-levodopa oral tablet extended release</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>carbidopa-levodopa oral tablet, disintegrating</i>	2	
RYTARY ORAL CAPSULE, EXTENDED RELEASE	4	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
<i>rasagiline oral tablet</i>	2	
<i>selegiline hcl oral capsule</i>	2	
<i>selegiline hcl oral tablet</i>	2	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED	5	HRM; NEDS
<i>chlorpromazine oral tablet</i>	4	HRM
FLUPHENAZINE DECANOATE (BULK) OIL	4	EX; HRM
<i>fluphenazine decanoate injection solution</i>	4	HRM
<i>fluphenazine hcl injection solution</i>	4	HRM
<i>fluphenazine hcl oral concentrate</i>	2	HRM

Drug Name	Drug Tier	Requirements /Limits
<i>fluphenazine hcl oral elixir</i>	2	HRM
<i>fluphenazine hcl oral tablet</i>	2	HRM
<i>haloperidol decanoate intramuscular solution</i>	4	HRM
<i>haloperidol lactate injection solution</i>	4	HRM
<i>haloperidol lactate oral concentrate</i>	2	HRM
<i>haloperidol oral tablet</i>	2	HRM
<i>loxapine succinate oral capsule</i>	2	HRM
<i>molindone oral tablet</i>	2	HRM
<i>perphenazine oral tablet</i>	2	HRM
<i>pimozide oral tablet</i>	2	HRM
<i>thioridazine oral tablet</i>	2	HRM
<i>thiothixene oral capsule</i>	2	HRM
<i>trifluoperazine oral tablet</i>	2	HRM
2ND GENERATION/ATYPICAL		

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
ABILIFY MAINTENANCE INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE	5	ST; HRM; NEDS
ABILIFY MAINTENANCE INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRINGE	5	ST; HRM; NEDS
<i>aripiprazole oral solution</i>	3	HRM
<i>aripiprazole oral tablet</i>	3	HRM
<i>aripiprazole oral tablet, disintegrating</i>	2	HRM
ARISTADA INITIO INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRINGE	5	ST; HRM; NEDS
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRINGE	5	ST; HRM; NEDS
<i>asenapine maleate sublingual tablet</i>	3	HRM
CAPLYTA ORAL CAPSULE	5	ST; NEDS

Drug Name	Drug Tier	Requirements /Limits
FANAPT ORAL TABLET	4	HRM
FANAPT ORAL TABLETS, DOSE PACK	4	HRM
GEODON INTRAMUSCULAR RECON SOLN	4	HRM
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML	5	ST; HRM; NEDS
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	4	ST; HRM
INVEGA TRINZA INTRAMUSCULAR SYRINGE	5	ST; HRM; NEDS
LATUDA ORAL TABLET	5	ST; HRM; NEDS
NUPLAZID ORAL CAPSULE	5	PA; HRM; NEDS
NUPLAZID ORAL TABLET 10 MG	5	PA; HRM; NEDS
<i>olanzapine intramuscular recon soln</i>	4	HRM
<i>olanzapine oral tablet</i>	2	HRM

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>olanzapine oral tablet,disintegrating</i>	2	HRM
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	2	HRM; QL (90 per 90 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	2	HRM; QL (180 per 90 days)
PERSERIS ABDOMINAL SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING	5	ST; HRM; NEDS
<i>quetiapine oral tablet</i>	2	HRM
<i>quetiapine oral tablet extended release 24 hr</i>	2	HRM
REXULTI ORAL TABLET	5	ST; HRM; NEDS
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	4	ST; HRM

Drug Name	Drug Tier	Requirements /Limits
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	5	ST; HRM; NEDS
<i>risperidone oral solution</i>	2	HRM
<i>risperidone oral tablet</i>	2	HRM
<i>risperidone oral tablet,disintegrating</i>	2	HRM
SAPHRIS SUBLINGUAL TABLET	3	ST; HRM
SECUADO TRANSDERMAL PATCH 24 HOUR	5	ST; QL (31 per 31 days); NEDS
VRAYLAR ORAL CAPSULE	5	ST; HRM; NEDS
VRAYLAR ORAL CAPSULE,DOSE PACK	4	ST; HRM
<i>ziprasidone hcl oral capsule</i>	2	HRM
<i>ziprasidone mesylate intramuscular recon soln</i>	4	HRM

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	ST; HRM
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG, 405 MG	5	HRM; NEDS

TREATMENT-RESISTANT

<i>clozapine oral tablet</i>	2	HRM
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 25 mg</i>	2	HRM
<i>clozapine oral tablet, disintegrating 150 mg</i>	4	HRM
<i>clozapine oral tablet, disintegrating 200 mg</i>	5	HRM; NEDS
VERSACLOZ ORAL SUSPENSION	5	HRM; NEDS

ANTISPASTICITY AGENTS

ANTISPASTICITY AGENTS

<i>baclofen intrathecal solution</i>	2	
<i>baclofen oral tablet 10 mg, 20 mg</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>dantrolene oral capsule</i>	2	
LIORESAL INTRATHECAL SOLUTION 50 MCG/ML	4	
<i>revonto intravenous recon soln</i>	4	
<i>tizanidine oral capsule</i>	2	
<i>tizanidine oral tablet</i>	2	

ANTIVIRALS

ANTI-CYTOMEGALOVIRUS (CMV) AGENTS

<i>ganciclovir sodium intravenous solution</i>	4	B/D PA
PREVYMIS ORAL TABLET	5	NEDS
<i>valganciclovir oral recon soln</i>	5	NEDS
<i>valganciclovir oral tablet</i>	3	

ANTI-HEPATITIS B (HBV) AGENTS

<i>adefovir oral tablet</i>	5	NEDS
<i>entecavir oral tablet</i>	3	
<i>lamivudine oral tablet 100 mg</i>	2	

ANTI-HEPATITIS C (HCV) AGENTS

EPCLUSA ORAL TABLET	5	PA; NEDS
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Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	5	PA; QL (31 per 31 days); NEDS
HARVONI ORAL PELLETS IN PACKET 45-200 MG	5	PA; QL (62 per 31 days); NEDS
HARVONI ORAL TABLET	5	PA; NEDS
LEDIPASVIR-SOFOSBUVIR ORAL TABLET	5	PA; NEDS
<i>ribavirin oral capsule</i>	2	
<i>ribavirin oral tablet 200 mg</i>	2	
SOFOBUVIR-VELPATASVIR ORAL TABLET	5	PA; NEDS
SOVALDI ORAL PELLETS IN PACKET 150 MG	5	PA; QL (31 per 31 days); NEDS
SOVALDI ORAL PELLETS IN PACKET 200 MG	5	PA; QL (62 per 31 days); NEDS
SOVALDI ORAL TABLET	5	PA; NEDS
VOSEVI ORAL TABLET	5	PA; NEDS
ANTIHERPETIC AGENTS		
<i>acyclovir oral capsule</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>acyclovir oral suspension 200 mg/5 ml</i>	2	
<i>acyclovir oral tablet</i>	2	
<i>acyclovir sodium intravenous solution</i>	4	B/D PA
<i>famciclovir oral tablet</i>	2	
<i>trifluridine ophthalmic (eye) drops</i>	2	
<i>valacyclovir oral tablet</i>	2	
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY ORAL TABLET	5	NEDS
CABENUVA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE	5	LA; NEDS
DOVATO ORAL TABLET	5	NEDS
GENVOYA ORAL TABLET	5	QL (31 per 31 days); NEDS
ISENTRESS HD ORAL TABLET	5	NEDS
ISENTRESS ORAL POWDER IN PACKET	5	NEDS
ISENTRESS ORAL TABLET	5	NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5	NEDS
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	3	
JULUCA ORAL TABLET	5	NEDS
STRIBILD ORAL TABLET	5	NEDS
TIVICAY ORAL TABLET 10 MG	4	
TIVICAY ORAL TABLET 25 MG, 50 MG	5	NEDS
TIVICAY PD ORAL TABLET FOR SUSPENSION	4	QL (372 per 31 days)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
ATRIPLA ORAL TABLET	5	NEDS
COMPLERA ORAL TABLET	5	NEDS
DELSTRIGO ORAL TABLET	5	NEDS
EDURANT ORAL TABLET	5	NEDS
<i>efavirenz oral capsule 200 mg</i>	4	
<i>efavirenz oral capsule 50 mg</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>efavirenz oral tablet</i>	4	
<i>efavirenz-emtricitabin-tenofovir oral tablet</i>	5	NEDS
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate oral tablet</i>	5	NEDS
<i>etravirine oral tablet 100 mg</i>	3	
<i>etravirine oral tablet 200 mg</i>	5	NEDS
INTELENCE ORAL TABLET 100 MG, 200 MG	5	NEDS
INTELENCE ORAL TABLET 25 MG	3	
<i>nevirapine oral suspension</i>	4	
<i>nevirapine oral tablet</i>	2	
<i>nevirapine oral tablet extended release 24 hr</i>	2	
PIFELTRO ORAL TABLET	5	NEDS
SYMFI LO ORAL TABLET	5	NEDS
SYMFI ORAL TABLET	5	NEDS
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>abacavir oral solution</i>	2	
<i>abacavir oral tablet</i>	4	
<i>abacavir-lamivudine oral tablet</i>	3	
<i>abacavir-lamivudine-zidovudine oral tablet</i>	5	NEDS
CIMDUO ORAL TABLET	5	NEDS
DESCOVY ORAL TABLET	5	NEDS
<i>didanosine oral capsule, delayed release(dr/ec) 250 mg, 400 mg</i>	2	
<i>emtricitabine oral capsule</i>	3	
<i>emtricitabine-tenofovir (tdf) oral tablet</i>	5	NEDS
EMTRIVA ORAL CAPSULE	3	
EMTRIVA ORAL SOLUTION	3	
<i>lamivudine oral solution</i>	2	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	2	
<i>lamivudine-zidovudine oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
ODEFSEY ORAL TABLET	5	NEDS
<i>stavudine oral capsule</i>	2	
TEMIXYS ORAL TABLET	5	NEDS
<i>tenofovir disoproxil fumarate oral tablet</i>	3	
TRIUMEQ ORAL TABLET	5	NEDS
TRUVADA ORAL TABLET	5	NEDS
VIREAD ORAL POWDER	5	NEDS
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	NEDS
<i>zidovudine oral capsule</i>	2	
<i>zidovudine oral syrup</i>	2	
<i>zidovudine oral tablet</i>	2	
ANTI-HIV AGENTS, OTHER		
FUZEON SUBCUTANEOUS RECON SOLN	5	NEDS
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR	5	QL (62 per 31 days); NEDS
SELZENTRY ORAL SOLUTION	5	NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	5	NEDS
SELZENTRY ORAL TABLET 25 MG	3	
TROGARZO INTRAVENOUS SOLUTION	5	NEDS
TYBOST ORAL TABLET	3	
ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)		
APTIVUS ORAL CAPSULE	5	NEDS
<i>atazanavir oral capsule</i>	4	
EVOTAZ ORAL TABLET	5	NEDS
<i>fosamprenavir oral tablet</i>	5	NEDS
INVIRASE ORAL TABLET	5	NEDS
KALETRA ORAL TABLET 100-25 MG	4	
KALETRA ORAL TABLET 200-50 MG	5	NEDS
LEXIVA ORAL SUSPENSION	4	
<i>lopinavir-ritonavir oral solution</i>	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	4	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	5	NEDS
NORVIR ORAL POWDER IN PACKET	3	
NORVIR ORAL SOLUTION	3	
PREZCOBIX ORAL TABLET	5	NEDS
PREZISTA ORAL SUSPENSION	5	NEDS
PREZISTA ORAL TABLET 150 MG, 75 MG	4	
PREZISTA ORAL TABLET 600 MG, 800 MG	5	NEDS
REYATAZ ORAL POWDER IN PACKET	5	NEDS
<i>ritonavir oral tablet</i>	2	
SYM TUZA ORAL TABLET	5	NEDS
VIRACEPT ORAL TABLET	5	NEDS
ANTI-INFLUENZA AGENTS		
<i>oseltamivir oral capsule 30 mg</i>	2	QL (168 per 180 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	2	QL (84 per 180 days)
<i>oseltamivir oral suspension for reconstitution</i>	2	QL (1050 per 180 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE	4	QL (180 per 90 days)
<i>rimantadine oral tablet</i>	2	

ANXIOLYTICS

ANXIOLYTICS, OTHER

<i>bupirone oral tablet</i>	2	
<i>meprobamate oral tablet</i>	4	HRM

BENZODIAZEPINES

<i>alprazolam intensol oral concentrate</i>	2	HRM
<i>alprazolam oral tablet</i>	2	HRM
<i>alprazolam oral tablet extended release 24 hr</i>	2	HRM
<i>chlordiazepoxide hcl oral capsule</i>	2	HRM
<i>clonazepam oral tablet</i>	2	HRM
<i>clonazepam oral tablet, disintegrating</i>	2	HRM

Drug Name	Drug Tier	Requirements /Limits
<i>clorazepate dipotassium oral tablet</i>	2	HRM
<i>diazepam injection solution</i>	4	HRM
<i>diazepam injection syringe</i>	4	HRM
<i>diazepam intensol oral concentrate</i>	2	HRM
<i>diazepam oral concentrate</i>	2	HRM
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	HRM
<i>diazepam oral tablet</i>	2	HRM
<i>lorazepam injection solution</i>	4	HRM
<i>lorazepam injection syringe</i>	4	HRM
<i>lorazepam intensol oral concentrate</i>	2	HRM
<i>lorazepam oral concentrate</i>	2	HRM
<i>lorazepam oral tablet</i>	2	HRM
<i>oxazepam oral capsule 10 mg, 15 mg</i>	2	HRM; QL (360 per 90 days)
<i>oxazepam oral capsule 30 mg</i>	2	HRM; QL (180 per 90 days)

BIPOLAR AGENTS

MOOD STABILIZERS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>lithium carbonate oral capsule</i>	2	
<i>lithium carbonate oral tablet</i>	2	
<i>lithium carbonate oral tablet extended release</i>	2	
<i>lithium citrate oral solution 8 meq/5 ml</i>	2	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

<i>acarbose oral tablet</i>	2	
<i>alcohol pads topical pads, medicated</i>	1	
ALOGLIPTIN ORAL TABLET	4	
ALOGLIPTIN-METFORMIN ORAL TABLET	4	
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET	4	
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR	3	QL (10.2 per 84 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	4	QL (7.2 per 84 days)

Drug Name	Drug Tier	Requirements /Limits
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	4	QL (3.6 per 84 days)
CYCLOSET ORAL TABLET	4	QL (540 per 90 days)
FARXIGA ORAL TABLET	3	QL (90 per 90 days)
GAUZE PADS 2 X 2	2	
<i>glimepiride oral tablet</i>	1	HRM
<i>glipizide oral tablet</i>	1	
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	QL (180 per 90 days)
<i>glipizide oral tablet extended release 24hr 2.5 mg, 5 mg</i>	1	QL (270 per 90 days)
<i>glipizide-metformin oral tablet</i>	1	
<i>glyburide micronized oral tablet</i>	1	HRM
<i>glyburide oral tablet</i>	1	HRM
<i>glyburide-metformin oral tablet</i>	1	
INSULIN PEN NEEDLE	1	
INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML	1	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG	3	QL (180 per 90 days)
INVOKAMET ORAL TABLET 50-500 MG	3	QL (360 per 90 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG	3	QL (180 per 90 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 50-500 MG	3	QL (360 per 90 days)
INVOKANA ORAL TABLET 100 MG	3	QL (180 per 90 days)
INVOKANA ORAL TABLET 300 MG	3	QL (90 per 90 days)
JANUMET ORAL TABLET	3	QL (180 per 90 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	QL (90 per 90 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	QL (180 per 90 days)
JANUVIA ORAL TABLET	3	QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
JARDIANCE ORAL TABLET	4	QL (90 per 90 days)
JENTADUETO ORAL TABLET	4	QL (180 per 90 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	3	QL (180 per 90 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	3	QL (90 per 90 days)
<i>metformin oral solution</i>	4	
<i>metformin oral tablet</i>	1	
<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	QL (360 per 90 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	QL (180 per 90 days)
<i>metformin oral tablet extended release (osm) 24 hr 1,000 mg</i>	1	QL (180 per 90 days)
<i>metformin oral tablet extended release (osm) 24 hr 500 mg</i>	1	QL (450 per 90 days)
<i>miglitol oral tablet</i>	2	
<i>nateglinide oral tablet</i>	1	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
NEEDLES, INSULIN DISP.,SAFETY	1	
NOVOFINE 32 NEEDLE	1	
NOVOFINE PLUS NEEDLE	1	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN	1	
NOVOTWIST NEEDLE	1	
ONGLYZA ORAL TABLET	3	QL (90 per 90 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	3	QL (1.5 per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML)	3	QL (3 per 28 days)
<i>pioglitazone oral tablet</i>	1	QL (90 per 90 days)
<i>pioglitazone-glimepiride oral tablet</i>	1	QL (90 per 90 days)
<i>pioglitazone-metformin oral tablet</i>	1	QL (270 per 90 days)
<i>repaglinide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements /Limits
RIOMET ORAL SOLUTION	4	
RYBELSUS ORAL TABLET 14 MG	3	QL (90 per 90 days)
RYBELSUS ORAL TABLET 3 MG	3	QL (420 per 90 days)
RYBELSUS ORAL TABLET 7 MG	3	QL (180 per 90 days)
SOLQUA 100/33 SUBCUTANEOUS INSULIN PEN	3	QL (60 per 90 days)
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR	4	
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR	4	
TRADJENTA ORAL TABLET	4	QL (90 per 90 days)
TRULICITY SUBCUTANEOUS PEN INJECTOR	3	QL (2 per 28 days)
V-GO 20 DEVICE	1	
V-GO 30 DEVICE	1	
V-GO 40 DEVICE	1	
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR	3	QL (27 per 90 days)
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR	3	QL (27 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	QL (90 per 90 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5- 500 MG	3	QL (180 per 90 days)
GLYCEMIC AGENTS		
BAQSIMI NASAL SPRAY, NON- AEROSOL	3	
<i>diazoxide oral suspension</i>	4	
GLUCAGEN HYPOKIT INJECTION RECON SOLN	3	
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN	3	
<i>glucagon emergency kit (human) injection recon soln</i>	3	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR	3	

Drug Name	Drug Tier	Requirements /Limits
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR	3	
GVOKE PFS 1- PACK SYRINGE SUBCUTANEOUS SYRINGE	3	
GVOKE PFS 2- PACK SYRINGE SUBCUTANEOUS SYRINGE	3	
KORLYM ORAL TABLET	5	PA; LA; NEDS
PROGLYCEM ORAL SUSPENSION	4	
INSULINS		
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN	4	ST
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION	4	ST
FIASP FLEXTOUCH U- 100 INSULIN SUBCUTANEOUS PEN	3	
FIASP PENFILL U- 100 INSULIN SUBCUTANEOUS CARTRIDGE	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT	4	ST
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN	4	ST
HUMALOG MIX 50-50 INSULN U-100 SUBCUTANEOUS SUSPENSION	4	ST
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION	4	ST
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE	4	ST

Drug Name	Drug Tier	Requirements /Limits
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION	4	ST
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION	4	ST
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN	4	ST
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION	4	ST
HUMULIN R REGULAR U-100 INSULN INJECTION SOLUTION	4	ST
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION	5	NEDS
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN	5	NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
INSULIN LISPRO PROTAMIN- LISPRO SUBCUTANEOUS INSULIN PEN	4	ST
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN	4	ST
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN, HALF-UNIT	4	ST
INSULIN LISPRO SUBCUTANEOUS SOLUTION	4	ST
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS PEN	3	
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
LEVEMIR FLEXTOUCH U- 100 INSULN SUBCUTANEOUS INSULIN PEN	3	
LEVEMIR U-100 INSULIN SUBCUTANEOUS SOLUTION	3	
NOVOLIN 70/30 U- 100 INSULIN SUBCUTANEOUS SUSPENSION	3	

Drug Name	Drug Tier	Requirements /Limits
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION	3	
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN	3	
NOVOLIN R REGULAR U-100 INSULN INJECTION SOLUTION	3	
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS PEN	3	
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION	3	
NOVOLOG MIX 70-30FLEXPEN U- 100 SUBCUTANEOUS INSULIN PEN	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	3	
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION	3	
TOUJEO MAX U- 300 SOLOSTAR SUBCUTANEOUS INSULIN PEN	3	
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS PEN	3	

BLOOD PRODUCTS AND MODIFIERS

ANTICOAGULANTS

ARGATROBAN IN 0.9 % SOD CHLOR INTRAVENOUS SOLUTION	4	
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	3	
ELIQUIS ORAL TABLET 2.5 MG	3	QL (180 per 90 days)
ELIQUIS ORAL TABLET 5 MG	3	QL (194 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>enoxaparin subcutaneous syringe</i>	4	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	5	NEDS
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	4	
FRAGMIN SUBCUTANEOUS SOLUTION	4	
FRAGMIN SUBCUTANEOUS SYRINGE	4	
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution</i>	4	
<i>heparin (porcine) injection solution</i>	2	
<i>jantoven oral tablet</i>	1	
PRADAXA ORAL CAPSULE	4	
SAVAYSA ORAL TABLET	4	
THROMBATE III INTRAVENOUS RECON SOLN	4	
<i>warfarin oral tablet</i>	1	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	3	
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (90 per 90 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (180 per 90 days)
BLOOD PRODUCTS AND MODIFIERS, OTHER		
<i>anagrelide oral capsule</i>	2	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	4	PA
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	4	PA
CEPROTIN (BLUE BAR) INTRAVENOUS RECON SOLN	4	
CEPROTIN (GREEN BAR) INTRAVENOUS RECON SOLN	4	

Drug Name	Drug Tier	Requirements /Limits
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	4	PA
GRANIX SUBCUTANEOUS SOLUTION	5	NEDS
GRANIX SUBCUTANEOUS SYRINGE	5	NEDS
NEULASTA ONPRO SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR	5	QL (1.2 per 28 days); NEDS
NEULASTA SUBCUTANEOUS SYRINGE	5	QL (1.2 per 28 days); NEDS
NEUPOGEN INJECTION SOLUTION	5	NEDS
NEUPOGEN INJECTION SYRINGE	5	NEDS
NIVESTYM INJECTION SOLUTION	5	NEDS
NIVESTYM SUBCUTANEOUS SYRINGE	5	NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
OXBRYTA ORAL TABLET	5	PA; LA; NEDS
PANHEMATIN INTRAVENOUS RECON SOLN	4	
<i>plasmanate intravenous parenteral solution</i>	4	
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	5	PA; NEDS
PROMACTA ORAL TABLET	5	PA; NEDS
<i>protamine intravenous solution</i>	4	
ZARXIO INJECTION SYRINGE	5	NEDS
HEMOSTASIS AGENTS		
<i>aminocaproic acid oral tablet 500 mg</i>	2	
ASTRINGYN TOPICAL SOLUTION	4	EX
<i>tranexamic acid oral tablet</i>	2	QL (90 per 63 days)

Drug Name	Drug Tier	Requirements /Limits
PLATELET MODIFYING AGENTS		
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr</i>	4	
BRILINTA ORAL TABLET	3	
CABLIVI INJECTION KIT	5	PA; NEDS
<i>cilostazol oral tablet</i>	2	
<i>clopidogrel oral tablet 75 mg</i>	1	
<i>dipyridamole intravenous solution</i>	4	
<i>dipyridamole oral tablet</i>	2	HRM
DOPTelet (10 TAB PACK) ORAL TABLET	5	PA; NEDS
DOPTelet (15 TAB PACK) ORAL TABLET	5	PA; NEDS
DOPTelet (30 TAB PACK) ORAL TABLET	5	PA; NEDS
<i>prasugrel oral tablet</i>	3	
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
<i>clonidine hcl oral tablet</i>	2	HRM
<i>clonidine transdermal patch weekly</i>	1	HRM; QL (12 per 84 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>dobutamine in d5w intravenous parenteral solution 1,000 mg/250 ml (4,000 mcg/ml), 250 mg/250 ml (1 mg/ml), 500 mg/250 ml (2,000 mcg/ml)</i>	4	
<i>dobutamine intravenous solution 250 mg/20 ml (12.5 mg/ml)</i>	4	
<i>droxidopa oral capsule</i>	4	
<i>guanfacine oral tablet</i>	2	HRM
<i>methyl dopa oral tablet</i>	2	HRM
<i>midodrine oral tablet</i>	2	
NORTHERA ORAL CAPSULE	5	LA; NEDS
ALPHA-ADRENERGIC BLOCKING AGENTS		
<i>doxazosin oral tablet</i>	2	HRM
<i>phenoxybenzamine oral capsule</i>	2	
<i>prazosin oral capsule</i>	2	HRM
<i>terazosin oral capsule</i>	2	HRM
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan oral tablet</i>	1	

Drug Name	Drug Tier	Requirements /Limits
EDARBI ORAL TABLET	4	
<i>irbesartan oral tablet</i>	1	
<i>losartan oral tablet</i>	1	
<i>olmesartan oral tablet</i>	1	
<i>telmisartan oral tablet</i>	1	
<i>valsartan oral tablet</i>	1	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
<i>benazepril oral tablet</i>	1	
<i>captopril oral tablet</i>	1	
<i>enalapril maleate oral tablet</i>	1	
<i>fosinopril oral tablet</i>	1	
<i>lisinopril oral tablet</i>	1	
<i>moexipril oral tablet</i>	1	
<i>perindopril erbumine oral tablet</i>	1	
<i>quinapril oral tablet</i>	1	
<i>ramipril oral capsule</i>	1	
<i>trandolapril oral tablet</i>	1	
ANTIARRHYTHMICS		
<i>adenosine intravenous syringe</i>	4	
<i>amiodarone oral tablet</i>	2	HRM

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>disopyramide phosphate oral capsule</i>	2	HRM
<i>dofetilide oral capsule</i>	2	
<i>flecainide oral tablet</i>	2	
<i>ibutilide fumarate intravenous solution</i>	4	
<i>mexiletine oral capsule</i>	2	
MULTAQ ORAL TABLET	3	HRM; QL (180 per 90 days)
NORPACE CR ORAL CAPSULE, EXTENDED RELEASE 100 MG	4	HRM
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	2	HRM
<i>propafenone oral capsule, extended release 12 hr</i>	2	
<i>propafenone oral tablet</i>	2	
<i>quinidine gluconate oral tablet extended release</i>	2	
<i>quinidine sulfate oral tablet</i>	2	
<i>sorine oral tablet</i>	2	
<i>sotalol af oral tablet</i>	2	
<i>sotalol oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
BETA-ADRENERGIC BLOCKING AGENTS		
<i>acebutolol oral capsule</i>	2	
<i>atenolol oral tablet</i>	1	
<i>betaxolol oral tablet</i>	1	
<i>bisoprolol fumarate oral tablet</i>	1	
BREVIBLOC IN NACL (ISO-OSM) INTRAVENOUS PARENTERAL SOLUTION	4	
BYSTOLIC ORAL TABLET 10 MG	4	ST; QL (360 per 90 days)
BYSTOLIC ORAL TABLET 2.5 MG, 5 MG	4	ST; QL (90 per 90 days)
BYSTOLIC ORAL TABLET 20 MG	4	ST; QL (180 per 90 days)
<i>carvedilol oral tablet</i>	1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr</i>	2	QL (90 per 90 days)
<i>esmolol in nacl (iso-osm) intravenous parenteral solution</i>	4	
<i>esmolol intravenous solution</i>	4	
<i>labetalol oral tablet</i>	1	
<i>metoprolol succinate oral tablet extended release 24 hr</i>	1	QL (180 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nadolol oral tablet</i>	1	
<i>pindolol oral tablet</i>	1	
<i>propranolol oral capsule,extended release 24 hr</i>	1	
<i>propranolol oral solution</i>	2	
<i>propranolol oral tablet</i>	1	
<i>timolol maleate oral tablet</i>	1	
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
<i>amlodipine oral tablet</i>	1	
<i>felodipine oral tablet extended release 24 hr</i>	1	
<i>isradipine oral capsule</i>	2	
<i>nicardipine oral capsule</i>	1	
<i>nifedipine oral tablet extended release</i>	1	
<i>nifedipine oral tablet extended release 24hr</i>	1	
<i>nimodipine oral capsule</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>nisoldipine oral tablet extended release 24 hr</i>	4	
CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYROPYRIDINES		
<i>cartia xt oral capsule,extended release 24hr</i>	1	
<i>diltiazem hcl oral capsule,ext.rel 24h degradable</i>	1	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	1	
<i>diltiazem hcl oral capsule,extended release 24 hr</i>	1	
<i>diltiazem hcl oral capsule,extended release 24hr</i>	1	
<i>diltiazem hcl oral tablet</i>	1	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	1	
<i>dilt-xr oral capsule,ext.rel 24h degradable</i>	1	
<i>matzim la oral tablet extended release 24 hr</i>	1	
<i>taztia xt oral capsule,extended release 24 hr</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>tiadylt er oral capsule,extended release 24 hr</i>	1	
<i>verapamil oral capsule, 24 hr er pellet ct</i>	1	
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	1	
<i>verapamil oral tablet</i>	1	
<i>verapamil oral tablet extended release</i>	1	

CARDIOVASCULAR AGENTS, OTHER

<i>acetazolamide oral tablet</i>	2	
<i>aliskiren oral tablet</i>	3	QL (90 per 90 days)
<i>amiloride-hydrochlorothiazide oral tablet</i>	1	
<i>amlodipine-atorvastatin oral tablet</i>	2	
<i>amlodipine-benazepril oral capsule</i>	2	
<i>amlodipine-olmesartan oral tablet</i>	2	
<i>amlodipine-valsartan oral tablet</i>	2	
<i>amlodipine-valsartan-hcthiiazid oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>atenolol-chlorthalidone oral tablet</i>	1	
<i>benazepril-hydrochlorothiazide oral tablet</i>	2	
<i>bisoprolol-hydrochlorothiazide oral tablet</i>	1	
<i>candesartan-hydrochlorothiazid oral tablet</i>	2	
<i>captopril-hydrochlorothiazide oral tablet</i>	2	
CORLANOR ORAL SOLUTION	4	QL (1350 per 90 days)
CORLANOR ORAL TABLET	4	QL (180 per 90 days)
CORLOPAM INTRAVENOUS SOLUTION	4	
DEMSEER ORAL CAPSULE	4	
<i>digitek oral tablet 125 mcg (0.125 mg)</i>	2	HRM; QL (90 per 90 days)
<i>digitek oral tablet 250 mcg (0.25 mg)</i>	2	HRM
<i>digox oral tablet 125 mcg (0.125 mg)</i>	2	HRM; QL (90 per 90 days)
<i>digox oral tablet 250 mcg (0.25 mg)</i>	2	HRM
<i>digoxin oral solution</i>	2	HRM
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	2	HRM; QL (90 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

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Drug Name	Drug Tier	Requirements /Limits
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	2	HRM
<i>dopamine in 5 % dextrose intravenous solution</i>	4	
<i>dopamine intravenous solution 200 mg/5 ml (40 mg/ml), 400 mg/10 ml (40 mg/ml)</i>	4	
EDARBYCLOR ORAL TABLET	4	
<i>enalapril-hydrochlorothiazide oral tablet</i>	2	
ENTRESTO ORAL TABLET	3	
<i>fosinopril-hydrochlorothiazide oral tablet</i>	2	
<i>ibuprofen lysine (pf) intravenous solution</i>	4	
<i>irbesartan-hydrochlorothiazide oral tablet</i>	2	
<i>isoproterenol hcl injection solution</i>	4	
ISUPREL INJECTION SOLUTION	4	
LEVOPHED (BITARTRATE) INTRAVENOUS SOLUTION	4	

Drug Name	Drug Tier	Requirements /Limits
<i>lisinopril-hydrochlorothiazide oral tablet</i>	1	
<i>losartan-hydrochlorothiazide oral tablet</i>	1	
<i>methyldopa-hydrochlorothiazide oral tablet</i>	2	
<i>metoprolol ta-hydrochlorothiazide oral tablet</i>	1	
<i>metyrosine oral capsule</i>	4	
<i>nadolol-bendroflumethiazide oral tablet 80-5 mg</i>	1	
<i>norepinephrine bitartrate intravenous solution</i>	2	
<i>olmesartan-amlodipin-hcthiiazid oral tablet</i>	1	
<i>olmesartan-hydrochlorothiazide oral tablet</i>	1	
<i>pentoxifylline oral tablet extended release</i>	2	
<i>propranolol-hydrochlorothiazid oral tablet</i>	1	
<i>quinapril-hydrochlorothiazide oral tablet</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>ranolazine oral tablet extended release 12 hr</i>	4	
<i>spironolactone-hydrochlorothiazide oral tablet</i>	1	
TEKTURNA HCT ORAL TABLET	3	QL (90 per 90 days)
<i>telmisartan-amlodipine oral tablet</i>	2	
<i>telmisartan-hydrochlorothiazide oral tablet</i>	2	
<i>trandolapril-verapamil oral tablet, ir - er, biphasic 24hr</i>	2	
<i>triamterene-hydrochlorothiazide oral capsule 37.5-25 mg</i>	1	
<i>triamterene-hydrochlorothiazide oral tablet</i>	1	
<i>valsartan-hydrochlorothiazide oral tablet</i>	2	
VECAMYL ORAL TABLET	5	PA; LA; NEDS
DIURETICS, LOOP		
<i>bumetanide injection solution</i>	4	
<i>bumetanide oral tablet</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>furosemide injection solution</i>	4	
<i>furosemide injection syringe</i>	4	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	
<i>furosemide oral tablet</i>	1	
<i>torsemide oral tablet</i>	2	
DIURETICS, POTASSIUM-SPARING		
<i>amiloride oral tablet</i>	2	
<i>eplerenone oral tablet</i>	2	
<i>spironolactone oral tablet</i>	1	
DIURETICS, THIAZIDE		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	
DIURIL ORAL SUSPENSION	4	
<i>hydrochlorothiazide oral capsule</i>	1	
<i>hydrochlorothiazide oral tablet</i>	1	
<i>indapamide oral tablet</i>	1	
<i>metolazone oral tablet</i>	2	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>fenofibrate micronized oral capsule</i>	2	QL (90 per 90 days)
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	2	
<i>fenofibrate oral tablet</i>	2	QL (90 per 90 days)
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 135 mg</i>	2	QL (90 per 90 days)
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 45 mg</i>	2	QL (270 per 90 days)
<i>fenofibric acid oral tablet</i>	2	
<i>gemfibrozil oral tablet</i>	2	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin oral tablet 10 mg, 20 mg, 40 mg</i>	1	
<i>atorvastatin oral tablet 80 mg</i>	1	QL (90 per 90 days)
EZALLOR SPRINKLE ORAL CAPSULE, SPRINKLE	4	QL (90 per 90 days)
<i>fluvastatin oral capsule 20 mg</i>	1	QL (360 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>fluvastatin oral capsule 40 mg</i>	1	QL (180 per 90 days)
<i>fluvastatin oral tablet extended release 24 hr</i>	1	QL (90 per 90 days)
LIVALO ORAL TABLET 1 MG	4	QL (360 per 90 days)
LIVALO ORAL TABLET 2 MG	4	QL (180 per 90 days)
LIVALO ORAL TABLET 4 MG	4	QL (90 per 90 days)
<i>lovastatin oral tablet 10 mg, 20 mg</i>	1	QL (360 per 90 days)
<i>lovastatin oral tablet 40 mg</i>	1	QL (180 per 90 days)
<i>pravastatin oral tablet 10 mg, 20 mg</i>	1	QL (360 per 90 days)
<i>pravastatin oral tablet 40 mg</i>	1	QL (180 per 90 days)
<i>pravastatin oral tablet 80 mg</i>	1	QL (90 per 90 days)
<i>rosuvastatin oral tablet 10 mg, 5 mg</i>	2	QL (360 per 90 days)
<i>rosuvastatin oral tablet 20 mg</i>	2	QL (180 per 90 days)
<i>rosuvastatin oral tablet 40 mg</i>	2	QL (90 per 90 days)
<i>simvastatin oral tablet 10 mg, 20 mg, 5 mg</i>	1	QL (360 per 90 days)
<i>simvastatin oral tablet 40 mg</i>	1	QL (180 per 90 days)
<i>simvastatin oral tablet 80 mg</i>	1	QL (90 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
DYSLIPIDEMICS, OTHER		
<i>cholestyramine (with sugar) oral powder</i>	2	
<i>cholestyramine (with sugar) oral powder in packet</i>	2	
<i>cholestyramine light oral powder</i>	2	
<i>cholestyramine light oral powder in packet</i>	2	
<i>colesevelam oral powder in packet</i>	3	
<i>colesevelam oral tablet</i>	3	
<i>colestipol oral granules</i>	2	
<i>colestipol oral packet</i>	2	
<i>colestipol oral tablet</i>	2	
<i>ezetimibe oral tablet</i>	2	QL (90 per 90 days)
<i>ezetimibe-simvastatin oral tablet</i>	2	QL (90 per 90 days)
<i>icosapent ethyl oral capsule</i>	4	
<i>niacin oral tablet 500 mg</i>	2	
<i>niacin oral tablet extended release 24 hr</i>	2	
<i>omega-3 acid ethyl esters oral capsule</i>	2	

Drug Name	Drug Tier	Requirements /Limits
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR	3	PA
<i>prevalite oral powder</i>	2	
<i>prevalite oral powder in packet</i>	2	
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR	3	PA
REPATHA SUBCUTANEOUS SYRINGE	3	PA
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR	3	PA
VASCEPA ORAL CAPSULE 1 GRAM	4	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
<i>isosorbide dinitrate oral tablet</i>	2	
<i>isosorbide mononitrate oral tablet</i>	2	
<i>isosorbide mononitrate oral tablet extended release 24 hr</i>	2	
<i>isoxsuprine oral tablet</i>	2	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>nitro-bid transdermal ointment</i>	2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	4	
<i>nitroglycerin in 5 % dextrose intravenous solution 100 mg/250 ml (400 mcg/ml), 25 mg/250 ml (100 mcg/ml), 50 mg/250 ml (200 mcg/ml)</i>	4	
<i>nitroglycerin oral capsule, extended release</i>	2	EX
<i>nitroglycerin sublingual tablet</i>	2	
<i>nitroglycerin transdermal patch 24 hour</i>	2	
<i>nitroglycerin translingual spray, non-aerosol</i>	4	
<i>nitro-time oral capsule, extended release</i>	2	EX
RECTIV RECTAL OINTMENT	4	
VASODILATORS, DIRECT-ACTING ARTERIAL		
<i>hydralazine oral tablet</i>	2	
<i>minoxidil oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
<i>dextroamphetamine oral capsule, extended release</i>	2	
<i>dextroamphetamine oral tablet 10 mg, 5 mg</i>	2	QL (540 per 90 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 10 mg, 15 mg, 25 mg, 30 mg</i>	2	QL (180 per 90 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 20 mg</i>	2	QL (270 per 90 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 5 mg</i>	2	QL (90 per 90 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	2	QL (270 per 90 days)
<i>dextroamphetamine-amphetamine oral tablet 30 mg</i>	2	QL (180 per 90 days)
<i>methamphetamine oral tablet</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
VYVANSE ORAL CAPSULE	4	PA
<i>zenzedi oral tablet 10 mg, 5 mg</i>	2	QL (540 per 90 days)
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	4	
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg, 60 mg</i>	4	QL (180 per 90 days)
<i>atomoxetine oral capsule 100 mg, 80 mg</i>	4	QL (90 per 90 days)
<i>clonidine hcl oral tablet extended release 12 hr</i>	2	HRM; QL (360 per 90 days)
DAYTRANA TRANSDERMAL PATCH 24 HOUR	4	
<i>guanfacine oral tablet extended release 24 hr</i>	2	HRM
<i>methylphenidate hcl oral capsule, er biphasic 30-70 20 mg, 40 mg</i>	2	
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 60 mg</i>	2	
<i>methylphenidate hcl oral solution</i>	2	
<i>methylphenidate hcl oral tablet</i>	2	QL (270 per 90 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	2	
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	2	
<i>methylphenidate hcl oral tablet,chewable</i>	2	
CENTRAL NERVOUS SYSTEM, OTHER		
<i>caffeine citrate intravenous solution</i>	4	
<i>caffeine citrate oral solution</i>	4	
DOPRAM INTRAVENOUS SOLUTION	4	
FIRDAPSE ORAL TABLET	5	PA; NEDS
MYOBLOC INTRAMUSCULAR SOLUTION	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
NEOSTIGMINE METHYLSULFATE INTRAVENOUS SYRINGE 3 MG/3 ML (1 MG/ML)	3	
NUEDEXTA ORAL CAPSULE	4	PA; QL (180 per 90 days)
<i>riluzole oral tablet</i>	2	
RUZURGI ORAL TABLET	5	PA; NEDS
<i>tetrabenazine oral tablet 12.5 mg</i>	5	PA; QL (248 per 31 days); NEDS
<i>tetrabenazine oral tablet 25 mg</i>	5	PA; QL (124 per 31 days); NEDS
FIBROMYALGIA AGENTS		
SAVELLA ORAL TABLET	3	PA; QL (180 per 90 days)
SAVELLA ORAL TABLETS,DOSE PACK	3	PA; QL (165 per 84 days)
MULTIPLE SCLEROSIS AGENTS		
AUBAGIO ORAL TABLET	5	PA; LA; NEDS
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	5	PA; NEDS
AVONEX INTRAMUSCULAR SYRINGE KIT	5	PA; NEDS
BETASERON SUBCUTANEOUS KIT	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	5	PA; NEDS
<i>dalfampridine oral tablet extended release 12 hr</i>	5	PA; QL (62 per 31 days); NEDS
<i>dimethyl fumarate oral capsule, delayed release(dr/ec)</i>	5	PA; QL (62 per 31 days); NEDS
EXTAVIA SUBCUTANEOUS KIT	5	PA; NEDS
EXTAVIA SUBCUTANEOUS RECON SOLN	5	PA; NEDS
GILENYA ORAL CAPSULE 0.5 MG	5	PA; NEDS
<i>glatiramer subcutaneous syringe</i>	5	NEDS
<i>glatopa subcutaneous syringe</i>	5	NEDS
PLEGRIDY INTRAMUSCULAR SYRINGE	5	PA; LA; NEDS
PLEGRIDY SUBCUTANEOUS PEN INJECTOR	5	PA; LA; NEDS
PLEGRIDY SUBCUTANEOUS SYRINGE	5	PA; LA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE	5	PA; NEDS
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE	5	PA; NEDS
TECFIDERA ORAL CAPSULE,DELAY ED RELEASE(DR/EC)	5	PA; LA; QL (62 per 31 days); NEDS

DENTAL AND ORAL AGENTS

DENTAL AND ORAL AGENTS

<i>cevimeline oral capsule</i>	2	
<i>chlorhexidine gluconate mucous membrane mouthwash</i>	2	
DEBACTEROL MUCOUS MEMBRANE SOLUTION	4	EX
DEBACTEROL MUCOUS MEMBRANE SWAB	4	EX
<i>oralone dental paste</i>	2	
<i>paroex oral rinse mucous membrane mouthwash</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>periogard mucous membrane mouthwash</i>	2	
<i>pilocarpine hcl oral tablet</i>	2	
<i>triamcinolone acetonide dental paste</i>	2	

DERMATOLOGICAL AGENTS

ACNE AND ROSACEA AGENTS

ABSORICA ORAL CAPSULE	4	
<i>accutane oral capsule 20 mg, 30 mg, 40 mg</i>	2	
<i>acitretin oral capsule 10 mg, 25 mg</i>	4	
<i>acitretin oral capsule 17.5 mg</i>	5	NEDS
<i>adapalene topical cream</i>	2	
<i>adapalene topical gel</i>	2	
<i>adapalene topical gel with pump</i>	2	
<i>amnestem oral capsule</i>	2	
AVAR LS TOPICAL CLEANSER	4	EX
<i>avar topical cleanser</i>	2	EX
AVAR-E GREEN TOPICAL CREAM	4	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
AVAR-E LS TOPICAL CREAM	4	EX
AVAR-E TOPICAL CREAM	4	EX
<i>avita topical cream</i>	2	
<i>azelaic acid topical gel</i>	4	
BENZEFOAM TOPICAL FOAM	4	EX
BENZEPRO (MICROSPHERES) TOPICAL CLEANSER	4	EX
<i>benzebro topical towelette</i>	2	EX
<i>benzoyl peroxide topical cleanser 7 %</i>	2	EX
<i>benzoyl peroxide topical foam 9.8 %</i>	2	EX
<i>bp 10-1 topical cleanser</i>	2	EX
<i>claravis oral capsule</i>	2	
<i>clindamycin-benzoyl peroxide topical gel</i>	2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i>	2	
ENZOCLEAR TOPICAL FOAM	4	EX
<i>erythromycin-benzoyl peroxide topical gel</i>	2	
FINACEA TOPICAL GEL	4	

Drug Name	Drug Tier	Requirements /Limits
INOVA 4-1 TOPICAL COMBO PACK	4	EX
INOVA 8-2 TOPICAL COMBO PACK	4	EX
INOVA TOPICAL COMBO PACK	4	EX
<i>isotretinoin oral capsule</i>	2	
<i>myorisan oral capsule</i>	2	
<i>neuac topical gel</i>	2	
OVACE TOPICAL CLEANSER	4	EX
PACNEX TOPICAL CLEANSER	4	EX
PR BENZOYL PEROXIDE TOPICAL CLEANSER	4	EX
<i>refissa topical cream</i>	4	EX
RENOVA TOPICAL CREAM 0.02 %	4	EX
ROSANIL TOPICAL CLEANSER	4	EX
<i>rosula cleansing cloths topical pads, medicated</i>	2	EX
<i>sss 10-5 topical cream</i>	2	EX
<i>sss 10-5 topical foam</i>	2	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>sulfacetamide sodium topical cleanser</i>	2	EX
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	2	EX
<i>sulfacetamide sodium-sulfur topical cream 10-5 % (w/w)</i>	2	EX
<i>sulfacetamide sodium-sulfur topical pads, medicated 10-4 %</i>	2	EX
<i>sulfacetamide sodium-sulfur topical suspension 8-4 %</i>	2	EX
<i>sulfacleanse 8-4 topical suspension</i>	2	EX
SUMADAN TOPICAL CLEANSER	4	EX
SUMAXIN TOPICAL CLEANSER	4	EX
SUMAXIN TOPICAL PADS, MEDICATED	4	EX
SUMAXIN TS TOPICAL SUSPENSION	4	EX
<i>tazarotene topical cream</i>	4	

Drug Name	Drug Tier	Requirements /Limits
TAZORAC TOPICAL CREAM 0.05 %	4	
<i>tretinoin (emollient) topical cream</i>	4	EX
<i>tretinoin topical cream</i>	2	
<i>tretinoin topical gel</i>	2	
VANOXIDE-HC TOPICAL SUSPENSION	4	EX
<i>zenatane oral capsule</i>	2	
DERMATITIS AND PRURITUS AGENTS		
<i>ala-cort topical cream</i>	2	
<i>alclometasone topical cream</i>	2	
<i>alclometasone topical ointment</i>	2	
<i>amcinonide topical cream</i>	4	
<i>amcinonide topical lotion</i>	4	
<i>amcinonide topical ointment</i>	4	
<i>ammonium lactate topical cream</i>	2	
<i>ammonium lactate topical lotion</i>	2	
<i>apexicon e topical cream</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>beseer topical lotion</i>	2	
<i>betamethasone dipropionate topical cream</i>	2	
<i>betamethasone dipropionate topical lotion</i>	2	
<i>betamethasone valerate topical cream</i>	2	
<i>betamethasone valerate topical lotion</i>	2	
<i>betamethasone valerate topical ointment</i>	2	
<i>betamethasone, augmented topical gel</i>	2	
<i>betamethasone, augmented topical lotion</i>	2	
<i>betamethasone, augmented topical ointment</i>	2	
<i>clobetasol scalp solution</i>	3	
<i>clobetasol topical cream</i>	3	
<i>clobetasol topical foam</i>	4	
<i>clobetasol topical gel</i>	4	
<i>clobetasol topical lotion</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>clobetasol topical ointment</i>	3	
<i>clobetasol topical shampoo</i>	4	
<i>clobetasol topical spray, non-aerosol</i>	4	
<i>clobetasol-emollient topical cream</i>	4	
<i>clobetasol-emollient topical foam</i>	4	
<i>clodan topical shampoo</i>	4	
COAL TAR (BULK) TOPICAL SOLUTION	4	EX
CORDRAN LARGE ROLL TOPICAL TAPE	3	
<i>desonide topical cream</i>	3	
<i>desonide topical lotion</i>	3	
<i>desonide topical ointment</i>	3	
<i>desoximetasone topical cream</i>	4	
<i>desoximetasone topical gel</i>	2	
<i>desoximetasone topical ointment</i>	4	
<i>diflorasone topical cream</i>	4	
<i>diflorasone topical ointment</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>drithocrema hp topical cream</i>	2	EX
<i>fluocinolone and shower cap scalp oil</i>	2	
<i>fluocinolone topical cream</i>	2	
<i>fluocinolone topical oil</i>	2	
<i>fluocinolone topical ointment</i>	2	
<i>fluocinolone topical solution</i>	2	
<i>fluocinonide topical cream 0.05 %</i>	2	
<i>fluocinonide topical cream 0.1 %</i>	3	
<i>fluocinonide topical gel</i>	3	
<i>fluocinonide topical ointment</i>	3	
<i>fluocinonide topical solution</i>	3	
<i>fluocinonide-e topical cream</i>	4	
<i>fluocinonide-emollient topical cream</i>	4	
<i>fluticasone propionate topical cream</i>	2	
<i>fluticasone propionate topical ointment</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>halobetasol propionate topical cream</i>	2	
<i>halobetasol propionate topical ointment</i>	2	
<i>hydrocortisone butyrate topical cream</i>	2	
<i>hydrocortisone butyrate topical ointment</i>	2	
<i>hydrocortisone butyrate topical solution</i>	2	
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	2	
<i>hydrocortisone topical cream with perineal applicator</i>	2	
<i>hydrocortisone topical lotion 2.5 %</i>	2	
<i>hydrocortisone topical ointment 2.5 %</i>	2	
<i>hydrocortisone valerate topical cream</i>	2	
<i>hydrocortisone valerate topical ointment</i>	2	
LUXIQ TOPICAL FOAM	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>mometasone topical cream</i>	2	
<i>mometasone topical ointment</i>	2	
<i>mometasone topical solution</i>	2	
<i>nolix topical cream</i>	4	
PANDEL TOPICAL CREAM	4	
<i>prednicarbate topical cream</i>	2	
<i>prednicarbate topical ointment</i>	2	
<i>procto-med hc topical cream with perineal applicator</i>	2	
<i>procto-pak topical cream with perineal applicator</i>	2	
<i>proctosol hc topical cream with perineal applicator</i>	2	
<i>proctozone-hc topical cream with perineal applicator</i>	2	
<i>selenium sulfide topical lotion</i>	2	
<i>selenium sulfide topical shampoo 2.25 %</i>	2	EX
<i>tacrolimus topical ointment</i>	4	
TOPICORT TOPICAL OINTMENT 0.05 %	4	

Drug Name	Drug Tier	Requirements /Limits
<i>tovet emollient topical foam</i>	4	
<i>triamcinolone acetonide topical cream</i>	2	
<i>triamcinolone acetonide topical lotion</i>	2	
<i>triamcinolone acetonide topical ointment</i>	2	
<i>triderm topical cream</i>	2	
<i>tritocin topical ointment</i>	2	
DERMATOLOGICAL AGENTS, OTHER		
ALCORTIN A TOPICAL GEL IN PACKET	4	EX
ANALPRAM-HC RECTAL CREAM 1-1 %	4	
ANALPRAM-HC TOPICAL LOTION	4	
AQUA GLYCOLIC HC TOPICAL COMBO PACK	4	EX
<i>calcipotriene scalp solution</i>	2	PA; QL (180 per 90 days)
<i>calcipotriene topical cream</i>	2	PA; QL (360 per 90 days)
<i>calcipotriene topical ointment</i>	2	PA; QL (360 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>calcipotriene-betamethasone topical ointment</i>	4	
<i>calcitriol topical ointment</i>	4	
<i>cem-urea topical gel</i>	2	EX
<i>cleansing wash topical cleanser</i>	2	EX
<i>clotrimazole-betamethasone topical cream</i>	2	
<i>clotrimazole-betamethasone topical lotion</i>	2	
<i>corti-sav topical cream</i>	2	EX
DUOBRII TOPICAL LOTION	4	
FLUOROURACIL TOPICAL CREAM 0.5 %	4	
<i>fluorouracil topical cream 5 %</i>	2	
<i>fluorouracil topical solution</i>	2	
GUAIACOL LIQUID	4	EX
HYDRO 35 TOPICAL FOAM	4	EX
HYDRO 40 TOPICAL FOAM	4	EX
<i>hydrocortisone-iodoquinol topical cream</i>	2	EX

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	4	
<i>imiquimod topical cream in packet 5 %</i>	2	
IODOFLEX TOPICAL PADS, MEDICATED	4	EX
IODOSORB TOPICAL GEL	4	EX
KERAFOAM TOPICAL FOAM	4	EX
KERALYT RX TOPICAL GEL	4	EX
KERALYT SCALP COMPLETE TOPICAL KIT,SHAMPOO AND GEL	4	EX
KERALYT SCALP TOPICAL GEL	4	EX
<i>keralyt topical shampoo 6 %</i>	2	EX
<i>lugols topical solution</i>	2	EX
<i>methoxsalen oral capsule,liqd-filled,rapid rel</i>	5	NEDS
<i>nystatin-triamcinolone topical cream</i>	2	
<i>nystatin-triamcinolone topical ointment</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
OTEZLA ORAL TABLET	5	PA; NEDS
PICATO TOPICAL GEL 0.015 %	5	QL (3 per 31 days); NEDS
PICATO TOPICAL GEL 0.05 %	5	QL (2 per 31 days); NEDS
PODOCON TOPICAL LIQUID	4	EX
<i>podofilox topical solution</i>	2	
PROPECIA ORAL TABLET	4	EX
SALEX TOPICAL SHAMPOO	4	EX
<i>salicylic acid topical cream</i>	2	EX
<i>salicylic acid topical cream,extended release</i>	2	EX
<i>salicylic acid topical film forming liquid w/appl</i>	2	EX
<i>salicylic acid topical foam</i>	2	EX
<i>salicylic acid topical gel</i>	2	EX
<i>salicylic acid topical liquid</i>	2	EX
<i>salicylic acid topical lotion</i>	2	EX
<i>salicylic acid topical lotion,extended release</i>	4	EX

Drug Name	Drug Tier	Requirements /Limits
<i>salicylic acid topical shampoo</i>	2	EX
SALKERA TOPICAL FOAM	4	EX
SALVAX DUO PLUS TOPICAL FOAM	4	EX
<i>salvax topical foam</i>	2	EX
SANTYL TOPICAL OINTMENT	3	
<i>silver nitrate topical solution</i>	4	EX
<i>silver sulfadiazine topical cream</i>	2	
<i>ssd topical cream</i>	2	
TERSI TOPICAL FOAM	4	EX
TRI-LUMA TOPICAL CREAM	4	EX
<i>umecta topical foam</i>	2	EX
URAMAXIN TOPICAL FOAM	4	EX
URAMAXIN TOPICAL GEL	4	EX
<i>urea topical cream 39 %, 40 %, 45 %, 50 %</i>	2	EX
<i>urea topical foam</i>	2	EX
<i>urea topical gel</i>	2	EX
VANIQA TOPICAL CREAM	4	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
VIRASAL TOPICAL FILM FORMING LIQUID W/APPL	4	EX
XUREA TOPICAL CREAM	4	EX
DERMATOLOGICAL AGENTS		
ALA-QUIN TOPICAL CREAM	4	EX
PEDICULICIDES/SCABICIDES		
<i>crotan topical lotion</i>	4	
<i>ivermectin topical cream</i>	4	
<i>ivermectin topical lotion</i>	4	
<i>lindane topical shampoo</i>	2	
<i>malathion topical lotion</i>	4	
<i>permethrin topical cream</i>	2	
SKLICE TOPICAL LOTION	4	
SOOLANTRA TOPICAL CREAM	4	
TOPICAL ANTI-INFECTIVES		
<i>acyclovir topical cream</i>	4	
<i>acyclovir topical ointment</i>	4	
<i>ciclopirox topical gel</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>ciclopirox topical shampoo</i>	2	
<i>ciclopirox topical solution</i>	2	
<i>clindacin etz topical swab</i>	2	
<i>clindacin p topical swab</i>	2	
<i>clindamycin phosphate topical gel</i>	2	
<i>clindamycin phosphate topical lotion</i>	2	
<i>clindamycin phosphate topical solution</i>	2	
<i>clindamycin phosphate topical swab</i>	2	
<i>clindamycin phosphate vaginal cream</i>	2	
<i>dapsone topical gel</i>	4	
<i>ery pads topical swab</i>	2	
<i>erygel topical gel</i>	2	
<i>erythromycin with ethanol topical gel</i>	2	
<i>erythromycin with ethanol topical solution</i>	2	
<i>mafenide acetate topical packet</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>mupirocin calcium topical cream</i>	2	
<i>mupirocin topical ointment</i>	2	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
<i>calcium chloride intravenous solution</i>	4	
<i>calcium chloride intravenous syringe</i>	4	
<i>calcium gluconate intravenous solution</i>	4	
CARBAGLU ORAL TABLET, DISPERSIBLE	5	LA; NEDS
CLINIMIX E 2.75%/D5W SULF FREE INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
CLINIMIX E 4.25%/D5W SULF FREE INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
CLINIMIX E 5%/D15W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION	3	B/D PA

Drug Name	Drug Tier	Requirements /Limits
CLINIMIX E 5%/D20W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
<i>d10 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>d2.5 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>d5 % and 0.9 % sodium chloride intravenous parenteral solution</i>	4	
<i>d5 %-0.45 % sodium chloride intravenous parenteral solution</i>	4	
<i>denta 5000 plus dental cream</i>	2	
<i>dextrose 10 % in water (d10w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose 30 % in water (d30w) intravenous parenteral solution</i>	4	B/D PA
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	4	

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Drug Name	Drug Tier	Requirements /Limits
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	4	
<i>dextrose 5%-0.2 % sod chloride intravenous parenteral solution</i>	4	
<i>dextrose 5%-0.3 % sod.chloride intravenous parenteral solution</i>	4	
<i>dextrose 50 % in water (d50w) intravenous parenteral solution</i>	2	B/D PA
<i>dextrose 70 % in water (d70w) intravenous parenteral solution</i>	4	B/D PA
EFFER-K ORAL TABLET, EFFERVESCENT 20 MEQ	4	EX
<i>fluoride (sodium) dental paste</i>	2	
<i>fluoride (sodium) oral tablet</i>	2	
<i>fluoride (sodium) oral tablet, chewable 1 mg (2.2 mg sod. fluoride)</i>	2	
<i>freamine iii 10 % intravenous parenteral solution</i>	2	B/D PA

Drug Name	Drug Tier	Requirements /Limits
<i>intralipid intravenous emulsion 20 %</i>	4	B/D PA
INTRALIPID INTRAVENOUS EMULSION 30 %	4	B/D PA
IONOSOL-MB IN D5W INTRAVENOUS PARENTERAL SOLUTION	4	
ISOLYTE S PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	4	
ISOLYTE-P IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION	4	
ISOLYTE-S INTRAVENOUS PARENTERAL SOLUTION	4	
<i>klor-con 10 oral tablet extended release</i>	2	
<i>klor-con 8 oral tablet extended release</i>	2	
<i>klor-con m10 oral tablet, er particles/crystals</i>	2	
<i>klor-con m15 oral tablet, er particles/crystals</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>klor-con m20 oral tablet,er particles/crystals</i>	2	
<i>k-tab oral tablet extended release 8 meq</i>	2	
<i>levocarnitine (with sugar) oral solution</i>	2	
<i>levocarnitine oral solution 100 mg/ml</i>	2	
<i>levocarnitine oral tablet</i>	2	
<i>ludent fluoride oral tablet,chewable 1 mg (2.2 mg sod. fluoride)</i>	2	
MAGNESIUM SULFATE IN D5W INTRAVENOUS PIGGYBACK 1 GRAM/100 ML	4	
<i>magnesium sulfate in water intravenous parenteral solution</i>	4	
<i>magnesium sulfate in water intravenous piggyback</i>	4	
<i>magnesium sulfate injection syringe</i>	4	
NORMOSOL-R PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	4	

Drug Name	Drug Tier	Requirements /Limits
PLASMA-LYTE 148 INTRAVENOUS PARENTERAL SOLUTION	4	
PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION	4	
<i>potassium acetate intravenous solution</i>	4	
<i>potassium chlorid-d5-0.45%nacl intravenous parenteral solution</i>	4	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	4	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 30 meq/l, 40 meq/l</i>	4	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	4	
<i>potassium chloride in water intravenous piggyback</i>	4	
<i>potassium chloride oral capsule, extended release</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride oral liquid</i>	2	
<i>potassium chloride oral tablet extended release</i>	2	
<i>potassium chloride oral tablet, er particles/crystals</i>	2	
<i>potassium chloride-0.45 % nacl intravenous parenteral solution</i>	4	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l, 30 meq/l, 40 meq/l</i>	4	
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution</i>	4	
<i>potassium citrate oral tablet extended release</i>	2	
<i>potassium phosphate m-/d-basic intravenous solution 3 mmol/ml</i>	4	
<i>premasol 10 % intravenous parenteral solution</i>	4	B/D PA
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE	4	

Drug Name	Drug Tier	Requirements /Limits
PREVIDENT 5000 DRY MOUTH DENTAL GEL	4	
PREVIDENT 5000 ENAMEL PROTECT DENTAL PASTE	4	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE	4	
PREVIDENT 5000 SENSITIVE DENTAL PASTE	4	
PREVIDENT DENTAL SOLUTION	4	
PROCALAMINE 3% INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION	4	B/D PA
<i>sf 5000 plus dental cream</i>	2	
<i>sodium acetate intravenous solution</i>	4	
<i>sodium bicarbonate intravenous syringe 8.4 % (1 meq/ml)</i>	4	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	4	

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Drug Name	Drug Tier	Requirements /Limits
<i>sodium chloride 0.9 % injection solution</i>	2	EX
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	4	
<i>sodium chloride 0.9 % intravenous piggyback</i>	4	
<i>sodium chloride 3 % intravenous parenteral solution</i>	4	
<i>sodium chloride 5 % intravenous parenteral solution</i>	4	
<i>sodium chloride intravenous parenteral solution</i>	4	
<i>sodium chloride irrigation solution</i>	4	
<i>sodium fluoride 5000 dry mouth dental gel</i>	4	
<i>sodium fluoride-pot nitrate dental paste</i>	2	
<i>sodium phosphate intravenous solution</i>	4	
<i>travasol 10 % intravenous parenteral solution</i>	4	B/D PA
ELECTROLYTE/MINERAL/METAL MODIFIERS		
BAL IN OIL INTRAMUSCULAR SOLUTION	4	

Drug Name	Drug Tier	Requirements /Limits
CHEMET ORAL CAPSULE	3	
<i>deferasirox oral tablet</i>	5	NEDS
<i>deferasirox oral tablet, dispersible</i>	5	NEDS
<i>deferiprone oral tablet</i>	5	NEDS
EXJADE ORAL TABLET, DISPERSIBLE	5	LA; NEDS
FERRIPROX (2 TIMES A DAY) ORAL TABLET	5	NEDS
FERRIPROX ORAL SOLUTION	5	NEDS
FERRIPROX ORAL TABLET	5	NEDS
GALZIN ORAL CAPSULE	4	EX
JADENU ORAL TABLET	5	LA; NEDS
JYNARQUE ORAL TABLET	5	PA; NEDS
JYNARQUE ORAL TABLETS, SEQUENTIAL	5	PA; NEDS
SAMSCA ORAL TABLET	5	PA; NEDS
TOLVAPTAN ORAL TABLET 15 MG	5	PA; NEDS
<i>tolvaptan oral tablet 30 mg</i>	5	PA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

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Drug Name	Drug Tier	Requirements /Limits
<i>trientine oral capsule</i>	5	NEDS
PHOSPHATE BINDERS		
AURYXIA ORAL TABLET	5	PA; NEDS
<i>calcium acetate(phosphat bind) oral capsule</i>	2	
<i>calcium acetate(phosphat bind) oral tablet</i>	2	
<i>lanthanum oral tablet,chewable</i>	4	
PHOSLYRA ORAL SOLUTION	4	
<i>sevelamer carbonate oral powder in packet</i>	2	
<i>sevelamer carbonate oral tablet</i>	2	
POTASSIUM BINDERS		
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sps (with sorbitol) oral suspension</i>	2	
<i>sps (with sorbitol) rectal enema</i>	2	
VELTASSA ORAL POWDER IN PACKET	4	
VITAMINS		
DRISDOL ORAL CAPSULE	4	EX

Drug Name	Drug Tier	Requirements /Limits
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	2	EX
<i>folic acid oral tablet 1 mg</i>	2	EX
MEPHYTON ORAL TABLET	4	EX
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
<i>constulose oral solution</i>	2	
<i>enulose oral solution</i>	2	
<i>generlac oral solution</i>	2	
<i>lactulose oral packet</i>	2	
<i>lactulose oral solution</i>	2	
LINZESS ORAL CAPSULE	3	QL (90 per 90 days)
MOVANTIK ORAL TABLET	4	PA
RELISTOR ORAL TABLET	5	PA; NEDS
RELISTOR SUBCUTANEOUS SOLUTION	5	PA; QL (16.8 per 28 days); NEDS
RELISTOR SUBCUTANEOUS SYRINGE	5	PA; NEDS
TRULANCE ORAL TABLET	3	QL (90 per 90 days)
ANTI-DIARRHEAL AGENTS		

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Drug Name	Drug Tier	Requirements /Limits
<i>alosetron oral tablet</i>	5	PA; NEDS
<i>diphenoxylate-atropine oral liquid</i>	2	HRM
<i>diphenoxylate-atropine oral tablet</i>	2	HRM
<i>loperamide oral capsule</i>	2	
ANTISPASMODICS, GASTROINTESTINAL		
<i>dicyclomine oral capsule</i>	2	HRM
<i>dicyclomine oral solution</i>	2	HRM
<i>dicyclomine oral tablet</i>	2	HRM
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	
<i>methscopolamine oral tablet</i>	2	
GASTROINTESTINAL AGENTS, OTHER		
<i>amoxicil-clarithromy-lansopraz oral combo pack</i>	4	
<i>atropine injection solution 0.4 mg/ml</i>	4	
<i>chlordiazepoxide-clidinium oral capsule</i>	2	HRM
DONNATAL ORAL ELIXIR 16.2-0.1037 -0.0194 MG/5 ML	4	EX

Drug Name	Drug Tier	Requirements /Limits
DONNATAL ORAL TABLET	4	EX
GATTEX 30-VIAL SUBCUTANEOUS KIT	5	PA; LA; NEDS
GATTEX ONE-VIAL SUBCUTANEOUS KIT	5	PA; NEDS
<i>gavilyte-c oral recon soln</i>	2	
<i>gavilyte-g oral recon soln</i>	2	
<i>gavilyte-n oral recon soln</i>	2	
<i>metoclopramide hcl oral solution</i>	2	HRM
<i>metoclopramide hcl oral tablet</i>	2	HRM
<i>metoclopramide hcl oral tablet, disintegrating</i>	2	HRM
MYALEPT SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
OMECLAMOX-PAK ORAL COMBO PACK	4	
OSMOPREP ORAL TABLET	4	
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
<i>peg-electrolyte oral recon soln</i>	2	
<i>phenobarb-hyoscy-atropine-scop oral elixir 16.2-0.1037 - 0.0194 mg/5 ml</i>	2	EX
<i>phenobarb-hyoscy-atropine-scop oral tablet</i>	2	EX
<i>phenohydro oral tablet</i>	2	EX
<i>polyethylene glycol 3350 oral powder</i>	2	
SUPREP BOWEL PREP KIT ORAL RECON SOLN	4	
SUTAB ORAL TABLET	4	
<i>trilyte with flavor packets oral recon soln</i>	2	
<i>ursodiol oral capsule</i>	2	
<i>ursodiol oral tablet</i>	2	
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
<i>cimetidine hcl oral solution</i>	1	
<i>cimetidine oral tablet</i>	1	
<i>famotidine oral suspension</i>	1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>nizatidine oral capsule</i>	2	
<i>nizatidine oral solution</i>	2	
PROTECTANTS		
<i>misoprostol oral tablet</i>	2	
<i>sucralfate oral tablet</i>	2	
PROTON PUMP INHIBITORS		
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS	4	QL (90 per 90 days)
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	3	
<i>lansoprazole oral capsule, delayed release(dr/ec)</i>	2	
<i>lansoprazole oral tablet, disintegrat, delay rel</i>	4	
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET	4	
<i>omeprazole oral capsule, delayed release(dr/ec) 10 mg</i>	2	
<i>omeprazole oral capsule, delayed release(dr/ec) 20 mg, 40 mg</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	2	
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	2	
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
CERDELGA ORAL CAPSULE	5	LA; NEDS
CHOLBAM ORAL CAPSULE	5	PA; NEDS
CREON ORAL CAPSULE, DELAYED RELEASE (DR/EC)	3	
<i>cromolyn oral concentrate</i>	2	
CYSTADANE ORAL POWDER	4	
CYSTAGON ORAL CAPSULE	4	LA
CYSTARAN OPHTHALMIC (EYE) DROPS	5	LA; NEDS
DOJOLVI ORAL LIQUID	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
ENDARI ORAL POWDER IN PACKET	5	LA; NEDS
EVRYSDI ORAL RECON SOLN	5	PA; LA; NEDS
GALAFOLD ORAL CAPSULE	5	PA; NEDS
KUVAN ORAL POWDER IN PACKET	5	LA; NEDS
KUVAN ORAL TABLET, SOLUBLE	5	LA; NEDS
<i>miglustat oral capsule</i>	5	LA; NEDS
<i>nitisinone oral capsule</i>	5	NEDS
NITYR ORAL TABLET	5	PA; NEDS
ORFADIN ORAL CAPSULE	5	LA; NEDS
ORFADIN ORAL SUSPENSION	5	LA; NEDS
PALYNZIQ SUBCUTANEOUS SYRINGE	5	PA; NEDS

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Drug Name	Drug Tier	Requirements /Limits
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500-61,500 UNIT, 16,800-56,800-98,400 UNIT, 2,600-8,800- 15,200 UNIT, 21,000-54,700-83,900 UNIT, 37,000-97,300-149,900 UNIT, 4,200-14,200-24,600 UNIT	4	ST
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 24,000-86,250-90,750 UNIT	4	
<i>plenamine intravenous parenteral solution</i>	4	B/D PA
PROLASTIN-C INTRAVENOUS RECON SOLN	5	PA; LA; NEDS
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; NEDS
RAVICTI ORAL LIQUID	5	PA; LA; NEDS
REVCIVI INTRAMUSCULAR SOLUTION	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
<i>sapropterin oral powder in packet</i>	5	NEDS
<i>sapropterin oral tablet,soluble</i>	5	NEDS
<i>sodium benzoate-sodium phenylacet intravenous solution</i>	4	
<i>sodium phenylbutyrate oral powder</i>	5	NEDS
<i>sodium phenylbutyrate oral tablet</i>	5	NEDS
SUCRAID ORAL SOLUTION	5	NEDS
TEGSEDI SUBCUTANEOUS SYRINGE	5	PA; NEDS
VYNDAMAX ORAL CAPSULE	5	PA; NEDS
VYNDAQEL ORAL CAPSULE	5	PA; NEDS
ZEMAIRA INTRAVENOUS RECON SOLN	5	PA; LA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000-84,000 UNIT, 3,000-10,000 -14,000-UNIT, 5,000-17,000- 24,000 UNIT	4	ST

ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000-105,000 UNIT, 40,000-126,000-168,000 UNIT	5	ST; NEDS
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ZOKINVY ORAL CAPSULE	5	PA; LA; NEDS
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GENITOURINARY AGENTS

ANTISPASMODICS, URINARY

<i>darifenacin oral tablet extended release 24 hr</i>	2	QL (90 per 90 days)
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<i>flavoxate oral tablet</i>	2	
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MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	3	QL (90 per 90 days)
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<i>oxybutynin chloride oral syrup</i>	2	
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Drug Name	Drug Tier	Requirements /Limits
<i>oxybutynin chloride oral tablet</i>	2	
<i>oxybutynin chloride oral tablet extended release 24hr</i>	2	QL (180 per 90 days)
<i>solifenacin oral tablet</i>	3	
<i>tolterodine oral capsule,extended release 24hr</i>	2	QL (90 per 90 days)
<i>tolterodine oral tablet</i>	2	

TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR	3	
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<i>tropium oral capsule,extended release 24hr</i>	2	QL (90 per 90 days)
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<i>tropium oral tablet</i>	2	
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BENIGN PROSTATIC HYPERTROPHY AGENTS

<i>alfuzosin oral tablet extended release 24 hr</i>	2	QL (90 per 90 days)
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<i>dutasteride oral capsule</i>	2	QL (90 per 90 days)
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<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr</i>	2	QL (90 per 90 days)
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<i>finasteride oral tablet 5 mg</i>	2	
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RAPAFLO ORAL CAPSULE 4 MG	4	QL (180 per 90 days)
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Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

Brand-name drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
RAPAFLO ORAL CAPSULE 8 MG	4	QL (90 per 90 days)
<i>silodosin oral capsule 4 mg</i>	4	QL (180 per 90 days)
<i>silodosin oral capsule 8 mg</i>	4	QL (90 per 90 days)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	3	PA; QL (90 per 90 days)
<i>tamsulosin oral capsule</i>	2	QL (180 per 90 days)

GENITOURINARY AGENTS, OTHER

<i>bethanechol chloride oral tablet</i>	2	
CUPRIMINE ORAL CAPSULE	3	
DEPEN TITRATABS ORAL TABLET	4	
ELMIRON ORAL CAPSULE	3	
LITHOSTAT ORAL TABLET	4	
<i>penicillamine oral capsule</i>	3	
<i>penicillamine oral tablet</i>	4	
RIMSO-50 INTRAVESICAL SOLUTION	4	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)

Drug Name	Drug Tier	Requirements /Limits
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ALA-SCALP TOPICAL LOTION	4	
ANALPRAM-HC SINGLES RECTAL CREAM	4	EX
<i>anucort-hc rectal suppository</i>	2	EX
ANUSOL-HC RECTAL SUPPOSITORY	4	EX
<i>betamethasone dipropionate topical ointment</i>	2	
<i>betamethasone, augmented topical cream</i>	2	
<i>decadron oral tablet 0.5 mg</i>	1	
<i>dexamethasone intensol oral drops</i>	2	
<i>dexamethasone oral elixir</i>	1	
<i>dexamethasone oral solution</i>	1	
<i>dexamethasone oral tablet</i>	1	
<i>dexamethasone oral tablets, dose pack 1.5 mg (21 tabs)</i>	2	
<i>dexamethasone sodium phos (pf) injection solution</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>fludrocortisone oral tablet</i>	2	
HEMADY ORAL TABLET	3	PA
<i>hidex oral tablets,dose pack</i>	2	
<i>hydrocortisone acetate rectal suppository</i>	2	EX
<i>hydrocortisone butyr-emollient topical cream</i>	2	
<i>hydrocortisone-pramoxine rectal cream 2.5-1 % (4g)</i>	2	EX
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	2	EX
MEDROL ORAL TABLET 2 MG	4	
<i>methylprednisolone oral tablet</i>	1	
<i>methylprednisolone oral tablets,dose pack</i>	1	
<i>millipred oral tablet</i>	2	
PRAMOSONE TOPICAL CREAM 2.5-1 %	4	EX
<i>prednisolone oral solution</i>	2	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 15 mg/5 ml (5 ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	2	
<i>prednisolone sodium phosphate oral tablet,disintegrating 15 mg, 30 mg</i>	2	
<i>prednisone intensol oral concentrate</i>	2	
<i>prednisone oral solution</i>	2	
<i>prednisone oral tablet</i>	2	
<i>prednisone oral tablets,dose pack</i>	2	
PROCORT RECTAL CREAM	4	EX
PROCTOCORT RECTAL SUPPOSITORY	4	EX
RAYOS ORAL TABLET,DELAYE D RELEASE (DR/EC)	4	B/D PA
SCALACORT DK TOPICAL COMBO PACK	4	EX
TAPERDEX ORAL TABLETS,DOSE PACK	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
DDAVP INJECTION SOLUTION	4	HRM
<i>desmopressin injection solution</i>	2	HRM
<i>desmopressin nasal spray with pump</i>	4	HRM
<i>desmopressin nasal spray, non-aerosol</i>	4	HRM
<i>desmopressin oral tablet</i>	2	HRM
EGRIFTA SV SUBCUTANEOUS RECON SOLN	5	NEDS
FOLLISTIM AQ SUBCUTANEOUS CARTRIDGE	4	EX
GONAL-F RFF REDI-JECT SUBCUTANEOUS PEN INJECTOR	4	EX
GONAL-F RFF SUBCUTANEOUS RECON SOLN	4	EX
GONAL-F SUBCUTANEOUS RECON SOLN	4	EX

Drug Name	Drug Tier	Requirements /Limits
HUMATROPE INJECTION CARTRIDGE	5	PA; HRM; NEDS
HUMATROPE INJECTION RECON SOLN	5	PA; HRM; NEDS
INCRELEX SUBCUTANEOUS SOLUTION	5	PA; LA; NEDS
NORDITROPIN FLEXPEN SUBCUTANEOUS PEN INJECTOR	5	PA; HRM; NEDS
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR	5	PA; LA; HRM; NEDS
OMNITROPE SUBCUTANEOUS CARTRIDGE	4	PA; HRM
OMNITROPE SUBCUTANEOUS RECON SOLN	5	PA; HRM; NEDS
OVIDREL SUBCUTANEOUS SYRINGE	4	EX
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	5	PA; HRM; NEDS
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	5	PA; HRM; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

Brand-name drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS}		
CAVERJECT INTRACAVERNOSAL RECON SOLN	3	EX; QL (18 per 90 days)
EDEX INTRACAVERNOSAL KIT	4	EX; QL (18 per 90 days)
MUSE INTRA-URETHRAL SUPPOSITORY 1,000 MCG, 250 MCG, 500 MCG	3	EX; QL (18 per 90 days)
PROSTIN VR PEDIATRIC INJECTION SOLUTION	4	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
<i>oxandrolone oral tablet</i>	2	PA
ANDROGENS		

Drug Name	Drug Tier	Requirements /Limits
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; HRM; QL (450 per 90 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	3	PA; HRM; QL (900 per 90 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM)	3	PA; HRM; QL (225 per 90 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (40.5 MG/2.5 GRAM)	3	PA; HRM; QL (450 per 90 days)
AVEED INTRAMUSCULAR SOLUTION	4	PA; HRM
<i>danazol oral capsule</i>	2	
FORTESTA TRANSDERMAL GEL IN METERED-DOSE PUMP	4	HRM
METHITEST ORAL TABLET	4	HRM
<i>methyltestosterone oral capsule</i>	2	HRM
TESTOPEL IMPLANT PELLETT	4	HRM

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	3	HRM
<i>testosterone enanthate intramuscular oil</i>	3	HRM
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	4	HRM
TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP 12.5 MG/ 1.25 GRAM (1 %)	4	HRM
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	3	PA; HRM; QL (450 per 90 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i>	2	PA; HRM; QL (900 per 90 days)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	3	PA; HRM; QL (225 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	3	PA; HRM; QL (450 per 90 days)
<i>testosterone transdermal solution in metered pump w/app</i>	4	PA; HRM
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	4	HRM
ESTROGENS		
<i>covaryx h.s. oral tablet</i>	2	EX
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML	4	
DIVIGEL TRANSDERMAL GEL IN PACKET	4	
<i>eemt hs oral tablet</i>	2	EX
<i>eemt oral tablet</i>	2	EX
ENDOMETRIN VAGINAL INSERT	4	EX
<i>estradiol oral tablet</i>	2	
<i>estradiol transdermal patch semiweekly</i>	2	QL (24 per 84 days)
<i>estradiol transdermal patch weekly</i>	2	QL (12 per 84 days)
<i>estradiol vaginal cream</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>estradiol vaginal tablet</i>	2	
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	4	
ESTRING VAGINAL RING	3	QL (1 per 90 days)
<i>estrogens-methyltestosterone oral tablet</i>	2	EX
ESTRONE (BULK) CRYSTALS	4	EX
EVAMIST TRANSDERMAL SPRAY, NON-AEROSOL	4	
FEMRING VAGINAL RING	3	QL (1 per 90 days)
IMVEXXY MAINTENANCE PACK VAGINAL INSERT	3	
IMVEXXY STARTER PACK VAGINAL INSERT, DOSE PACK	3	
MENEST ORAL TABLET	4	HRM
MENOSTAR TRANSDERMAL PATCH WEEKLY	4	QL (12 per 84 days)
MIRENA INTRAUTERINE DEVICE	4	

Drug Name	Drug Tier	Requirements /Limits
PREMARIN ORAL TABLET	4	HRM
PREMARIN VAGINAL CREAM	3	HRM
<i>yuvafem vaginal tablet</i>	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS), OTHER		
<i>amabelz oral tablet</i>	2	
<i>amethia oral tablets, dose pack, 3 month</i>	4	QL (91 per 91 days)
<i>apri oral tablet</i>	2	
<i>ashlyna oral tablets, dose pack, 3 month</i>	4	QL (91 per 91 days)
<i>aurovela 24 fe oral tablet</i>	2	
<i>aurovela fe 1.5/30 (28) oral tablet</i>	2	
<i>aurovela fe 1-20 (28) oral tablet</i>	2	
<i>azurette (28) oral tablet</i>	2	
<i>blisovi fe 1.5/30 (28) oral tablet</i>	2	
<i>blisovi fe 1/20 (28) oral tablet</i>	2	
<i>camrese lo oral tablets, dose pack, 3 month</i>	2	QL (91 per 91 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>camrese oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<i>caziant (28) oral tablet</i>	2	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY	4	QL (12 per 84 days)
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY	4	QL (24 per 84 days)
<i>cryselle (28) oral tablet</i>	2	
<i>cyred eq oral tablet</i>	2	
<i>cyred oral tablet</i>	2	
<i>daysee oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<i>desog-e.estradiol/e.estradiol oral tablet</i>	2	
<i>desogestrel-ethinyl estradiol oral tablet</i>	2	
<i>drospirenone-e.estradiol-lm.fa oral tablet</i>	2	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.03 mg</i>	2	
<i>elinest oral tablet</i>	2	
<i>eluryng vaginal ring</i>	4	
<i>emoquette oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>enskyce oral tablet</i>	2	
<i>estarylla oral tablet</i>	2	
<i>estradiol-norethindrone acet oral tablet</i>	2	
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	2	
<i>etonogestrel-ethinyl estradiol vaginal ring</i>	4	
<i>fayosim oral tablets,dose pack,3 month</i>	4	
<i>femynor oral tablet</i>	2	
<i>fyavolv oral tablet</i>	2	
<i>hailey fe 1.5/30 (28) oral tablet</i>	2	
<i>isibloom oral tablet</i>	2	
<i>jaimiess oral tablets,dose pack,3 month</i>	4	QL (91 per 91 days)
<i>jasmiel (28) oral tablet</i>	2	
<i>jinteli oral tablet</i>	2	
<i>juleber oral tablet</i>	2	
<i>junel 1/20 (21) oral tablet</i>	2	
<i>junel fe 1.5/30 (28) oral tablet</i>	2	
<i>junel fe 1/20 (28) oral tablet</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>kariva (28) oral tablet</i>	2	
<i>kelnor 1-50 (28) oral tablet</i>	2	
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)</i>	2	QL (91 per 91 days)
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)</i>	4	QL (91 per 91 days)
<i>larin 1/20 (21) oral tablet</i>	2	
<i>larin fe 1.5/30 (28) oral tablet</i>	2	
<i>larin fe 1/20 (28) oral tablet</i>	2	
LO LOESTRIN FE ORAL TABLET	4	
<i>lojaimiess oral tablets,dose pack,3 month</i>	2	QL (91 per 91 days)
<i>low-ogestrel (28) oral tablet</i>	2	
<i>microgestin 1/20 (21) oral tablet</i>	2	
<i>microgestin fe 1.5/30 (28) oral tablet</i>	2	
<i>microgestin fe 1/20 (28) oral tablet</i>	2	
<i>mili oral tablet</i>	2	
<i>mimvey oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>mono-lynyah oral tablet</i>	2	
NATAZIA ORAL TABLET	4	
NEXPLANON SUBDERMAL IMPLANT	4	
<i>norethindrone ac-eth estradiol oral tablet</i>	2	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2	
<i>norgestimate-ethinyl estradiol oral tablet</i>	2	
NUVARING VAGINAL RING	4	
<i>nymyo oral tablet</i>	2	
<i>ocella oral tablet</i>	2	
<i>pimtrea (28) oral tablet</i>	2	
PREFEST ORAL TABLET	4	
PREMPHASE ORAL TABLET	3	
PREMPRO ORAL TABLET	4	
<i>previfem oral tablet</i>	2	
<i>reclipsen (28) oral tablet</i>	2	
<i>rivelsa oral tablets,dose pack,3 month</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

Brand-name drugs are CAPITALIZED. **Generic** drugs are *lower-case italics*.

This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
SAFYRAL ORAL TABLET	4	
<i>simliya (28) oral tablet</i>	2	
<i>sprintec (28) oral tablet</i>	2	
<i>syeda oral tablet</i>	2	
<i>tarina 24 fe oral tablet</i>	2	
<i>tarina fe 1/20 (28) oral tablet</i>	2	
<i>tarina fe 1-20 eq (28) oral tablet</i>	2	
<i>tri femynor oral tablet</i>	2	
<i>tri-estarylla oral tablet</i>	2	
<i>tri-linyah oral tablet</i>	2	
<i>tri-lo-estarylla oral tablet</i>	2	
<i>tri-lo-marzia oral tablet</i>	2	
<i>tri-lo-sprintec oral tablet</i>	2	
<i>tri-mili oral tablet</i>	2	
<i>tri-nymyo oral tablet</i>	2	
<i>tri-previfem (28) oral tablet</i>	2	
<i>tri-sprintec (28) oral tablet</i>	2	
<i>tri-vylibra lo oral tablet</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>tri-vylibra oral tablet</i>	2	
<i>tydemy oral tablet</i>	2	
<i>velivet triphasic regimen (28) oral tablet</i>	2	
<i>vestura (28) oral tablet</i>	2	
<i>viorele (28) oral tablet</i>	2	
<i>volnea (28) oral tablet</i>	2	
<i>vylibra oral tablet</i>	2	
<i>xulane transdermal patch weekly</i>	2	
<i>zafemy transdermal patch weekly</i>	2	
<i>zarah oral tablet</i>	2	
PROGESTINS		
<i>camila oral tablet</i>	2	
CRINONE VAGINAL GEL	4	
<i>deblitane oral tablet</i>	2	
<i>errin oral tablet</i>	2	
<i>heather oral tablet</i>	2	
<i>incassia oral tablet</i>	2	
<i>jencycla oral tablet</i>	2	
<i>lyleq oral tablet</i>	2	
<i>lyza oral tablet</i>	2	
<i>medroxyprogesterone intramuscular suspension</i>	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
<i>medroxyprogesterone intramuscular syringe</i>	3	
<i>medroxyprogesterone oral tablet</i>	2	
<i>megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	4	PA; HRM
<i>megestrol oral tablet</i>	2	PA; HRM
<i>nora-be oral tablet</i>	2	
<i>norethindrone (contraceptive) oral tablet</i>	2	
<i>norethindrone acetate oral tablet</i>	2	
<i>norlyda oral tablet</i>	2	
<i>progesterone micronized oral capsule</i>	2	
<i>sharobel oral tablet</i>	2	
<i>tulana oral tablet</i>	2	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
<i>clomiphene citrate oral tablet</i>	2	PA
DUAVEE ORAL TABLET	3	
<i>raloxifene oral tablet</i>	1	QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
ARMOUR THYROID ORAL TABLET	4	HRM
<i>euthyrox oral tablet</i>	1	
<i>levo-t oral tablet</i>	1	
<i>levothyroxine intravenous recon soln 200 mcg, 500 mcg</i>	1	
<i>levothyroxine oral tablet</i>	1	
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	
<i>liothyronine oral tablet</i>	2	
<i>np thyroid oral tablet</i>	2	HRM
SYNTHROID ORAL TABLET	3	
<i>unithroid oral tablet</i>	1	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN ORAL TABLET	3	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
<i>cabergoline oral tablet</i>	2	
CETROTIDE SUBCUTANEOUS KIT	4	EX
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	NEDS
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	
<i>leuprolide subcutaneous kit</i>	2	
LUPANETA PACK (1 MONTH) KIT. SYRINGE AND TABLET	4	
LUPANETA PACK (3 MONTH) KIT. SYRINGE AND TABLET	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT	5	NEDS
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT	5	NEDS
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT	5	NEDS
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT	5	NEDS
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	5	NEDS
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	5	NEDS
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	5	NEDS
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	
ORGOVYX ORAL TABLET	5	PA; QL (30 per 28 days); NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
SIGNIFOR SUBCUTANEOUS SOLUTION	5	LA; NEDS
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE	5	NEDS
SOMAVERT SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
SYNAREL NASAL SPRAY, NON-AEROSOL	3	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	5	NEDS

HORMONAL AGENTS, SUPPRESSANT (THYROID)

ANTITHYROID AGENTS

<i>methimazole oral tablet 10 mg, 5 mg</i>	2	
<i>propylthiouracil oral tablet</i>	2	

IMMUNOLOGICAL AGENTS

ANGIOEDEMA AGENTS

BERINERT INTRAVENOUS KIT	5	PA; LA; NEDS
CINRYZE INTRAVENOUS RECON SOLN	5	NEDS

Drug Name	Drug Tier	Requirements /Limits
FIRAZYR SUBCUTANEOUS SYRINGE	5	PA; LA; NEDS
HAEGARDA SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
<i>icatibant subcutaneous syringe</i>	5	PA; NEDS

IMMUNOGLOBULINS

BIVIGAM INTRAVENOUS SOLUTION	5	B/D PA; NEDS
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	5	B/D PA; NEDS
GAMMAGARD LIQUID INJECTION SOLUTION	5	B/D PA; NEDS
GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN	5	B/D PA; NEDS
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 20 GRAM/200 ML (10 %)	5	B/D PA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
GAMMAPLEX (WITH SORBITOL) INTRAVENOUS SOLUTION	5	B/D PA; NEDS
GAMMAPLEX INTRAVENOUS SOLUTION	5	B/D PA; NEDS
GAMUNEX-C INJECTION SOLUTION	5	B/D PA; NEDS
HYPERHEP B INTRAMUSCULAR SOLUTION	4	
HYPERHEP B INTRAMUSCULAR SYRINGE	4	
HYPERHEP B NEONATAL INTRAMUSCULAR SYRINGE	4	
HYQVIA SUBCUTANEOUS SOLUTION 2.5 GRAM /25 ML (10 %)	5	B/D PA; NEDS
NABI-HB INTRAMUSCULAR SOLUTION	4	
OCTAGAM INTRAVENOUS SOLUTION	5	B/D PA; NEDS
PRIVIGEN INTRAVENOUS SOLUTION	5	B/D PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
VARIZIG INTRAMUSCULAR SOLUTION	3	
IMMUNOLOGICAL AGENTS, OTHER		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
ACTEMRA SUBCUTANEOUS SYRINGE	5	PA; NEDS
ARCALYST SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR	5	LA; NEDS
BENLYSTA SUBCUTANEOUS SYRINGE	5	LA; NEDS
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE	5	PA; LA; NEDS
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR	5	PA; LA; NEDS
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; LA; NEDS
ENSPRYNG SUBCUTANEOUS SYRINGE	5	PA; QL (3 per 28 days); NEDS
GAMIFANT INTRAVENOUS SOLUTION	5	PA; NEDS
ILARIS (PF) SUBCUTANEOUS SOLUTION	5	PA; NEDS
KINERET SUBCUTANEOUS SYRINGE	5	PA; QL (18.8 per 28 days); NEDS
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR	5	PA; NEDS
ORENCIA SUBCUTANEOUS SYRINGE	5	PA; NEDS
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; NEDS
RIDAURA ORAL CAPSULE	3	
STELARA SUBCUTANEOUS SOLUTION	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
STELARA SUBCUTANEOUS SYRINGE	5	PA; NEDS
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML	5	NEDS
XELJANZ ORAL SOLUTION	5	PA; QL (720 per 30 days); NEDS
XELJANZ ORAL TABLET 10 MG	5	PA; NEDS
XELJANZ ORAL TABLET 5 MG	5	PA; QL (60 per 30 days); NEDS
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR	5	PA; QL (30 per 30 days); NEDS
XOLAIR SUBCUTANEOUS RECON SOLN	5	PA; LA; NEDS
XOLAIR SUBCUTANEOUS SYRINGE	5	PA; NEDS
IMMUNOSTIMULANTS		
ACTIMMUNE SUBCUTANEOUS SOLUTION	5	LA; NEDS
INTRON A INJECTION RECON SOLN	5	LA; NEDS

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML	5	LA; NEDS
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	3	LA
PEGASYS SUBCUTANEOUS SYRINGE	5	QL (4 per 28 days); NEDS
IMMUNOSUPPRESSANTS		
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG	4	B/D PA
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG	5	B/D PA; NEDS
<i>azathioprine oral tablet</i>	2	B/D PA
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT	5	PA; NEDS
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
CIMZIA SUBCUTANEOUS SYRINGE KIT	5	PA; NEDS
<i>cyclosporine modified oral capsule</i>	2	B/D PA
<i>cyclosporine modified oral solution</i>	2	B/D PA
<i>cyclosporine oral capsule</i>	2	B/D PA
ENBREL MINI SUBCUTANEOUS CARTRIDGE	5	PA; QL (8 per 28 days); NEDS
ENBREL SUBCUTANEOUS RECON SOLN	5	PA; QL (16 per 28 days); NEDS
ENBREL SUBCUTANEOUS SOLUTION	5	PA; QL (16 per 28 days); NEDS
ENBREL SUBCUTANEOUS SYRINGE	5	PA; QL (8 per 28 days); NEDS
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR	5	PA; QL (8 per 28 days); NEDS
ENVARUS XR ORAL TABLET EXTENDED RELEASE 24 HR	4	B/D PA
<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	4	B/D PA

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>everolimus</i> (immunosuppressive) oral tablet 0.5 mg, 0.75 mg	5	B/D PA; NEDS
<i>gengraf oral capsule</i>	2	B/D PA
<i>gengraf oral solution</i>	2	B/D PA
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS INJECTOR KIT	5	PA; QL (6 per 28 days); NEDS
HUMIRA PEN PSOR-UEITS- ADOL HS SUBCUTANEOUS INJECTOR KIT	5	PA; QL (6 per 28 days); NEDS
HUMIRA PEN SUBCUTANEOUS INJECTOR KIT	5	PA; QL (6 per 28 days); NEDS
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (6 per 28 days); NEDS
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	5	PA; LA; QL (4 per 28 days); NEDS
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; QL (2 per 28 days); NEDS

Drug Name	Drug Tier	Requirements /Limits
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS INJECTOR KIT	5	PA; QL (4 per 28 days); NEDS
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT	5	PA; QL (4 per 28 days); NEDS
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS INJECTOR KIT	5	PA; QL (2 per 28 days); NEDS
HUMIRA(CF) PEN SUBCUTANEOUS INJECTOR KIT 40 MG/0.4 ML	5	PA; QL (6 per 28 days); NEDS
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; QL (4 per 28 days); NEDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5	PA; QL (2 per 28 days); NEDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (6 per 28 days); NEDS
<i>leflunomide oral tablet</i>	2	QL (90 per 90 days)
<i>methotrexate sodium (pf) injection solution</i>	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>methotrexate sodium injection solution</i>	3	
<i>methotrexate sodium oral tablet</i>	1	B/D PA
<i>mycophenolate mofetil oral capsule</i>	2	B/D PA
<i>mycophenolate mofetil oral suspension for reconstitution</i>	5	B/D PA; NEDS
<i>mycophenolate mofetil oral tablet</i>	2	B/D PA
<i>mycophenolate sodium oral tablet, delayed release (dr/ec)</i>	4	B/D PA
OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR	4	
PROGRAF ORAL GRANULES IN PACKET	3	B/D PA
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR	4	
SANDIMMUNE ORAL SOLUTION	4	B/D PA
SIMPONI SUBCUTANEOUS PEN INJECTOR	5	PA; NEDS
SIMPONI SUBCUTANEOUS SYRINGE	5	PA; NEDS

Drug Name	Drug Tier	Requirements /Limits
SIMULECT INTRAVENOUS RECON SOLN 10 MG	5	B/D PA; NEDS
<i>sirolimus oral solution</i>	4	B/D PA
<i>sirolimus oral tablet</i>	4	B/D PA
<i>tacrolimus oral capsule</i>	2	B/D PA
TREXALL ORAL TABLET	3	B/D PA
XATMEP ORAL SOLUTION	4	B/D PA
ZORTRESS ORAL TABLET 0.25 MG	4	B/D PA
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG, 1 MG	5	B/D PA; NEDS
VACCINES		
ACTHIB (PF) INTRAMUSCULAR RECON SOLN	3	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION	3	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
BEXSERO INTRAMUSCULAR SYRINGE	3	
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION	3	
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	3	
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION	3	
ENGRIX-B (PF) INTRAMUSCULAR SUSPENSION	3	B/D PA
ENGRIX-B (PF) INTRAMUSCULAR SYRINGE	3	B/D PA
ENGRIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	3	B/D PA
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION	3	
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE	3	

Drug Name	Drug Tier	Requirements /Limits
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE	3	
HIBERIX (PF) INTRAMUSCULAR RECON SOLN	3	
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN	3	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	3	
IPOLE INJECTION SUSPENSION	3	
IXIARO (PF) INTRAMUSCULAR SYRINGE	3	
KINRIX (PF) INTRAMUSCULAR SUSPENSION	3	
KINRIX (PF) INTRAMUSCULAR SYRINGE	3	
MENACTRA (PF) INTRAMUSCULAR SOLUTION	3	
MENQUADFI (PF) INTRAMUSCULAR SOLUTION	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	3	
M-M-R II (PF) SUBCUTANEOUS RECON SOLN	3	
PEDIARIX (PF) INTRAMUSCULAR SYRINGE	3	
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION	3	
PENTACEL (PF) INTRAMUSCULAR KIT	3	
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	3	
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION	3	B/D PA

Drug Name	Drug Tier	Requirements /Limits
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	3	B/D PA
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION	3	
ROTATEQ VACCINE ORAL SOLUTION	3	
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	
STAMARIL (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
TDVAX INTRAMUSCULAR SUSPENSION	3	
TENIVAC (PF) INTRAMUSCULAR SUSPENSION	3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	3	
TETANUS,DIPHTHERIA TOX PED(PF) INTRAMUSCULAR SUSPENSION	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION	3	
TRUMENBA INTRAMUSCULAR SYRINGE	3	
TWINRIX (PF) INTRAMUSCULAR SYRINGE	3	
TYPHIM VI INTRAMUSCULAR SOLUTION	3	
TYPHIM VI INTRAMUSCULAR SYRINGE	3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION	3	
VAQTA (PF) INTRAMUSCULAR SYRINGE	3	
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	

Drug Name	Drug Tier	Requirements /Limits
ZOSTAVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	3	
INFERTILITY AGENTS		
INFERTILITY AGENTS		
MENOPUR SUBCUTANEOUS RECON SOLN	4	EX
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
<i>balsalazide oral capsule</i>	2	
<i>mesalamine oral capsule (with del rel tablets)</i>	3	
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	4	
<i>mesalamine oral tablet, delayed release (dr/ec) 800 mg</i>	3	
<i>mesalamine rectal enema</i>	4	QL (5400 per 90 days)
<i>mesalamine rectal suppository</i>	3	
<i>mesalamine with cleansing wipe rectal enema kit</i>	4	QL (5400 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
PENTASA ORAL CAPSULE, EXTENDED RELEASE	4	
<i>sulfasalazine oral tablet</i>	1	
<i>sulfasalazine oral tablet, delayed release (dr/ec)</i>	2	
GLUCOCORTICOIDS		
ANALPRAM-HC RECTAL CREAM 2.5-1 %	4	EX
<i>budesonide oral capsule, delayed, extended release</i>	3	
<i>budesonide oral tablet, delayed and extended release</i>	5	NEDS
<i>hydrocortisone oral tablet</i>	1	
<i>hydrocortisone rectal enema</i>	2	
<i>hydrocortisone-pramoxine rectal cream 2.5-1 %</i>	2	EX
METABOLIC BONE DISEASE AGENTS		
METABOLIC BONE DISEASE AGENTS		
<i>alendronate oral solution</i>	2	
<i>alendronate oral tablet 10 mg, 5 mg</i>	1	QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	QL (12 per 84 days)
BINOSTO ORAL TABLET, EFFERVESCENT	4	QL (12 per 84 days)
<i>calcitonin (salmon) nasal spray, non-aerosol</i>	2	
<i>calcitriol oral capsule</i>	2	
<i>calcitriol oral solution</i>	2	
<i>cinacalcet oral tablet 30 mg</i>	3	
<i>cinacalcet oral tablet 60 mg, 90 mg</i>	5	NEDS
<i>doxercalciferol intravenous solution</i>	4	
<i>doxercalciferol oral capsule 2.5 mcg</i>	2	
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (620MCG/2.48ML)	5	PA; QL (3 per 28 days); NEDS
FOSAMAX PLUS D ORAL TABLET	4	QL (12 per 84 days)
<i>ibandronate oral tablet</i>	2	QL (3 per 84 days)
NATPARA SUBCUTANEOUS CARTRIDGE	5	PA; LA; NEDS
<i>paricalcitol oral capsule</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
PROLIA SUBCUTANEOUS SYRINGE	4	PA
<i>risedronate oral tablet 150 mg</i>	2	QL (3 per 84 days)
<i>risedronate oral tablet 30 mg, 5 mg</i>	2	QL (90 per 90 days)
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	2	QL (12 per 84 days)
<i>risedronate oral tablet, delayed release (dr/ec)</i>	2	QL (12 per 84 days)
TYMLOS SUBCUTANEOUS PEN INJECTOR	3	
XGEVA SUBCUTANEOUS SOLUTION	5	PA; NEDS

MISCELLANEOUS THERAPEUTIC AGENTS

MISCELLANEOUS THERAPEUTIC AGENTS

<i>anaspaz oral tablet, disintegrating</i>	2	EX; HRM
ANTICOAG CITRATE PHOS DEXTROSE SOLUTION	4	EX

Drug Name	Drug Tier	Requirements /Limits
ARIDOL BRONCHIAL CHALLENGE INHALATION CAPSULE, W/INHALATION DEVICE	4	EX
CALCIUM DISODIUM VERSENATE INJECTION SOLUTION	4	
<i>cardioplegic soln perfusion solution</i>	4	
<i>codeine-guaifenesin oral liquid</i>	2	EX
<i>cryoserv solution</i>	2	EX
CYANOKIT INTRAVENOUS RECON SOLN	4	EX
CYSTO-CONRAY II URETHRAL SOLUTION	4	EX
DESFERAL INJECTION RECON SOLN 500 MG	4	
<i>ed-spaz oral tablet, disintegrating</i>	2	EX; HRM
ENTERO VU ORAL LIQUID	4	EX
E-Z DISK ORAL TABLET	4	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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This drug list was last updated on 09/01/2021.

Drug Name	Drug Tier	Requirements /Limits
E-Z-HD BARIUM ORAL SUSPENSION FOR RECONSTITUTION	4	EX
E-Z-PAQUE ORAL SUSPENSION FOR RECONSTITUTION	4	EX
E-Z-PASTE ORAL CREAM	4	EX
<i>fem ph vaginal gel</i>	2	EX
<i>flumazenil intravenous solution</i>	4	
GASTROGRAFIN ORAL SOLUTION	4	EX
GASTROMARK ORAL SUSPENSION	4	EX
<i>guaiafenesin ac oral liquid</i>	2	EX
HISTAMINE PHOSPHATE (BULK) CRYSTALS	4	EX
HISTATROL INTRADERMAL SOLUTION	4	EX
HYDRAZINE SULFATE (BULK) CRYSTALS	4	EX
<i>hydrocodone-homatropine oral tablet</i>	2	EX; HRM
<i>hyphen oral tablet</i>	2	EX

Drug Name	Drug Tier	Requirements /Limits
<i>hyoscyamine sulfate oral drops</i>	2	EX; HRM
<i>hyoscyamine sulfate oral elixir</i>	2	EX; HRM
<i>hyoscyamine sulfate oral tablet</i>	2	EX; HRM
<i>hyoscyamine sulfate oral tablet, disintegrating</i>	2	EX; HRM
<i>hyoscyamine sulfate sublingual tablet</i>	2	EX; HRM
<i>hyosyne oral drops</i>	2	EX; HRM
<i>hyosyne oral elixir</i>	2	EX; HRM
LEVBIID ORAL TABLET EXTENDED RELEASE 12 HR	4	EX; HRM
LEVSIN ORAL TABLET	4	EX; HRM
LEVSIN/SL SUBLINGUAL TABLET	4	EX; HRM
LIQUID E-Z PAQUE ORAL SUSPENSION	4	EX
LIQUID POLIBAR PLUS ORAL SUSPENSION	4	EX
<i>lugols oral solution</i>	2	EX
<i>mannitol 20 % intravenous parenteral solution</i>	4	
<i>mannitol 25 % intravenous solution</i>	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
<i>maxi-tuss ac oral liquid</i>	2	EX
<i>md-gastroview oral solution</i>	2	EX
<i>methen-sod phos-meth blue-hyos oral tablet</i>	2	EX
<i>methergine oral tablet</i>	2	
<i>methylergonovine oral tablet</i>	4	
METOPIRONE ORAL CAPSULE	4	EX
MURI-LUBE OIL	4	EX
NEULUMEX ORAL SUSPENSION	4	EX
NULEV ORAL TABLET,DISINTEGRATING	4	EX; HRM
ORACIT ORAL SOLUTION	4	EX
<i>oscimin oral tablet</i>	2	EX; HRM
<i>oscimin sl sublingual tablet</i>	2	EX; HRM
<i>oscimin sr oral tablet extended release 12 hr</i>	2	EX; HRM
OSMITROL 10 % INTRAVENOUS PARENTERAL SOLUTION	4	
<i>osmitrol 15 % intravenous parenteral solution</i>	4	

Drug Name	Drug Tier	Requirements /Limits
<i>osmitrol 20 % intravenous parenteral solution</i>	4	
OSMITROL 5 % INTRAVENOUS PARENTERAL SOLUTION	4	
<i>phendimetrazine tartrate oral tablet</i>	2	EX
POLIBAR ACB RECTAL ENEMA	4	EX
PROTOPAM CHLORIDE INJECTION RECON SOLN	4	
PROVOCHOLINE INHALATION RECON SOLN	4	EX
READI-CAT 2 ORAL SUSPENSION 2.1 % (W/V), 2.0 % (W/W)	4	EX
RELAGARD VAGINAL GEL	4	EX
SITZMARKS ORAL CAPSULE	4	EX
SORBITOL IRRIGATION SOLUTION 3 %	4	
SSKI ORAL SOLUTION	4	EX
<i>strong iodine oral solution</i>	2	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy

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Drug Name	Drug Tier	Requirements /Limits
SYMAX DUOTAB ORAL TABLET,EXT RELEASE MULTIPHASE	4	EX; HRM
<i>symax fastabs oral tablet,disintegrating</i>	2	EX; HRM
<i>symax-sl sublingual tablet</i>	2	EX; HRM
<i>symax-sr oral tablet extended release 12 hr</i>	2	EX; HRM
URELLE ORAL TABLET	4	EX
<i>uretron d-s oral tablet</i>	2	EX
URIBEL ORAL CAPSULE	4	EX
<i>urogesic-blue oral tablet</i>	2	EX
UROQID-ACID NO.2 ORAL TABLET	4	EX
<i>uryl oral tablet</i>	2	EX
<i>ustell oral capsule</i>	2	EX
<i>virtussin ac oral liquid</i>	2	EX
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
<i>ak-poly-bac ophthalmic (eye) ointment</i>	2	

Drug Name	Drug Tier	Requirements /Limits
AKTEN (PF) OPHTHALMIC (EYE) GEL	4	EX
<i>altacaine ophthalmic (eye) drops</i>	2	EX
<i>atropine ophthalmic (eye) drops</i>	2	
<i>atropine ophthalmic (eye) ointment</i>	2	EX
<i>bacitracin-polymyxin b ophthalmic (eye) ointment</i>	2	
<i>balanced salt intraocular solution</i>	2	
BETADINE OPHTHALMIC PREP OPHTHALMIC (EYE) SOLUTION	4	EX
BLEPHAMIDE S.O.P. OPHTHALMIC (EYE) OINTMENT	3	
<i>bss intraocular solution</i>	2	
BSS PLUS INTRAOCULAR SOLUTION	4	
COMBIGAN OPHTHALMIC (EYE) DROPS	3	
CYCLOMYDRIL OPHTHALMIC (EYE) DROPS	4	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	4	
<i>dorzolamide-timolol ophthalmic (eye) drops</i>	1	
<i>fluorescein-proparacaine ophthalmic (eye) drops</i>	2	EX
FUL-GLO OPHTHALMIC (EYE) STRIP 0.6 MG	4	EX
<i>homatropaire ophthalmic (eye) drops</i>	2	EX
LACRISERT OPHTHALMIC (EYE) INSERT	3	
<i>neomycin-bacitracin-poly-hc ophthalmic (eye) ointment</i>	2	
<i>neomycin-bacitracin-polymyxin ophthalmic (eye) ointment</i>	2	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension</i>	2	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>neomycin-polymyxin-gramicidin ophthalmic (eye) drops</i>	2	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension</i>	2	
OXERVATE OPHTHALMIC (EYE) DROPS	5	PA; NEDS
PAREMYD OPHTHALMIC (EYE) DROPS	4	EX
<i>phenylephrine hcl ophthalmic (eye) drops</i>	2	EX
<i>polycin ophthalmic (eye) ointment</i>	2	
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops</i>	2	
PRED-G OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
PRED-G S.O.P. OPHTHALMIC (EYE) OINTMENT	4	
<i>proparacaine ophthalmic (eye) drops</i>	2	EX

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
RESTASIS MULTIDOSE OPHTHALMIC (EYE) DROPS	3	QL (16.5 per 90 days)
RESTASIS OPHTHALMIC (EYE) DROPPERETTE	3	QL (180 per 90 days)
ROCKLATAN OPHTHALMIC (EYE) DROPS	3	
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
<i>sulfacetamide-prednisolone ophthalmic (eye) drops</i>	1	
<i>tetracaine hcl ophthalmic (eye) drops</i>	2	EX
TOBRADEX OPHTHALMIC (EYE) OINTMENT	3	
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension</i>	2	

Drug Name	Drug Tier	Requirements /Limits
OPHTHALMIC ANTI-ALLERGY AGENTS		
ALOCRILOPHTHALMIC (EYE) DROPS	4	
<i>azelastine ophthalmic (eye) drops</i>	2	
<i>cromolyn ophthalmic (eye) drops</i>	2	
<i>epinastine ophthalmic (eye) drops</i>	2	
<i>olopatadine ophthalmic (eye) drops</i>	2	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE OPHTHALMIC (EYE) DROPS	4	
<i>bacitracin ophthalmic (eye) ointment</i>	2	
<i>ciprofloxacin hcl ophthalmic (eye) drops</i>	2	
<i>erythromycin ophthalmic (eye) ointment</i>	2	
<i>gatifloxacin ophthalmic (eye) drops</i>	2	
<i>gentak ophthalmic (eye) ointment</i>	2	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
<i>gentamicin ophthalmic (eye) drops</i>	2	
<i>levofloxacin ophthalmic (eye) drops</i>	2	
<i>moxifloxacin ophthalmic (eye) drops</i>	2	
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>ofloxacin ophthalmic (eye) drops</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	2	
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	2	
<i>tobramycin ophthalmic (eye) drops</i>	1	
ZIRGAN OPHTHALMIC (EYE) GEL	3	
OPHTHALMIC ANTI-INFLAMMATORIES		
<i>dexamethasone sodium phosphate ophthalmic (eye) drops</i>	2	

Drug Name	Drug Tier	Requirements /Limits
DUREZOL OPHTHALMIC (EYE) DROPS	3	
<i>fluorometholone ophthalmic (eye) drops,suspension</i>	2	
<i>flurbiprofen sodium ophthalmic (eye) drops</i>	2	
FML FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
FML S.O.P. OPHTHALMIC (EYE) OINTMENT	4	
ILEVRO OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
<i>ketorolac ophthalmic (eye) drops</i>	2	HRM
<i>loteprednol etabonate ophthalmic (eye) drops,suspension</i>	4	
NEVANAC OPHTHALMIC (EYE) DROPS,SUSPENSION	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION	3	
<i>prednisolone acetate ophthalmic (eye) drops,suspension</i>	2	
<i>prednisolone sodium phosphate ophthalmic (eye) drops</i>	2	
PROLENSA OPHTHALMIC (EYE) DROPS	4	
OPHTHALMIC BETA- ADRENERGIC BLOCKING AGENTS		
<i>betaxolol ophthalmic (eye) drops</i>	1	
BETOPTIC S OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
<i>carteolol ophthalmic (eye) drops</i>	2	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>timolol maleate ophthalmic (eye) drops</i>	1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	1	

Drug Name	Drug Tier	Requirements /Limits
OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER		
<i>acetazolamide oral capsule, extended release</i>	2	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	3	
<i>apraclonidine ophthalmic (eye) drops</i>	2	
AZOPT OPHTHALMIC (EYE) DROPS,SUSPENSION	4	
<i>brimonidine ophthalmic (eye) drops</i>	2	
<i>brinzolamide ophthalmic (eye) drops,suspension</i>	4	
<i>dorzolamide ophthalmic (eye) drops</i>	2	
<i>methazolamide oral tablet</i>	4	
<i>miostat intraocular solution</i>	2	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	2	

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Drug Name	Drug Tier	Requirements /Limits
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
<i>bimatoprost ophthalmic (eye) drops</i>	4	
<i>latanoprost ophthalmic (eye) drops</i>	2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	3	
TRAVATAN Z OPHTHALMIC (EYE) DROPS	3	
<i>travoprost ophthalmic (eye) drops</i>	3	
ZIOPTAN (PF) OPHTHALMIC (EYE) DROPPERETTE	3	
OTIC AGENTS		
OTIC AGENTS		
CIPRO HC OTIC (EAR) DROPS,SUSPENSION	4	
CIPRODEX OTIC (EAR) DROPS,SUSPENSION	3	
<i>ciprofloxacin hcl otic (ear) dropperette</i>	2	

Drug Name	Drug Tier	Requirements /Limits
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension</i>	3	
<i>flac oil otic (ear) drops</i>	2	
<i>fluocinolone acetonide oil otic (ear) drops</i>	2	
<i>hydrocortisone-acetic acid otic (ear) drops</i>	2	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension</i>	2	
<i>neomycin-polymyxin-hc otic (ear) solution</i>	2	
<i>ofloxacin otic (ear) drops</i>	2	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-HISTAMINES		
<i>alavert d-12 allergy-sinus oral tablet extended release 12 hr</i>	No Copay	EX
<i>alavert oral tablet,disintegrating</i>	No Copay	EX
<i>all day allergy (cetirizine) oral capsule</i>	No Copay	EX

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Drug Name	Drug Tier	Requirements /Limits
<i>all day allergy (cetirizine) oral tablet</i>	No Copay	EX
<i>all day allergy-d oral tablet extended release 12 hr</i>	No Copay	EX
<i>allerclear d-12hr oral tablet extended release 12 hr</i>	No Copay	EX
<i>allerclear d-24hr oral tablet extended release 24 hr</i>	No Copay	EX
<i>allerclear oral tablet</i>	No Copay	EX
<i>aller-ease oral tablet</i>	No Copay	EX
<i>aller-fex oral tablet</i>	No Copay	EX
<i>allergy and congestion relief oral tablet extended release 12 hr</i>	No Copay	EX
<i>allergy and congestion relief oral tablet extended release 24 hr</i>	No Copay	EX
<i>allergy complete-d oral tablet extended release 12 hr</i>	No Copay	EX
<i>allergy relief (cetirizine) oral capsule</i>	No Copay	EX
<i>allergy relief (cetirizine) oral tablet</i>	No Copay	EX

Drug Name	Drug Tier	Requirements /Limits
<i>allergy relief (fexofenadine) oral tablet</i>	No Copay	EX
<i>allergy relief (loratadine) oral solution</i>	No Copay	EX
<i>allergy relief (loratadine) oral tablet</i>	No Copay	EX
<i>allergy relief (loratadine) oral tablet, disintegrating</i>	No Copay	EX
<i>allergy relief d12 oral tablet extended release 12 hr</i>	No Copay	EX
<i>allergy relief d-24hr oral tablet extended release 24 hr</i>	No Copay	EX
<i>allergy relief, nasal decongest oral tablet extended release 24 hr</i>	No Copay	EX
<i>allergy relief-d (cetirizine) oral tablet extended release 12 hr</i>	No Copay	EX
<i>allergy relief-d (loratadine) oral tablet extended release 12 hr</i>	No Copay	EX
<i>allergy relief-d (fexofenadine) oral tablet extended release 12 hr</i>	No Copay	EX

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Drug Name	Drug Tier	Requirements /Limits
<i>allergy-congest relief-d(fexo) oral tablet extended release 12 hr</i>	No Copay	EX
<i>allergy-congestion relief-d oral tablet extended release 24 hr</i>	No Copay	EX
<i>aller-tec d oral tablet extended release 12 hr</i>	No Copay	EX
<i>aller-tec oral tablet</i>	No Copay	EX
<i>azelastine nasal aerosol,spray</i>	2	
<i>azelastine nasal spray,non-aerosol</i>	2	
<i>cetiri-d oral tablet extended release 12 hr</i>	No Copay	EX
<i>cetirizine oral solution 1 mg/ml</i>	2	
<i>cetirizine oral solution 5 mg/5 ml</i>	No Copay	EX
<i>cetirizine oral tablet</i>	No Copay	EX
<i>cetirizine oral tablet,chewable</i>	No Copay	EX
<i>cetirizine-pseudoephedrine oral tablet extended release 12 hr</i>	No Copay	EX
<i>children's allergy relief(lor) oral solution</i>	No Copay	EX

Drug Name	Drug Tier	Requirements /Limits
<i>children's cetirizine oral tablet,chewable</i>	No Copay	EX
<i>ciproheptadine oral syrup</i>	2	HRM
<i>ciproheptadine oral tablet</i>	2	HRM
<i>desloratadine oral tablet</i>	2	QL (90 per 90 days)
<i>desloratadine oral tablet,disintegrating</i>	2	QL (90 per 90 days)
<i>dexchlorpheniramine maleate oral solution</i>	2	HRM
<i>diphenhydramine hcl injection syringe</i>	4	
<i>diphenhydramine hcl oral elixir</i>	2	HRM
DYMISTA NASAL SPRAY, NON-AEROSOL	4	
<i>fexofenadine oral tablet</i>	No Copay	EX
<i>fexofenadine-pseudoephedrine oral tablet extended release 12 hr</i>	No Copay	EX
<i>hydroxyzine hcl oral solution</i>	2	HRM
<i>hydroxyzine hcl oral tablet</i>	2	HRM
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	2	HRM

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Drug Name	Drug Tier	Requirements /Limits
<i>levocetirizine oral solution</i>	2	
<i>levocetirizine oral tablet</i>	2	QL (90 per 90 days)
<i>loradamed oral tablet</i>	No Copay	EX
<i>lorata-d oral tablet extended release 24 hr</i>	No Copay	EX
<i>lorata-dine d oral tablet extended release 24 hr</i>	No Copay	EX
<i>loratadine oral solution</i>	No Copay	EX
<i>loratadine oral tablet</i>	No Copay	EX
<i>loratadine oral tablet, disintegrating</i>	No Copay	EX
<i>loratadine-d oral tablet extended release 12 hr</i>	No Copay	EX
<i>loratadine-d oral tablet extended release 24 hr</i>	No Copay	EX
<i>olopatadine nasal spray, non-aerosol</i>	2	
RESPA-AR ORAL TABLET EXTENDED RELEASE 12 HR	4	EX
<i>wal-fex allergy oral tablet</i>	No Copay	EX
<i>wal-fex d 24 hour oral tablet extended release 24 hr</i>	No Copay	EX; QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>wal-itin d 12 hour oral tablet extended release 12 hr</i>	No Copay	EX
<i>wal-itin d oral tablet extended release 24 hr</i>	No Copay	EX
<i>wal-itin oral solution</i>	No Copay	EX
<i>wal-itin oral tablet</i>	No Copay	EX
<i>wal-zyr (cetirizine) oral tablet</i>	No Copay	EX
<i>wal-zyr d oral tablet extended release 12 hr</i>	No Copay	EX
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ALVESCO INHALATION HFA AEROSOL INHALER	3	QL (37 per 90 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE	4	
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION , 200 MCG/ACTUATION	3	QL (39 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	3	QL (3 per 90 days)
BECONASE AQ NASAL SPRAY,NON- AEROSOL	4	
<i>budesonide inhalation suspension for nebulization</i>	4	B/D PA
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE	3	QL (360 per 90 days)
FLOVENT HFA AEROSOL INHALER	3	QL (72 per 90 days)
<i>flunisolide nasal spray,non-aerosol</i>	2	
<i>fluticasone propionate nasal spray,suspension</i>	2	
<i>mometasone nasal spray,non-aerosol</i>	2	

Drug Name	Drug Tier	Requirements /Limits
OMNARIS NASAL SPRAY,NON- AEROSOL	4	
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED	3	
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED	3	QL (64 per 90 days)
ANTILEUKOTRIENES		
<i>montelukast oral granules in packet</i>	4	QL (90 per 90 days)
<i>montelukast oral tablet</i>	2	QL (90 per 90 days)
<i>montelukast oral tablet,chewable</i>	2	QL (90 per 90 days)
<i>zafirlukast oral tablet</i>	3	QL (180 per 90 days)
<i>zileuton oral tablet, er multiphase 12 hr</i>	4	QL (360 per 90 days)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA AEROSOL INHALER	3	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
Requirements/Limits: B/D - Prior Authorization, Part D vs. Part B only EX - Excluded Drug HRM - High Risk Medication LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
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Drug Name	Drug Tier	Requirements /Limits
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE	3	
<i>ipratropium bromide inhalation solution</i>	1	B/D PA
<i>ipratropium bromide nasal spray, non-aerosol</i>	1	
SPIRIVA RESPIMAT INHALATION MIST	3	QL (12 per 90 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE	3	QL (90 per 90 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED	3	QL (3 per 90 days)
BRONCHODILATORS, SYMPATHOMIMETIC		
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	3	QL (102 per 90 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	3	QL (81 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
ALBUTEROL SULFATE INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION (NDA020983)	3	QL (216 per 90 days)
<i>albuterol sulfate inhalation solution for nebulization</i>	1	B/D PA
<i>albuterol sulfate oral syrup</i>	1	
<i>albuterol sulfate oral tablet</i>	1	
<i>albuterol sulfate oral tablet extended release 12 hr</i>	1	
<i>arformoterol inhalation solution for nebulization</i>	4	B/D PA; QL (360 per 90 days)
BROVANA INHALATION SOLUTION FOR NEBULIZATION	4	B/D PA; QL (360 per 90 days)
EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.15 ML, 0.3 MG/0.3 ML	3	
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	3	
EPIPEN 2-PAK INJECTION AUTO-INJECTOR	4	

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier

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Drug Name	Drug Tier	Requirements /Limits
EPIPEN INJECTION AUTO-INJECTOR	4	
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR	3	
EPIPEN JR INJECTION AUTO-INJECTOR	3	
<i>formoterol fumarate inhalation solution for nebulization</i>	4	B/D PA
<i>levalbuterol hcl inhalation solution for nebulization</i>	2	B/D PA
LEVALBUTEROL TARTRATE INHALATION HFA AEROSOL INHALER	3	QL (90 per 90 days)
<i>metaproterenol oral syrup</i>	2	
PERFOROMIST INHALATION SOLUTION FOR NEBULIZATION	4	B/D PA
PROAIR HFA AEROSOL INHALER	3	QL (102 per 90 days)
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED	3	QL (12 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
PROVENTIL HFA AEROSOL INHALER	3	QL (81 per 90 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
STRIVERDI RESPIMAT INHALATION MIST	3	QL (12 per 84 days)
SYMJEPI INJECTION SYRINGE	3	
<i>terbutaline oral tablet</i>	2	
VENTOLIN HFA AEROSOL INHALER	3	QL (216 per 90 days)
XOPENEX HFA AEROSOL INHALER	4	QL (90 per 90 days)
CYSTIC FIBROSIS AGENTS		
BRONCHITOL INHALATION CAPSULE, W/INHALATION DEVICE	5	PA; NEDS
CAYSTON INHALATION SOLUTION FOR NEBULIZATION	5	PA; LA; QL (84 per 28 days); NEDS
KALYDECO ORAL GRANULES IN PACKET 25 MG	5	PA; NEDS

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Drug Name	Drug Tier	Requirements /Limits
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	5	PA; LA; NEDS
KALYDECO ORAL TABLET	5	PA; LA; NEDS
ORKAMBI ORAL GRANULES IN PACKET	5	PA; NEDS
ORKAMBI ORAL TABLET	5	PA; LA; NEDS
PULMOZYME INHALATION SOLUTION	5	B/D PA; NEDS
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	5	NEDS
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization</i>	5	B/D PA; NEDS
<i>tobramycin inhalation solution for nebulization</i>	4	B/D PA
TRIKAFTA ORAL TABLETS, SEQUENTIAL	5	PA; NEDS
MAST CELL STABILIZERS		
<i>cromolyn inhalation solution for nebulization</i>	2	B/D PA
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		

Drug Name	Drug Tier	Requirements /Limits
<i>aminophylline intravenous solution 500 mg/20 ml</i>	4	
DALIRESP ORAL TABLET	4	
<i>theophylline oral elixir</i>	2	
<i>theophylline oral solution</i>	2	
<i>theophylline oral tablet extended release 12 hr 300 mg</i>	2	
<i>theophylline oral tablet extended release 24 hr</i>	2	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS ORAL TABLET	5	PA; LA; NEDS
<i>alyq oral tablet</i>	5	PA; QL (62 per 31 days); NEDS
<i>ambrisentan oral tablet</i>	5	PA; NEDS
<i>bosentan oral tablet</i>	5	PA; NEDS
OPSUMIT ORAL TABLET	5	PA; LA; QL (31 per 31 days); NEDS
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	4	PA; LA

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Drug Name	Drug Tier	Requirements /Limits
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG	5	PA; LA; NEDS
<i>sildenafil (pulmonary arterial hypertension) oral suspension for reconstitution 10 mg/ml</i>	5	PA; QL (180 per 30 days); NEDS
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	2	PA; QL (270 per 90 days)
<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	5	PA; QL (62 per 31 days); NEDS
TRACLEER ORAL TABLET FOR SUSPENSION	5	PA; LA; NEDS
<i>treprostinil sodium injection solution</i>	4	B/D PA
TYVASO INHALATION SOLUTION FOR NEBULIZATION	5	B/D PA; NEDS
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION	5	B/D PA; NEDS
UPTRAVI ORAL TABLET	5	PA; LA; NEDS

Drug Name	Drug Tier	Requirements /Limits
UPTRAVI ORAL TABLETS,DOSE PACK	5	PA; LA; NEDS
VENTAVIS INHALATION SOLUTION FOR NEBULIZATION	5	B/D PA; LA; NEDS
PULMONARY FIBROSIS AGENTS		
ESBRIET ORAL TABLET 267 MG	5	PA; LA; QL (279 per 31 days); NEDS
ESBRIET ORAL TABLET 801 MG	5	PA; LA; QL (93 per 31 days); NEDS
OFEV ORAL CAPSULE	5	PA; LA; NEDS
RESPIRATORY TRACT AGENTS, OTHER		
<i>acetylcysteine intravenous solution</i>	2	
<i>acetylcysteine solution</i>	2	B/D PA
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
ADVAIR HFA AEROSOL INHALER	3	QL (36 per 90 days)
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
<i>benzonatate oral capsule</i>	2	EX

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Drug Name	Drug Tier	Requirements /Limits
BREO ELLIPTA INHALATION BLISTER WITH DEVICE	3	QL (180 per 90 days)
BROMFED DM ORAL SYRUP	4	EX
<i>brompheniramine-pseudoeph-dm oral syrup</i>	4	EX
COMBIVENT RESPIMAT INHALATION MIST	4	
CUROSURF INTRATRACHEAL SUSPENSION	4	
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED	5	QL (1 per 31 days); NEDS
DULERA INHALATION HFA AEROSOL INHALER	3	QL (39 per 90 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	1	QL (180 per 90 days)
<i>hydrocodone-chlorpheniramine oral suspension,extended rel 12 hr</i>	2	EX

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocodone-homatropine oral syrup 5-1.5 mg/5 ml</i>	2	EX; HRM
<i>hydromet oral syrup</i>	2	EX; HRM
<i>hydroxocobalamin intramuscular solution</i>	2	EX
<i>ipratropium-albuterol inhalation solution for nebulization</i>	2	B/D PA
NUCALA SUBCUTANEOUS AUTO-INJECTOR	5	NEDS
NUCALA SUBCUTANEOUS RECON SOLN	5	NEDS
NUCALA SUBCUTANEOUS SYRINGE	5	NEDS
<i>promethazine vc-codeine oral syrup</i>	2	EX
<i>promethazine-codeine oral syrup</i>	2	EX
<i>promethazine-dm oral syrup</i>	2	EX
<i>promethazine-phenyleph-codeine oral syrup</i>	2	EX
STIOLTO RESPIMAT INHALATION MIST	3	QL (12 per 90 days)

Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-Non-Preferred Drug 5-Specialty Tier
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Drug Name	Drug Tier	Requirements /Limits
SURVANTA INTRATRACHEAL SUSPENSION	4	
SYMBICORT INHALATION HFA AEROSOL INHALER	3	QL (30.6 per 90 days)
TESSALON PERLES ORAL CAPSULE	4	EX
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE	3	
TUSSICAPS ORAL CAPSULE,EXTENDED RELEASE 12 HR 10-8 MG	4	EX
<i>wixela inhub inhalation blister with device</i>	2	QL (180 per 90 days)

SEXUAL DISORDER AGENTS

SEXUAL DISORDER AGENTS

CIALIS ORAL TABLET 10 MG, 20 MG	3	EX; QL (18 per 90 days)
<i>sildenafil oral tablet</i>	2	EX; QL (18 per 90 days)
<i>tadalafil oral tablet 10 mg, 20 mg</i>	3	EX; QL (18 per 90 days)
<i>varденаfil oral tablet</i>	4	EX; QL (18 per 90 days)
<i>varденаfil oral tablet,disintegrating</i>	4	EX; QL (18 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
SKELETAL MUSCLE RELAXANTS		
SKELETAL MUSCLE RELAXANTS		
<i>carisoprodol oral tablet</i>	2	HRM
<i>carisoprodol-aspirin oral tablet</i>	2	
<i>carisoprodol-aspirin-codeine oral tablet</i>	2	
<i>chlorzoxazone oral tablet</i>	2	HRM
<i>cyclobenzaprine oral tablet</i>	2	HRM
<i>metaxalone oral tablet</i>	2	HRM
<i>methocarbamol oral tablet</i>	2	HRM

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

EDLUAR SUBLINGUAL TABLET	4	HRM; QL (90 per 90 days)
<i>estazolam oral tablet</i>	4	HRM
<i>eszopiclone oral tablet</i>	2	HRM; QL (90 per 90 days)
HETLIOZ ORAL CAPSULE	5	PA; LA; QL (31 per 31 days); NEDS
<i>ramelteon oral tablet</i>	3	QL (90 per 90 days)
ROZEREM ORAL TABLET	3	QL (90 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>seconal sodium oral capsule</i>	2	HRM
<i>temazepam oral capsule</i>	2	HRM
<i>triazolam oral tablet</i>	3	HRM
<i>zaleplon oral capsule</i>	2	HRM; QL (90 per 90 days)
<i>zolpidem oral tablet</i>	2	HRM; QL (90 per 90 days)
<i>zolpidem oral tablet,ext release multiphase</i>	2	HRM; QL (90 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
<i>zolpidem sublingual tablet</i>	4	HRM; QL (90 per 90 days)
WAKEFULNESS PROMOTING AGENTS		
<i>armodafinil oral tablet</i>	3	PA; QL (90 per 90 days)
<i>modafinil oral tablet</i>	3	PA; QL (180 per 90 days)
XYREM ORAL SOLUTION	5	PA; LA; NEDS

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