

# Essential Drug List

## Drug list — Four Tier Drug Plan

Your prescription benefit comes with a drug list, which is also called a formulary. This list is made up of brand-name and generic prescription drugs approved by the U.S. Food & Drug Administration (FDA). We're here to help. If you are a current Anthem member with questions about your pharmacy benefits, we're here to help. Just call us at the Member Services number on your ID card.

The product names to which this formulary applies are shown below.

\$5/\$15/\$25/\$45/30% to \$250	\$5/\$20/\$40/\$60/30% to \$250 Rx ded \$150
\$5/\$15/\$30/\$50/30% to \$250	\$5/\$20/\$40/\$75/30% to \$250
\$5/\$15/\$40/\$60/30% to \$250	\$5/\$20/\$40/\$75/30% to \$250 Rx ded \$250
\$5/\$15/\$50/\$65/30% to \$250 after deductible	\$5/\$20/\$50/\$65/30% to \$250 Rx ded \$500
\$5/\$20/\$30/\$50/30% to \$250	\$5/\$20/\$50/\$70/30% to \$250
\$5/\$20/\$40/\$60/30% to \$250	\$5/\$20/\$50/\$70/30% to \$250 after deductible

Here are a few things to remember:

- You can view and search our current drug lists when you visit [anthem.com/ca/pharmacyinformation](http://anthem.com/ca/pharmacyinformation). Please note: The formulary is subject to change and all previous versions of the formulary are no longer in effect.
- Additional tools and resources are available for current Anthem members to view the most up-to-date list of drugs for your plan - including drugs that have been added, generic drugs and more – by logging in at [anthem.com/ca/pharmacyinformation](http://anthem.com/ca/pharmacyinformation).
- Your coverage has limitations and exclusions, which means there are certain rules about what's covered by your plan and what isn't. Already a member? You can view your Certificate/Evidence of Coverage or your Summary Plan Description by logging in at [anthem.com/ca](http://anthem.com/ca) and go to **My Plan ->Benefits-> Plan Documents**.
- You and your doctor can use this list as a guide to choose drugs that are best for you. Drugs that aren't on this list may not be covered by your plan and may cost you more out of pocket. To help you see how the drug list works with your drug benefit, we've included some frequently asked questions (FAQ) in this document about how the list is set up and what to do if a drug you take isn't on it.

# Essential Drug List

## Four-Tier

### Table of Contents

<b>INFORMATIONAL SECTION</b> .....	4
<b>*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	11
<b>*AMINOGLYCOSIDES* - DRUGS FOR INFECTIONS</b> .....	12
<b>*ANALGESICS - ANTI-INFLAMMATORY* - DRUGS FOR PAIN AND FEVER</b> .....	12
<b>*ANALGESICS - NONNARCOTIC* - DRUGS FOR PAIN AND FEVER</b> .....	15
<b>*ANALGESICS - OPIOID* - DRUGS FOR PAIN AND FEVER</b> .....	16
<b>*ANDROGENS-ANABOLIC* - HORMONES</b> .....	19
<b>*ANORECTAL AGENTS* - RECTAL PREPARATIONS</b> .....	19
<b>*ANTHELMINTICS* - DRUGS FOR INFECTIONS</b> .....	19
<b>*ANTIANGINAL AGENTS* - DRUGS FOR THE HEART</b> .....	19
<b>*ANTIANGIOTENSIN AGENTS* - DRUGS FOR THE HEART</b> .....	19
<b>*ANTIARRHYTHMICS* - DRUGS FOR THE HEART</b> .....	21
<b>*ANTIASTHMATIC AND BRONCHODILATOR AGENTS* - DRUGS FOR THE LUNGS</b> .....	21
<b>*ANTICOAGULANTS* - DRUGS FOR THE BLOOD</b> .....	23
<b>*ANTICONSULTANTS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	24
<b>*ANTIDEPRESSANTS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	26
<b>*ANTIDIABETICS* - HORMONES</b> .....	28
<b>*ANTIDIARRHEALS* - DRUGS FOR THE STOMACH</b> .....	31
<b>*ANTIDOTES AND SPECIFIC ANTAGONISTS* - DRUGS FOR OVERDOSE OR POISONING</b> .....	31
<b>*ANTIDOTES* - DRUGS FOR OVERDOSE OR POISONING</b> .....	31
<b>*ANTIEMETICS* - DRUGS FOR THE STOMACH</b> .....	32
<b>*ANTIFUNGALS* - DRUGS FOR INFECTIONS</b> .....	33
<b>*ANTIHISTAMINES* - DRUGS FOR THE LUNGS</b> .....	33
<b>*ANTIHYPERLIPIDEMICS* - DRUGS FOR THE HEART</b> .....	34
<b>*ANTIHYPERTENSIVES* - DRUGS FOR THE HEART</b> .....	35
<b>*ANTI-INFECTIVE AGENTS - MISC.* - DRUGS FOR INFECTIONS</b> .....	38
<b>*ANTIMALARIALS* - DRUGS FOR INFECTIONS</b> .....	39
<b>*ANTIMYASTHENIC AGENTS* - DRUGS FOR NERVES AND MUSCLES</b> .....	39
<b>*ANTIMYASTHENIC/CHOLINERGIC AGENTS* - DRUGS FOR NERVES AND MUSCLES</b> .....	40
<b>*ANTIMYCOBACTERIAL AGENTS* - DRUGS FOR INFECTIONS</b> .....	40
<b>*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES* - DRUGS FOR CANCER</b> .....	40
<b>*ANTIPARKINSON AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	44
<b>*ANTIPSYCHOTICS/ANTIMANIC AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	45
<b>*ANTIVIRALS* - DRUGS FOR INFECTIONS</b> .....	47
<b>*ASSORTED CLASSES* - VITAMINS AND MINERALS</b> .....	50
<b>*BETA BLOCKERS* - DRUGS FOR THE HEART</b> .....	51
<b>*CALCIUM CHANNEL BLOCKERS* - DRUGS FOR THE HEART</b> .....	52
<b>*CARDIOTONICS* - DRUGS FOR THE HEART</b> .....	53
<b>*CARDIOVASCULAR AGENTS - MISC.* - DRUGS FOR THE HEART</b> .....	54
<b>*CEPHALOSPORINS* - DRUGS FOR INFECTIONS</b> .....	55
<b>*CONTRACEPTIVES* - DRUGS FOR WOMEN</b> .....	56
<b>*CORTICOSTEROIDS* - HORMONES</b> .....	61
<b>*COUGH/COLD/ALLERGY* - DRUGS FOR THE LUNGS</b> .....	62
<b>*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER</b> .....	63
<b>*DERMATOLOGICALS* - DRUGS FOR THE SKIN</b> .....	63
<b>*DIAGNOSTIC PRODUCTS*</b> .....	72
<b>*DIGESTIVE AIDS* - DRUGS FOR THE STOMACH</b> .....	72
<b>*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD</b> .....	72
<b>*DIURETICS* - DRUGS FOR THE HEART</b> .....	73
<b>*ENDOCRINE AND METABOLIC AGENTS - MISC.* - HORMONES</b> .....	74
<b>*ESTROGENS* - HORMONES</b> .....	76
<b>*FLUOROQUINOLONES* - DRUGS FOR INFECTIONS</b> .....	77
<b>*GASTROINTESTINAL AGENTS - MISC.* - DRUGS FOR THE STOMACH</b> .....	77
<b>*GENERAL ANESTHETICS* - DRUGS FOR PAIN AND FEVER</b> .....	78
<b>*GENTOURINARY AGENTS - MISCELLANEOUS* - DRUGS FOR THE URINARY SYSTEM</b> .....	79
<b>*GLYCOPOLYMER*** - DRUGS FOR INFECTIONS</b> .....	79
<b>*GOUT AGENTS* - DRUGS FOR PAIN AND FEVER</b> .....	79
<b>*HEMATOLOGICAL AGENTS - MISC.* - DRUGS FOR THE BLOOD</b> .....	80

<b>*HEMATOPOIETIC AGENTS* - DRUGS FOR NUTRITION</b> .....	81
<b>*HEMOSTATICS* - DRUGS FOR THE BLOOD</b> .....	83
<b>*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR INFECTIONS</b> .....	83
<b>*HYPNOTICS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	83
<b>*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH</b> .....	84
<b>*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR THE STOMACH</b> .....	84
<b>*LAXATIVES* - DRUGS FOR THE STOMACH</b> .....	84
<b>*LOCAL ANESTHETICS-PARENTERAL* - DRUGS FOR PAIN AND FEVER</b> .....	85
<b>*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - DRUGS FOR THE EYE</b> .....	85
<b>*MACROLIDES* - DRUGS FOR INFECTIONS</b> .....	86
<b>*MEDICAL DEVICES* - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b> .....	86
<b>*MIGRAINE PRODUCTS* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	95
<b>*MINERALS &amp; ELECTROLYTES* - DRUGS FOR NUTRITION</b> .....	95
<b>*MONOBACTAMS*** - DRUGS FOR INFECTIONS</b> .....	98
<b>*MOUTH/THROAT/DENTAL AGENTS* - DRUGS FOR THE MOUTH AND THROAT</b> .....	98
<b>*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR THE NERVOUS SYSTEM</b> .....	99
<b>*MULTIVITAMINS* - DRUGS FOR NUTRITION</b> .....	99
<b>*MUSCULOSKELETAL THERAPY AGENTS* - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b> .....	101
<b>*NASAL AGENTS - SYSTEMIC AND TOPICAL* - DRUGS FOR THE NOSE</b> .....	102
<b>*NEPRILYSIN INHIB (ARND)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR THE HEART</b> .....	103
<b>*NEUROMUSCULAR AGENTS* - DRUGS FOR NERVES AND MUSCLES</b> .....	103
<b>*NUTRIENTS* - DRUGS FOR NUTRITION</b> .....	103
<b>*OPHTHALMIC AGENTS* - DRUGS FOR THE EYE</b> .....	103
<b>*OTIC AGENTS* - DRUGS FOR THE EAR</b> .....	106
<b>*OXYTOCICS* - HORMONES</b> .....	107
<b>*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR INFECTIONS</b> .....	107
<b>*PASSIVE IMMUNIZING AGENTS* - BIOLOGICAL AGENTS</b> .....	107
<b>*PCSK9 INHIBITORS*** - DRUGS FOR THE HEART</b> .....	108
<b>*PENICILLINS* - DRUGS FOR INFECTIONS</b> .....	108
<b>*PHARMACEUTICAL ADJUVANTS*</b> .....	109
<b>*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE HEART</b> .....	109
<b>*POTASSIUM REMOVING AGENTS*** - DRUGS FOR NUTRITION</b> .....	109
<b>*PROGESTINS* - HORMONES</b> .....	109
<b>*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.* - DRUGS FOR THE NERVOUS SYSTEM</b> .....	109
<b>*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR CANCER</b> .....	112
<b>*RESPIRATORY AGENTS - MISC.* - DRUGS FOR THE LUNGS</b> .....	112
<b>*SEROTONIN MODULATORS*** - DRUGS FOR THE NERVOUS SYSTEM</b> .....	112
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - HORMONES</b> .....	112
<b>*STERIODS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT</b> .....	112
<b>*TETRACYCLINES* - DRUGS FOR INFECTIONS</b> .....	113
<b>*THYROID AGENTS* - HORMONES</b> .....	113
<b>*TOXOIDS* - BIOLOGICAL AGENTS</b> .....	114
<b>*ULCER DRUGS* - DRUGS FOR THE STOMACH</b> .....	114
<b>*URINARY ANTI-INFECTIVES* - DRUGS FOR THE URINARY SYSTEM</b> .....	115
<b>*URINARY ANTISPASMODICS* - DRUGS FOR THE URINARY SYSTEM</b> .....	116
<b>*VACCINES* - BIOLOGICAL AGENTS</b> .....	117
<b>*VAGINAL PRODUCTS* - DRUGS FOR WOMEN</b> .....	119
<b>*VASOPRESSORS* - DRUGS FOR THE HEART</b> .....	119
<b>*VITAMINS* - DRUGS FOR NUTRITION</b> .....	120

## Essential Drug List – Informational Section

### Definitions

“**\$0**” next to a drug means this is a preventive drug. For some members, this product may be covered at 100% with \$0 cost share with a prescription from your provider if specified criteria are met.

“**BRAND name drug**” means a drug that is marketed under a proprietary, trademark-protected name. A BRAND name drug is listed in this formulary in all **CAPITAL** letters.

“**Coinsurance**” means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

“**Copayment**” means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

“**Deductible**” means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

“**Dose Optimization (DO)**” means dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

“**Drug Tier**” means a group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

“**Exception request**” means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

“**Exigent circumstances**” means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

“**Formulary**” or “**prescription drug list**” means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

“**Generic drug**” means a drug that is the same as its BRAND name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in *italicized lowercase letters*.

“**Limited Distribution (LD)**” means limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

“**Medically Necessary**” means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

“**Non-formulary drug**” means a prescription drug that is not listed on this formulary.

“**Oral Chemotherapy (OC)**” Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.

“**Out-of-pocket costs**” means your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

**“Prescribing provider”** means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

**“Prescription”** means an oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.

**“Prescription drug”** means a drug that by law requires a prescription.

**“Prior Authorization (PA)”** means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

**“Quantity limit (QL)”** means a restriction on the number of doses of a prescription drug covered by a health insurance product during a specific time period, or any other limitation on the quantity of a drug that is covered.

**“Specialty Drugs (SP)”** means specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

**“Step therapy (ST)”** means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

## Frequently Asked Questions

### How do I know what drugs are covered under my benefits?

This is a complete listing of all the drugs on the drug list. But, it's possible a drug(s) on this list may not be covered, depending on your plan's design.

Your pharmacy benefit covers prescription drugs, including Specialty Drugs, that may be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. Benefits that are administered to you in your provider's office are typically covered under your medical benefit. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables and any drug that must be administered by a Provider.

### How can I find a drug on the list?

(A) A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the **BRAND** name or *generic* name of the drug in the alphabetical index; and

(B) If a generic equivalent for a **BRAND** name drug is not available on the market or is not covered, the drug will not be separately listed by its *generic* name.

You can search the PDF drug list by:

- Drug name, using Ctrl + F on your keyboard, then type in the name of the drug you're looking for.
- Drug class, using the categories listed in alphabetical order.

### How are drugs shown on the list?

- A drug is listed alphabetically by its **BRAND** name and generic names in the therapeutic category and class to which it belongs;
- The *generic* name for a **BRAND** name drug is included after the **BRAND** name in parentheses and all *lowercase italicized letters*;

**ANALGESIC OPIOID AGONISTS - ARTHRITIS AND PAIN DRUGS**

**ABSTRAL SUBLINGUAL TABLET 100 MCG, 200 MCG, 300 MCG, 400 MCG, 600 MCG, 800 MCG (*fentanyl*)**

- If a *generic* equivalent for a **BRAND** name drug is both available and covered, the *generic* drug will be listed separately from the **BRAND** name drug in all *lowercase italicized letters*; and

*codeine sulfate oral tablet 15 mg, 30 mg*

- If a *generic* drug is marketed under a proprietary, trademark-protected **BRAND** name, the **BRAND** name will be listed after the *generic* name in parentheses and regular typeface with the first letter of each word capitalized.

*levonorgestrel-ethinyl estrad (Portia Oral Tablet 0.15-0.03 Mg)*

The "Under Coverage Requirements and Limits" section will indicate if you need preapproval before you can take the drug (called prior authorization or PA), or if you need to try other drugs first for your treatment (called step therapy or ST).

*Note: The presence of a prescription drug on the formulary does not guarantee that your doctor will prescribe that prescription drug for a particular medical condition.*

### What are my options for getting my prescriptions?

You have plenty of choices about how and where to get your prescription medicines, including local pharmacies in your plan, convenient home delivery or specialty pharmacies. Most plans include our home delivery program at no extra cost to you.

Current Anthem members can find out more by logging in at [anthem.com/ca](http://anthem.com/ca) and choose Prescription Benefits or call 833-236-6196. For more details about your coverage, you can call the phone number on your member ID card.

### **What if my drug isn't on the list?**

We understand that only you and your doctor know what is best for you. If you want to take a drug that's not on the drug list, you may have to pay the full cost for it. You can also talk to your doctor or pharmacist to see if there's another drug covered by your plan that will work just as well, or if generic or OTC drugs are an option. Only you and your doctor can decide what drugs are right for you.

If a drug you're taking isn't covered, your doctor can ask us to review the coverage. This process is called preapproval or prior authorization.

Your doctor can get the process started by completing an electronic Prior Authorization, calling the Pharmacy Member Services number on the back of your member ID card or by downloading a prior authorization form from our website and submitting it. If your request is approved, the amount you pay for the drug will depend on your plan's benefit.

There are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to <https://www.covermyeds.com/main/partners/anthem>.
2. Log in at [anthem.com/ca](https://www.anthem.com/ca) and choose **Pharmacy**.
  - o Go to **Pharmacy Resources** and **Search Your Drug List** for your medication.
  - o Choose the correct medication strength and form.
  - o Scroll down to **Definition of Restrictions** and locate the applicable Fax Form in the table.
  - o Your doctor [completes and faxes the form](#) to us at 844-474-3347.
3. Calling Pharmacy Member Services number on the back of your member ID card.

### **Who decides what drugs are on the list?**

The drugs on the list are reviewed through our Pharmacy and Therapeutics (P&T) process. In this process, a group of independent doctors, pharmacists and other health care professionals decides which drugs we include on our lists. This group meets regularly to look at new and existing drugs and recommends drugs based on how safe they are, how well they work and the value they offer our members.

### **What is a specialty drug and how do I get them?**

If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered. Specialty drugs come in many forms like pills, liquids, injections (shots), infusions or inhalers and may need special storage and handling. Typically benefits for specialty drugs that are self-administered will be covered under the pharmacy benefit. Benefits for specialty drugs that are administered to you in your provider's office are typically covered under your medical benefit. If you use pharmacies that are not in the network, your medicine may not be covered and you may have to pay the full cost. For more details about your coverage, you can call the phone number on your member ID card.

### **Does the drug list change, and how will I know if it does?**

Drugs on our list are reviewed and updated on a monthly basis. Sometimes, drugs are added, removed, change tiers or have updated requirements. The changes will usually go into effect the first day of the month. But don't worry, we'll let you know if a drug you take is taken off the list and, in some cases, if a drug you take is moved to a higher tier.

You can always check the drug list to make sure medicines you take are still on it. You'll find the most up-to-date drug list when you log in at [anthem.com/ca](https://www.anthem.com/ca).

### **What kind of drugs can I find on the formulary?**

We cover FDA-approved preventive care drugs with zero cost share in compliance with the Affordable Care Act (ACA) and California state regulations. Your doctor may need to write a prescription for these preventive services to be covered by your plan, even if they are listed as over-the-counter. The availability or coverage of these medications without cost-sharing may be subject to criteria established by the health plan.

We cover FDA-approved equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program authorized by the State's Diabetes Control Project within the Bureau of Health.

### What drugs can I find in each tier?

We place drugs on different tiers based on how well they work to improve health, whether there are over-the-counter (OTC) options and their costs compared to other drugs used for the same type of treatment. The lower the tier, the lower your share of the cost. Here's a breakdown of the tiers in your plan:

- Tier 1 drugs have the lowest cost share for you. These are usually *generic* drugs that offer the best value compared to other drugs that treat the same conditions. Some plans split Tier 1 into Tier 1a and Tier 1b:
  - Tier 1a drugs have the lowest cost share. These are often *generic* drugs that offer the greatest value compared to others that treat the same conditions.
  - Tier 1b drugs have a low cost share. These are typically *generic* drugs that offer the greatest value compared to others that treat the same conditions.
- Tier 2 drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.
- Tier 3 drugs have a higher cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition. Tier 3 may also include drugs recently approved by the FDA.
- Tier 4 drugs have the highest cost share and usually include specialty brand and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition. Tier 4 may also include drugs recently approved by the FDA or specialty drugs used to treat serious, long-term health conditions and that may need special handling.

### How will I know how much my drug will cost?

Current Anthem members can go online and with the Price a Medication Tool, get pharmacy-specific pricing from a number of local retail pharmacies in your zip code.

*Note: For oral chemotherapy drugs - Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.*

### How does Anthem promote safety?

When you go to a pharmacy, the pharmacist will get an electronic message from Anthem if a drug needs prior authorization, requires step therapy or has a limit on the amount that can be given. Here's a closer look at all of the programs we've put into place to help make sure you get the care you need, while helping to keep you safe.<sup>1</sup>

Our clinical edit programs are:

- Prior authorization, which requires you to get approval before taking a medicine. This helps make sure a drug is used properly and focuses on drugs that may have:
  - Risk of side effects.
  - Risk of harmful effects when taken with other drugs.
  - Potential for incorrect use or abuse.
  - Rules for use with certain conditions.
- Step therapy, which requires that other drugs be tried first. It focuses on whether a drug is right for your condition.
- Dose optimization, which involves changing from taking a dose twice a day to once a day, when medically appropriate. Taking fewer doses may lower your costs; a single higher dose of a drug taken once a day may cost less than a lower dose taken twice a day.
- Quantity Limits impose a limit on the amount in a prescription and how often it can be refilled.
  - If a refill request is submitted too soon or the doctor prescribes an amount that's higher than what is allowed, the drug won't be covered at that time.
  - If there are medical reasons to prescribe the drug as originally dosed, the doctor can ask for review by our Prior Authorization Center.

Also, If you're taking a medicine that is considered a specialty drug, you may need to use a specialty pharmacy in order for your drug to be covered.



### **How does my doctor start the Prior Authorization process?**

If your drug is on our formulary but requires a PA or Step Therapy, there are a few options for your doctor to start the Prior Authorization (PA) process:

1. Submit an electronic PA request by going to <https://www.covermymeds.com/main/partners/anthem>.
2. Log in at [anthem.com/ca](https://anthem.com/ca) and choose Pharmacy.
  - Go to Pharmacy Resources and Search Your Drug List for your medication.
  - Choose the correct medication strength and form.
  - Scroll down to Definition of Restrictions and locate the applicable Fax Form in the table.
  - Your doctor completes the form and faxes it to Anthem at 844-474-3347.
3. Calling Pharmacy Member Services number on the back of your member ID card.

### **What is Step Therapy? How does it work?**

Step therapy requires trying other drugs before certain medications may be covered. The pharmacy will let you know if step therapy is required and you must first try the drug or treatment included in the program. If the drug or treatment does not treat the condition well, the doctor can contact our Prior Authorization Center to ask that we approve the original drug.<sup>1</sup>

A few more notes about the exception process:

- If we fail to respond to a completed prior authorization or step therapy exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed approved and we may not deny any subsequent requests for this medication.
- Don't worry, if you've changed policies, we won't ask you to repeat an approved step therapy request that is already being used to treat a medical condition provided that the drug is still appropriately prescribed and is considered safe and effective.

A note about opioid analgesics. The member cost share for certain abuse-deterrent opioid analgesics may be lower in some states because of laws in those states. Opioid analgesics are a type of painkiller. In response to the global opioid epidemic, the U.S. Food and Drug Administration (FDA) has encouraged drug manufacturers to develop opioids with properties that help deter their misuse and abuse.

Drug(s) may be excluded from the list based on your plan's benefit design.

<sup>1</sup> If the Prior Authorization Center concludes the prescription claim should be denied, members and their doctors will get letters that explain the appeals and/or grievance process.

## KEY

Here are some terms and notes you'll find on the drug list.

**Brand name drugs are in UPPER CASE, bold type.**

**Generic drugs are in lower case, plain type.**

**\$0** = preventive drugs. For some members, this product may be covered at 100% with \$0 cost share with a prescription from your provider if specified criteria are met.

**DO** = dose optimization. Usually, this means you may have to switch from taking a drug twice a day to taking it once a day at a higher strength.

**LD** = limited distribution. These drugs are available only through certain pharmacies or wholesalers, depending on what the manufacturer decides.

**OC** = oral chemotherapy. These drugs after deductible shall not exceed \$200 per an individual prescription for up to a 30 day supply.

**PA** = prior authorization. You may need to get benefits approved before certain prescriptions can be filled.

**QL** = quantity limits. There are limits on the amount of medicine covered within a certain amount of time.

**SP** = specialty drugs. Specialty drugs are used to treat difficult, long-term conditions. You may need to get this drug through a specialty pharmacy.

**ST** = step therapy. You may need to use another recommended drug first before a prescribed drug is covered.

**Tier 1** = drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions.

**Tier 1a** = drugs have the lowest cost share. These are often generic drugs that offer the greatest value compared to others that treat the same conditions.

**Tier 1b** = drugs have a low cost share. These are typically generic drugs that offer the greatest value compared to others that treat the same conditions.

**Tier 2** = drugs have a higher cost share than Tier 1. They may be preferred brand drugs, based on how well they work and their cost compared to other drugs used for the same type of treatment. Some are generic drugs that may cost more because they're newer to the market.

**Tier 3** = drugs have a higher cost share. They often include brand and generic drugs that may cost more than drugs on lower tiers that are used to treat the same condition.

**Tier 4** = drugs have the highest cost share and usually include specialty brand and generic drugs. They may cost more than drugs on lower tiers that are used to treat the same condition.

## Essential Drug List

### Four-Tier

CURRENT AS OF 2/1/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ADHD AGENT - SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>clonidine hcl er oral tablet extended release 12 hour</i>	1 or 1b*	PA
<i>guanfacine hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA
<b>*ADHD AGENT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>atomoxetine hcl oral capsule</i>	1 or 1b*	PA
<b>*AMPHETAMINE MIXTURES*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<b>ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR</b> <i>(amphetamine-dextroamphetamine)</i>	1 or 1b*	PA
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour</i>	1 or 1b*	PA
<i>amphetamine-dextroamphetamine oral tablet</i>	1 or 1b*	PA
<b>*AMPHETAMINES*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>amphetamine sulfate oral tablet</i>	1 or 1b*	
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour</i>	1 or 1b*	PA
<i>dextroamphetamine sulfate oral solution</i>	1 or 1b*	PA
<i>dextroamphetamine sulfate oral tablet</i>	1 or 1b*	PA
<i>methamphetamine hcl oral tablet</i>	1 or 1b*	PA
<b>VYVANSE ORAL CAPSULE</b> <i>(lisdexamfetamine dimesylate)</i>	2	PA
<b>VYVANSE ORAL TABLET CHEWABLE</b> <i>(lisdexamfetamine dimesylate)</i>	2	PA
<b>ZENZEDI ORAL TABLET</b> <i>(dextroamphetamine sulfate)</i>	1 or 1b*	PA
<b>*ANALEPTICS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>caffeine citrate intravenous solution</i>	2	
<i>caffeine citrate oral solution</i>	2	
<b>*ANOREXIANTS NON-AMPHETAMINE*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>benzphetamine hcl oral tablet 25 mg</i>	1 or 1b*	
<i>benzphetamine hcl oral tablet 50 mg</i>	1 or 1b*	PA
<i>diethylpropion hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA
<i>diethylpropion hcl oral tablet</i>	1 or 1b*	PA
<i>phendimetrazine tartrate er oral capsule extended release 24 hour</i>	1 or 1b*	PA

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phendimetrazine tartrate oral tablet</i>	1 or 1b*	PA
<i>phentermine hcl oral capsule</i>	1 or 1b*	PA
<i>phentermine hcl oral tablet</i>	1 or 1b*	PA
<b>*STIMULANTS - MISC.*** - DRUGS FOR ATTENTION DEFICIT DISORDER</b>		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	2	PA; QL (1 tablet per 1 day)
<i>armodafinil oral tablet 50 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour</i>	1 or 1b*	PA
<i>dexmethylphenidate hcl oral tablet</i>	1 or 1b*	PA
<i>methylphenidate hcl (Metadate Er Oral Tablet Extended Release)</i>	1 or 1b*	PA
<i>methylphenidate hcl er (cd) oral capsule extended release</i>	1 or 1b*	PA
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour</i>	1 or 1b*	PA
<i>methylphenidate hcl er oral tablet extended release</i>	1 or 1b*	PA
<i>methylphenidate hcl er oral tablet extended release 24 hour</i>	1 or 1b*	PA
<i>methylphenidate hcl oral solution</i>	1 or 1b*	PA
<i>methylphenidate hcl oral tablet</i>	1 or 1b*	PA
<i>methylphenidate hcl oral tablet chewable</i>	1 or 1b*	PA
<i>modafinil oral tablet 100 mg</i>	2	PA
<i>modafinil oral tablet 200 mg</i>	2	PA; QL (1 tablet per 1 day)
<b>*AMINOGLYCOSIDES* - DRUGS FOR INFECTIONS</b>		
<b>*AMINOGLYCOSIDES*** - ANTIBIOTICS</b>		
<i>amikacin sulfate injection solution</i>	2	
<i>gentamicin in saline intravenous solution</i>	2	
<i>gentamicin sulfate injection solution</i>	2	
<i>neomycin sulfate oral tablet</i>	1 or 1a*	
<i>paromomycin sulfate oral capsule</i>	1 or 1b*	
<i>streptomycin sulfate intramuscular solution reconstituted</i>	1 or 1b*	
<i>tobramycin inhalation nebulization solution</i>	4	SP
<i>tobramycin sulfate injection solution</i>	2	
<i>tobramycin sulfate injection solution reconstituted</i>	2	
<b>*ANALGESICS - ANTI-INFLAMMATORY* - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANTIRHEUMATIC - JANUS KINASE (JAK) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
<b>RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR</b> <i>(upadacitinib)</i>	4	PA; SP; QL (1 tablet per 1 day)
<b>XELJANZ ORAL TABLET</b> <i>(tofacitinib citrate)</i>	4	PA; SP; QL (2 tablets per 1 day)
<b>XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR</b> <i>(tofacitinib citrate)</i>	4	PA; SP; QL (1 tablet per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTIRHEUMATIC ANTIMETABOLITES*** - ARTHRITIS AND PAIN DRUGS</b>		
<b>RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> <i>(methotrexate (anti-rheumatic))</i>	4	PA; SP; QL (4 auto-injector per 28 days)
<b>*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - ARTHRITIS AND PAIN DRUGS</b>		
<b>HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 EA per 28 days)
<b>HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 EA per 28 days)
<b>HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 pens per 28 days)
<b>HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (1 kit per 365 days)
<b>HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 syringes per 28 days)
<b>HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (1 kit per 365 days)
<b>HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML &amp; 40MG/0.4ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 syringes per 28 days)
<b>HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 EA per 28 days)
<b>HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 syringes per 28 days)
<b>SIMPONI ARIA INTRAVENOUS SOLUTION</b> <i>(golimumab)</i>	4	PA; SP
<b>SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> <i>(golimumab)</i>	4	PA; SP; QL (1 pen per 28 days)
<b>SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> <i>(golimumab)</i>	4	PA; SP; QL (1 syringe per 28 days)
<b>*ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES*** - ARTHRITIS AND PAIN DRUGS</b>		
<b>HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 EA per 28 days)
<b>HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 EA per 28 days)
<b>HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 pens per 28 days)
<b>HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (1 kit per 365 days)
<b>HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 syringes per 28 days)
<b>HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (1 kit per 365 days)
<b>HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML &amp; 40MG/0.4ML</b> <i>(adalimumab)</i>	4	PA; SP; QL (2 syringes per 28 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**=Drugs with the lowest cost share **Tier 1 or 1b**=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML (adalimumab)</b>	4	PA; SP; QL (2 EA per 28 days)
<b>HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML (adalimumab)</b>	4	PA; SP; QL (2 syringes per 28 days)
<b>SIMPONI ARIA INTRAVENOUS SOLUTION (golimumab)</b>	4	PA; SP
<b>SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR (golimumab)</b>	4	PA; SP; QL (1 pen per 28 days)
<b>SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (golimumab)</b>	4	PA; SP; QL (1 syringe per 28 days)
<b>*CYCLOOXYGENASE 2 (COX-2) INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	2	ST; QL (2 capsules per 1 day)
<i>celecoxib oral capsule 400 mg</i>	2	ST; QL (1 capsule per 1 day)
<b>*GOLD COMPOUNDS*** - ARTHRITIS AND PAIN DRUGS</b>		
<b>RIDAURA ORAL CAPSULE (auranofin)</b>	2	
<b>*NONSTEROIDAL ANTI-INFLAMMATORY AGENT COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg</i>	2	ST; QL (4 tablets per 1 day)
<i>diclofenac-misoprostol oral tablet delayed release 75-0.2 mg</i>	2	ST; QL (2 tablets per 1 day)
<b>*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>diclofenac potassium oral tablet</i>	1 or 1b*	
<i>diclofenac sodium er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>diclofenac sodium oral tablet delayed release</i>	1 or 1b*	
<i>etodolac er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>etodolac oral capsule</i>	1 or 1b*	
<i>etodolac oral tablet</i>	1 or 1b*	
<i>fenoprofen calcium oral tablet</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>flurbiprofen oral tablet</i>	1 or 1b*	
<i>ibuprofen (Ibu Oral Tablet)</i>	1 or 1a*	
<i>ibuprofen oral tablet</i>	1 or 1a*	
<i>indomethacin er oral capsule extended release</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>indomethacin oral capsule 25 mg</i>	1 or 1b*	QL (3 capsule per 1 day)
<i>indomethacin oral capsule 50 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>indomethacin sodium intravenous solution reconstituted</i>	2	
<i>ketoprofen er oral capsule extended release 24 hour</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>ketoprofen oral capsule</i>	1 or 1b*	
<i>ketorolac tromethamine injection solution 15 mg/ml</i>	2	QL (4 ML per 30 days)
<i>ketorolac tromethamine injection solution 30 mg/ml</i>	2	QL (2 syringe per 30 days)
<i>ketorolac tromethamine intramuscular solution</i>	2	QL (2 injections per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ketorolac tromethamine oral tablet</i>	1 or 1a*	QL (20 tablets per 30 days)
<i>meclofenamate sodium oral capsule</i>	1 or 1b*	
<i>mefenamic acid oral capsule</i>	1 or 1b*	QL (29 capsule per 1 fill)
<i>meloxicam oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>nabumetone oral tablet</i>	1 or 1b*	
<i>naproxen dr oral tablet delayed release</i>	1 or 1b*	
<i>naproxen oral suspension</i>	1 or 1b*	
<i>naproxen oral tablet</i>	1 or 1b*	
<i>naproxen sodium er oral tablet extended release 24 hour</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>naproxen sodium oral tablet</i>	1 or 1b*	
<i>oxaprozin oral tablet</i>	1 or 1b*	
<i>piroxicam oral capsule</i>	1 or 1b*	
<i>sulindac oral tablet</i>	1 or 1b*	
<i>tolmetin sodium oral capsule</i>	2	
<i>tolmetin sodium oral tablet</i>	2	
<b>*PYRIMIDINE SYNTHESIS INHIBITORS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>leflunomide oral tablet</i>	2	
<b>*SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS*** - ARTHRITIS AND PAIN DRUGS</b>		
<b>ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE</b> <i>(etanercept)</i>	4	PA; SP; QL (4 cartridge per 28 days)
<b>ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML</b> <i>(etanercept)</i>	4	PA; SP; QL (8 syringes per 28 days)
<b>ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML</b> <i>(etanercept)</i>	4	PA; SP; QL (4 syringes per 28 days)
<b>ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED</b> <i>(etanercept)</i>	4	PA; SP; QL (8 vials per 28 days)
<b>ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> <i>(etanercept)</i>	4	PA; SP; QL (4 pens per 28 days)
<b>*ANALGESICS - NONNARCOTIC* - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANALGESICS OTHER*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>clonidine hcl (analgesia) epidural solution</i>	1 or 1b*	
<b>*ANALGESICS-SEDATIVES*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>butalbital-acetaminophen oral capsule</i>	1 or 1b*	
<i>butalbital-acetaminophen oral tablet</i>	1 or 1b*	
<i>butalbital-apap-caffeine oral capsule</i>	1 or 1b*	
<i>butalbital-apap-caffeine oral tablet</i>	1 or 1b*	
<i>butalbital-aspirin-caffeine oral capsule</i>	1 or 1b*	
<b>TENCON ORAL TABLET</b> <i>(butalbital-acetaminophen)</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-apap-caffeine</i> (Zebutal Oral Capsule)	2	
<b>*SALICYLATES*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>diflunisal oral tablet</i>	1 or 1b*	
<b>*ANALGESICS - OPIOID* - DRUGS FOR PAIN AND FEVER</b>		
<b>*CODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>acetaminophen-codeine #2 oral tablet</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>acetaminophen-codeine #3 oral tablet</i>	1 or 1a*	QL (6 tablet per 1 day)
<i>acetaminophen-codeine #4 oral tablet</i>	1 or 1a*	QL (6 tablet per 1 day)
<i>acetaminophen-codeine oral solution</i>	1 or 1a*	QL (30 mL per 1 day)
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	1 or 1a*	QL (6 tablets per 1 day)
<i>acetaminophen-codeine oral tablet 300-30 mg, 300-60 mg</i>	1 or 1a*	QL (6 tablet per 1 day)
<i>butalbital-asa-caff-codeine</i> (Ascomp-Codeine Oral Capsule)	1 or 1b*	QL (6 capsule per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-300-40-30 mg</i>	1 or 1b*	QL (6 capsules per 1 day)
<i>butalbital-apap-caff-cod oral capsule 50-325-40-30 mg</i>	1 or 1b*	QL (6 capsule per 1 day)
<i>butalbital-asa-caff-codeine oral capsule</i>	1 or 1b*	QL (6 capsule per 1 day)
<b>*DIHYDROCODEINE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>apap-caff-dihydrocodeine oral capsule</i>	1 or 1b*	QL (6 capsules per 1 day)
<b>DVORAH ORAL TABLET</b> ( <i>apap-caff-dihydrocodeine</i> )	1 or 1b*	QL (6 tablets per 1 day)
<b>TREZIX ORAL CAPSULE</b> ( <i>apap-caff-dihydrocodeine</i> )	1 or 1b*	QL (6 capsules per 1 day)
<b>*HYDROCODONE COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>hydrocodone-acetaminophen oral solution</i>	1 or 1b*	QL (90 mL per 1 day)
<i>hydrocodone-acetaminophen oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>hydrocodone-ibuprofen oral tablet</i>	1 or 1b*	QL (5 tablets per 1 day)
<i>hydrocodone-acetaminophen</i> (Lorcet Hd Oral Tablet)	1 or 1b*	QL (6 tablets per 1 day)
<i>hydrocodone-acetaminophen</i> (Lorcet Oral Tablet)	1 or 1b*	QL (6 tablets per 1 day)
<i>hydrocodone-acetaminophen</i> (Lorcet Plus Oral Tablet)	1 or 1b*	QL (6 tablets per 1 day)
<i>hydrocodone-acetaminophen</i> (Vicodin Hp Oral Tablet)	1 or 1b*	QL (6 tablets per 1 day)
<b>*OPIOID AGONISTS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>duramorph injection solution</i>	1 or 1b*	QL (6 mL per 1 day)
<i>fentanyl citrate (pf) injection solution</i>	1 or 1b*	
<i>fentanyl citrate (pf) injection solution cartridge</i>	1 or 1b*	
<i>fentanyl citrate buccal lozenge on a handle</i>	2	PA; QL (4 lozenge per 1 day)
<i>fentanyl citrate buccal tablet</i>	2	PA; QL (4 tablet per 1 day)
<i>fentanyl transdermal patch 72 hour</i>	2	PA; QL (15 patches per 30 days)
<i>hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 12 mg, 16 mg, 32 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 8 mg</i>	2	PA; QL (1 tablet per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydromorphone hcl injection solution 1 mg/ml, 2 mg/ml</i>	1 or 1b*	QL (6 mL per 1 day)
<i>hydromorphone hcl injection solution 4 mg/ml</i>	1 or 1b*	QL (2 mL per 1 day)
<i>hydromorphone hcl oral liquid</i>	1 or 1b*	QL (24 mL per 1 day)
<i>hydromorphone hcl oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>hydromorphone hcl pf injection solution</i>	1 or 1b*	QL (1 injection per 30 days)
<i>levorphanol tartrate oral tablet</i>	2	PA; QL (6 tablets per 1 day)
<i>meperidine hcl injection solution</i>	1 or 1b*	QL (4 mL per 1 day)
<i>meperidine hcl oral solution</i>	1 or 1b*	QL (7 days per 1 fill)
<i>meperidine hcl oral tablet 100 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>meperidine hcl oral tablet 50 mg</i>	1 or 1b*	QL (12 tablet per 1 day)
<i>methadone hcl injection solution</i>	1 or 1b*	PA; QL (1 mL per 1 day)
<i>methadone hcl (Methadone Hcl Intensol Oral Concentrate)</i>	1 or 1b*	PA; QL (6 mL per 1 day)
<i>methadone hcl oral concentrate</i>	1 or 1b*	PA; QL (6 mL per 1 day)
<i>methadone hcl oral solution 10 mg/5ml</i>	1 or 1b*	PA; QL (30 mL per 1 day)
<i>methadone hcl oral solution 5 mg/5ml</i>	1 or 1b*	PA; QL (60 mL per 1 day)
<i>methadone hcl oral tablet 10 mg</i>	1 or 1b*	PA; QL (6 tablet per 1 day)
<i>methadone hcl oral tablet 5 mg</i>	1 or 1b*	PA; QL (12 tablet per 1 day)
<i>methadone hcl oral tablet soluble</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>methadone hcl (Methadose Oral Tablet Soluble)</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<i>morphine sulfate microinfusion (Mitigo Injection Solution)</i>	2	QL (2 vials per 30 days)
<i>morphine sulfate (concentrate) oral solution</i>	1 or 1b*	QL (6 mL per 1 day)
<i>morphine sulfate (pf) injection solution</i>	1 or 1b*	QL (6 mL per 1 day)
<i>morphine sulfate (pf) intravenous solution</i>	1 or 1b*	QL (6 mL per 1 day)
<i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 75 mg, 90 mg</i>	2	PA; QL (2 capsules per 1 day)
<i>morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg, 60 mg</i>	2	PA; QL (1 capsule per 1 day)
<i>morphine sulfate er oral capsule extended release 24 hour</i>	2	PA; QL (2 capsules per 1 day)
<i>morphine sulfate er oral tablet extended release 100 mg, 15 mg, 30 mg, 60 mg</i>	2	PA; QL (3 tablet per 1 day)
<i>morphine sulfate er oral tablet extended release 200 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>morphine sulfate intravenous solution 1 mg/ml, 50 mg/ml</i>	1 or 1b*	
<i>morphine sulfate intravenous solution 25 mg/ml</i>	1 or 1b*	QL (4 mL per 1 day)
<i>morphine sulfate oral solution</i>	1 or 1b*	QL (30 mL per 1 day)
<i>morphine sulfate oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>morphine sulfate rectal suppository</i>	1 or 1b*	QL (6 suppositories per 1 day)
<i>oxycodone hcl oral capsule</i>	2	QL (7 days per 1 fill)
<i>oxycodone hcl oral concentrate</i>	2	QL (6 mL per 1 day)
<i>oxycodone hcl oral solution</i>	2	QL (30 mL per 1 day)
<i>oxycodone hcl oral tablet</i>	2	QL (6 tablets per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 20 mg, 40 mg, 5 mg, 7.5 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>oxymorphone hcl er oral tablet extended release 12 hour 30 mg</i>	2	PA; QL (4 tablet per 1 day)
<i>oxymorphone hcl oral tablet 10 mg</i>	2	QL (6 tablet per 1 day)
<i>oxymorphone hcl oral tablet 5 mg</i>	2	QL (6 tablets per 1 day)
<i>remifentanil hcl intravenous solution reconstituted</i>	1 or 1b*	
<i>sufentanil citrate intravenous solution</i>	1 or 1b*	
<i>tramadol hcl er (biphasic) oral tablet extended release 24 hour</i>	2	PA; QL (1 tablet per 1 day)
<i>tramadol hcl er oral capsule extended release 24 hour</i>	2	PA; QL (1 capsule per 1 day)
<i>tramadol hcl er oral tablet extended release 24 hour</i>	2	PA; QL (1 tablet per 1 day)
<i>tramadol hcl oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)
<b>*OPIOID COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>oxycodone-acetaminophen (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 7.5-325 Mg)</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone-acetaminophen (Endocet Oral Tablet 5-325 Mg)</i>	1 or 1b*	QL (6 tablet per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone-acetaminophen oral tablet 5-325 mg</i>	1 or 1b*	QL (6 tablet per 1 day)
<i>oxycodone-aspirin oral tablet</i>	1 or 1b*	QL (6 tablets per 1 day)
<i>oxycodone-ibuprofen oral tablet</i>	1 or 1a*	QL (4 tablets per 1 day)
<b>*OPIOID PARTIAL AGONISTS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>buprenorphine hcl injection solution</i>	2	QL (3 mL per 1 day)
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	1 or 1b*	QL (12 tablets per 90 days)
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	1 or 1b*	QL (3 tablets per 90 days)
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	1 or 1b*	QL (2 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg</i>	1 or 1b*	QL (12 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	1 or 1b*	QL (6 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	1 or 1b*	QL (3 films per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1 or 1b*	QL (3 tablets per 1 day)
<i>buprenorphine transdermal patch weekly</i>	2	PA; QL (1 package per 28 days)
<i>butorphanol tartrate injection solution 1 mg/ml</i>	2	QL (8 mL per 1 day)
<i>butorphanol tartrate injection solution 2 mg/ml</i>	2	QL (4 mL per 1 day)
<i>butorphanol tartrate nasal solution</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>nalbuphine hcl injection solution</i>	2	QL (2 mL per 1 day)
<i>pentazocine-naloxone hcl oral tablet</i>	1 or 1b*	QL (12 tablet per 1 day)
<b>*TRAMADOL COMBINATIONS*** - ARTHRITIS AND PAIN DRUGS</b>		
<i>tramadol-acetaminophen oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANDROGENS-ANABOLIC* - HORMONES</b>		
<b>*ANABOLIC STEROIDS*** - DRUGS FOR MEN</b>		
<i>oxandrolone oral tablet 10 mg</i>	2	
<i>oxandrolone oral tablet 2.5 mg</i>	2	PA
<b>*ANDROGENS*** - DRUGS FOR MEN</b>		
<i>danazol oral capsule</i>	2	
<i>methyltestosterone oral capsule</i>	2	
<i>testosterone cypionate intramuscular solution</i>	1 or 1b*	PA
<i>testosterone enanthate intramuscular solution</i>	1 or 1b*	PA
<i>testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)</i>	2	PA; QL (2 bottle per 30 days)
<i>testosterone transdermal gel 10 mg/act (2%)</i>	2	PA; QL (1 pump per 30 days)
<i>testosterone transdermal gel 12.5 mg/act (1%)</i>	2	PA; QL (1 bottle per 30 days)
<i>testosterone transdermal gel 20.25 mg/1.25gm (1.62%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)</i>	2	PA; QL (1 packet per 1 day)
<i>testosterone transdermal gel 25 mg/2.5gm (1%)</i>	2	PA; QL (2 packet per 1 day)
<i>testosterone transdermal solution</i>	2	PA; QL (1 pump bottle per 30 days)
<b>*ANORECTAL AGENTS* - RECTAL PREPARATIONS</b>		
<b>*INTRARECTAL STEROIDS*** - RECTAL PREPARATIONS</b>		
<i>hydrocortisone (Colocort Rectal Enema)</i>	2	
<i>hydrocortisone rectal enema</i>	1 or 1b*	
<b>*RECTAL ANESTHETIC/STEROIDS*** - RECTAL PREPARATIONS</b>		
<i>hydrocortisone ace-pramoxine rectal cream</i>	1 or 1b*	
<b>*RECTAL STEROIDS*** - RECTAL PREPARATIONS</b>		
<i>hydrocortisone rectal cream</i>	1 or 1b*	
<i>hydrocortisone (Procto-Med Hc Rectal Cream)</i>	1 or 1b*	
<i>hydrocortisone (Procto-Pak Rectal Cream)</i>	1 or 1b*	
<i>hydrocortisone (Proctosol Hc Rectal Cream)</i>	1 or 1b*	
<i>hydrocortisone (Proctozone-Hc Rectal Cream)</i>	1 or 1b*	
<b>*ANTHELMINTICS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTHELMINTICS*** - DRUGS FOR PARASITES</b>		
<i>albendazole oral tablet</i>	1 or 1b*	PA; QL (4 tablets per 1 day)
<i>ivermectin oral tablet</i>	1 or 1b*	
<i>praziquantel oral tablet</i>	2	
<b>*ANTIANGINAL AGENTS* - DRUGS FOR THE HEART</b>		
<b>*ANTIANGINALS-OTHER*** - DRUGS FOR ANGINA</b>		
<i>ranolazine er oral tablet extended release 12 hour</i>	2	
<b>*NITRATES*** - DRUGS FOR ANGINA</b>		
<b>DILATRATE-SR ORAL CAPSULE EXTENDED RELEASE (<i>isosorbide dinitrate</i>)</b>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ISORDIL TITRADOSE ORAL TABLET</b> ( <i>isosorbide dinitrate</i> )	2	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1 or 1b*	
<i>isosorbide dinitrate oral tablet 40 mg</i>	2	
<i>isosorbide mononitrate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>isosorbide mononitrate oral tablet</i>	1 or 1b*	
<i>nitroglycerin</i> (Minitran Transdermal Patch 24 Hour)	1 or 1b*	
<b>NITRO-DUR TRANSDERMAL PATCH 24 HOUR</b> ( <i>nitroglycerin</i> )	2	
<i>nitroglycerin in d5w intravenous solution</i>	1 or 1b*	
<i>nitroglycerin sublingual tablet sublingual</i>	1 or 1b*	
<i>nitroglycerin transdermal patch 24 hour</i>	1 or 1b*	
<i>nitroglycerin translingual solution</i>	2	
<b>NITRO-TIME ORAL CAPSULE EXTENDED RELEASE</b> ( <i>nitroglycerin</i> )	1 or 1b*	
<b>*ANTI-ANXIETY AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTI-ANXIETY AGENTS - MISC.*** - DRUGS FOR ANXIETY</b>		
<i>bupirone hcl oral tablet</i>	1 or 1b*	
<i>droperidol injection solution</i>	1 or 1b*	
<i>hydroxyzine hcl intramuscular solution</i>	1 or 1b*	
<i>hydroxyzine hcl oral syrup</i>	1 or 1b*	
<i>hydroxyzine hcl oral tablet</i>	1 or 1b*	
<i>hydroxyzine pamoate oral capsule</i>	1 or 1a*	
<i>meprobamate oral tablet</i>	1 or 1b*	
<b>*BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>alprazolam er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>alprazolam oral tablet</i>	1 or 1b*	
<i>alprazolam oral tablet dispersible</i>	1 or 1b*	
<i>alprazolam xr oral tablet extended release 24 hour</i>	1 or 1b*	
<i>chlordiazepoxide hcl oral capsule</i>	1 or 1b*	
<i>clorazepate dipotassium oral tablet</i>	1 or 1b*	
<i>diazepam injection solution</i>	1 or 1a*	
<i>diazepam</i> (Diazepam Intensol Oral Concentrate)	1 or 1a*	
<i>diazepam oral concentrate</i>	1 or 1a*	
<i>diazepam oral solution</i>	1 or 1a*	
<i>diazepam oral tablet</i>	1 or 1a*	
<i>lorazepam injection solution</i>	1 or 1b*	
<i>lorazepam</i> (Lorazepam Intensol Oral Concentrate)	1 or 1b*	
<i>lorazepam oral concentrate</i>	1 or 1b*	
<i>lorazepam oral tablet</i>	1 or 1b*	
<i>oxazepam oral capsule</i>	2	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTIARRHYTHMICS* - DRUGS FOR THE HEART</b>		
<b>*ANTIARRHYTHMICS - MISC.*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>adenosine intravenous solution</i>	1 or 1b*	
<b>*ANTIARRHYTHMICS TYPE I-A*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>disopyramide phosphate oral capsule</i>	2	
<b>NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR</b> <i>(disopyramide phosphate)</i>	2	
<i>procainamide hcl injection solution</i>	2	
<i>quinidine gluconate er oral tablet extended release</i>	2	
<i>quinidine sulfate oral tablet</i>	1 or 1a*	
<b>*ANTIARRHYTHMICS TYPE I-B*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>lidocaine hcl (cardiac) intravenous solution prefilled syringe</i>	1 or 1b*	
<i>lidocaine hcl (cardiac) pf intravenous solution prefilled syringe</i>	1 or 1b*	
<i>lidocaine in d5w intravenous solution</i>	1 or 1b*	
<i>mexiletine hcl oral capsule</i>	2	
<b>*ANTIARRHYTHMICS TYPE I-C*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>flecainide acetate oral tablet</i>	2	
<i>propafenone hcl er oral capsule extended release 12 hour</i>	2	
<i>propafenone hcl oral tablet</i>	2	
<b>*ANTIARRHYTHMICS TYPE III*** - DRUGS FOR ABNORMAL HEART RHYTHMS</b>		
<i>amiodarone hcl intravenous solution</i>	1 or 1b*	
<i>amiodarone hcl oral tablet</i>	1 or 1b*	
<i>dofetilide oral capsule</i>	4	
<i>ibutilide fumarate intravenous solution</i>	1 or 1b*	
<i>amiodarone hcl (Pacerone Oral Tablet)</i>	1 or 1b*	
<b>*ANTIASTHMATIC AND BRONCHODILATOR AGENTS* - DRUGS FOR THE LUNGS</b>		
<b>*5-LIPOXYGENASE INHIBITORS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>zileuton er oral tablet extended release 12 hour</i>	2	PA
<b>*ADRENERGIC COMBINATIONS*** - DRUGS FOR ASTHMA/COPD</b>		
<b>ADVAIR HFA INHALATION AEROSOL</b> <i>(fluticasone-salmeterol)</i>	2	QL (1 inhaler per 30 days)
<b>ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED</b> <i>(umeclidinium-vilanterol)</i>	2	QL (1 inhaler per 30 days)
<b>BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED</b> <i>(fluticasone furoate-vilanterol)</i>	2	QL (1 inhaler per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION</b> ( <i>ipratropium-albuterol</i> )	2	QL (2 inhalers per 30 days)
<b>DULERA INHALATION AEROSOL</b> ( <i>mometasone furo-formoterol fum</i> )	2	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated</i>	1 or 1b*	QL (1 package per 30 days)
<i>ipratropium-albuterol inhalation solution</i>	1 or 1b*	
<b>STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION</b> ( <i>tiotropium bromide-olodaterol</i> )	2	QL (1 inhaler per 30 days)
<b>SYMBICORT INHALATION AEROSOL</b> ( <i>budesonide-formoterol fumarate</i> )	2	QL (1 inhaler per 30 days)
<i>fluticasone-salmeterol</i> (Wixela Inhub Inhalation Aerosol Powder Breath Activated)	1 or 1b*	QL (1 package per 30 days)
<b>*ANTI-INFLAMMATORY AGENTS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>cromolyn sodium inhalation nebulization solution</i>	1 or 1b*	
<b>*BETA ADRENERGICS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>albuterol sulfate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>albuterol sulfate hfa inhalation aerosol solution</i>	1 or 1b*	QL (2 inhalers per 30 days)
<i>albuterol sulfate inhalation nebulization solution</i>	1 or 1b*	
<i>albuterol sulfate oral syrup</i>	1 or 1b*	
<i>albuterol sulfate oral tablet</i>	1 or 1b*	
<i>levalbuterol hcl inhalation nebulization solution</i>	2	
<i>metaproterenol sulfate oral syrup</i>	1 or 1a*	
<b>PERFOROMIST INHALATION NEBULIZATION SOLUTION</b> ( <i>formoterol fumarate</i> )	2	QL (120 ML per 30 days)
<b>PROAIR HFA INHALATION AEROSOL SOLUTION</b> ( <i>albuterol sulfate</i> )	2	QL (2 inhalers per 30 days)
<b>PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED</b> ( <i>albuterol sulfate</i> )	2	QL (2 inhalers per 30 days)
<b>SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED</b> ( <i>salmeterol xinafoate</i> )	2	QL (1 inhaler per 30 days)
<i>terbutaline sulfate injection solution</i>	1 or 1b*	
<i>terbutaline sulfate oral tablet</i>	1 or 1b*	
<b>*BRONCHODILATORS - ANTICHOLINERGICS*** - DRUGS FOR ASTHMA/COPD</b>		
<b>ATROVENT HFA INHALATION AEROSOL SOLUTION</b> ( <i>ipratropium bromide hfa</i> )	2	QL (2 inhalers per 30 days)
<i>ipratropium bromide inhalation solution</i>	1 or 1b*	QL (378 ML per 30 days)
<b>SPIRIVA HANDIHALER INHALATION CAPSULE</b> ( <i>tiotropium bromide monohydrate</i> )	2	QL (30 capsules per 30 days)
<b>SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION</b> ( <i>tiotropium bromide monohydrate</i> )	2	QL (1 inhaler per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*LEUKOTRIENE RECEPTOR ANTAGONISTS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>montelukast sodium oral packet</i>	1 or 1b*	QL (1 packet per 1 day)
<i>montelukast sodium oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>montelukast sodium oral tablet chewable</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zafirlukast oral tablet</i>	1 or 1b*	
<b>*STEROID INHALANTS*** - DRUGS FOR ASTHMA/COPD</b>		
<b>ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED</b> ( <i>fluticasone furoate</i> )	2	QL (1 inhaler per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	1 or 1b*	QL (120 ML per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	1 or 1b*	QL (60 ML per 30 days)
<b>FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST, 50 MCG/BLIST</b> ( <i>fluticasone propionate (inhal)</i> )	2	QL (1 inhaler per 30 days)
<b>FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 250 MCG/BLIST</b> ( <i>fluticasone propionate (inhal)</i> )	2	QL (4 inhalers per 30 days)
<b>FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 44 MCG/ACT</b> ( <i>fluticasone propionate hfa</i> )	2	QL (1 inhaler per 30 days)
<b>FLOVENT HFA INHALATION AEROSOL 220 MCG/ACT</b> ( <i>fluticasone propionate hfa</i> )	2	QL (2 inhalers per 30 days)
<b>QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT</b> ( <i>beclomethasone diprop hfa</i> )	2	QL (1 inhaler per 30 days)
<b>QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 80 MCG/ACT</b> ( <i>beclomethasone diprop hfa</i> )	2	QL (2 inhalers per 30 days)
<b>*XANTHINE-EXPECTORANTS*** - DRUGS FOR ASTHMA/COPD</b>		
<i>dyphylline-guaifenesin (Difil-G Forte Oral Liquid)</i>	1 or 1b*	
<b>*XANTHINES*** - DRUGS FOR ASTHMA/COPD</b>		
<i>aminophylline intravenous solution</i>	1 or 1b*	
<b>THEO-24 ORAL CAPSULE EXTENDED RELEASE 24 HOUR</b> ( <i>theophylline</i> )	2	
<i>theophylline er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>theophylline er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>theophylline oral solution</i>	1 or 1b*	
<b>*ANTICOAGULANTS* - DRUGS FOR THE BLOOD</b>		
<b>*COUMARIN ANTICOAGULANTS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>warfarin sodium (Jantoven Oral Tablet)</i>	1 or 1a*	
<i>warfarin sodium oral tablet</i>	1 or 1a*	
<b>*DIRECT FACTOR XA INHIBITORS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<b>ELIQUIS ORAL TABLET 2.5 MG</b> ( <i>apixaban</i> )	2	QL (2 tablets per 1 day)
<b>ELIQUIS ORAL TABLET 5 MG</b> ( <i>apixaban</i> )	2	QL (74 tablets per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELIQUIS STARTER PACK ORAL TABLET ( <i>apixaban</i> )	2	QL (1 pack per 365 days)
XARELTO ORAL TABLET 10 MG, 20 MG ( <i>rivaroxaban</i> )	2	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 15 MG ( <i>rivaroxaban</i> )	2	QL (42 tablet per 1 fill)
XARELTO ORAL TABLET 2.5 MG ( <i>rivaroxaban</i> )	2	QL (2 tablets per 1 day)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK ( <i>rivaroxaban</i> )	2	QL (1 pack per 365 days)
<b>*HEPARINS AND HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>heparin (porcine) in nacl intravenous solution</i>	2	
<i>heparin lock flush intravenous solution</i>	2	
<i>heparin sod (porcine) in d5w intravenous solution</i>	2	
<i>heparin sodium (porcine) injection solution</i>	2	
<i>heparin sodium (porcine) pf injection solution</i>	2	
<i>heparin sodium lock flush intravenous solution</i>	2	
<b>*LOW MOLECULAR WEIGHT HEPARINS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>enoxaparin sodium injection solution</i>	4	QL (30 syringes per 30 days)
<i>enoxaparin sodium subcutaneous solution</i>	4	QL (30 syringes per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML ( <i>dalteparin sodium</i> )	4	QL (20 mL per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML ( <i>dalteparin sodium</i> )	4	QL (20 syringe per 30 days)
FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML ( <i>dalteparin sodium</i> )	4	QL (76 mL per 30 days)
<b>*SYNTHETIC HEPARINOID-LIKE AGENTS*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>fondaparinux sodium subcutaneous solution</i>	4	QL (1 syringe per 1 day)
<b>*THROMBIN INHIBITORS - SELECTIVE DIRECT &amp; REVERSIBLE*** - DRUGS TO PREVENT BLOOD CLOTS</b>		
<i>argatroban intravenous solution</i>	1 or 1b*	
PRADAXA ORAL CAPSULE ( <i>dabigatran etexilate mesylate</i> )	3	QL (2 capsules per 1 day)
<b>*ANTICONSULSANTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTICONSULSANTS - BENZODIAZEPINES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>clobazam oral suspension</i>	2	
<i>clobazam oral tablet</i>	2	
<i>clonazepam oral tablet</i>	1 or 1b*	
<i>clonazepam oral tablet dispersible</i>	1 or 1b*	
<i>diazepam rectal gel</i>	1 or 1b*	QL (5 kits per 25 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTICONVULSANTS - MISC.*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>carbamazepine er oral capsule extended release 12 hour</i>	1 or 1b*	
<i>carbamazepine er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>carbamazepine oral suspension</i>	1 or 1b*	
<i>carbamazepine oral tablet</i>	1 or 1b*	
<i>carbamazepine oral tablet chewable</i>	1 or 1b*	
<i>carbamazepine (Epilex Oral Tablet)</i>	1 or 1b*	
<i>gabapentin oral capsule</i>	2	
<i>gabapentin oral solution</i>	2	
<i>gabapentin oral tablet</i>	2	
<i>lamotrigine er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>lamotrigine oral tablet</i>	1 or 1b*	
<i>lamotrigine oral tablet chewable</i>	1 or 1b*	
<i>lamotrigine oral tablet dispersible</i>	1 or 1b*	
<i>lamotrigine starter kit-blue oral kit</i>	1 or 1b*	
<i>lamotrigine starter kit-green oral kit</i>	1 or 1b*	
<i>lamotrigine starter kit-orange oral kit</i>	1 or 1b*	
<i>levetiracetam er oral tablet extended release 24 hour</i>	2	
<i>levetiracetam intravenous solution</i>	2	
<i>levetiracetam oral solution</i>	2	
<i>levetiracetam oral tablet</i>	2	
<i>oxcarbazepine oral suspension</i>	1 or 1b*	
<i>oxcarbazepine oral tablet</i>	1 or 1b*	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	2	QL (3 capsule per 1 day)
<i>pregabalin oral capsule 225 mg, 300 mg, 75 mg</i>	2	QL (2 capsules per 1 day)
<i>pregabalin oral solution</i>	2	QL (30 mL per 1 day)
<i>primidone oral tablet</i>	1 or 1b*	
<i>levetiracetam (Roweepra Oral Tablet)</i>	2	
<i>levetiracetam (Roweepra Xr Oral Tablet Extended Release 24 Hour)</i>	2	
<i>lamotrigine (Subvenite Oral Tablet)</i>	1 or 1b*	
<i>lamotrigine (Subvenite Starter Kit-Blue Oral Kit)</i>	1 or 1b*	
<i>lamotrigine (Subvenite Starter Kit-Green Oral Kit)</i>	1 or 1b*	
<i>lamotrigine (Subvenite Starter Kit-Orange Oral Kit)</i>	1 or 1b*	
<i>topiramate er oral capsule er 24 hour sprinkle</i>	1 or 1b*	ST
<i>topiramate oral capsule sprinkle</i>	1 or 1b*	
<i>topiramate oral tablet</i>	1 or 1b*	
<i>zonisamide oral capsule</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*CARBAMATES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>felbamate oral suspension</i>	2	
<i>felbamate oral tablet</i>	2	
<b>*GABA MODULATORS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>tiagabine hcl oral tablet</i>	2	
<i>vigabatrin oral packet</i>	4	LD; SP
<i>vigabatrin oral tablet</i>	4	LD; SP
<i>vigabatrin (Vigadrone Oral Packet)</i>	4	LD
<b>*HYDANTOINS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<b>DILANTIN ORAL CAPSULE</b> ( <i>phenytoin sodium extended</i> )	2	
<i>fosphenytoin sodium injection solution</i>	2	
<i>phenytoin (Phenytoin Infatabs Oral Tablet Chewable)</i>	1 or 1b*	
<i>phenytoin oral suspension</i>	1 or 1b*	
<i>phenytoin oral tablet chewable</i>	1 or 1b*	
<i>phenytoin sodium extended oral capsule</i>	1 or 1b*	
<i>phenytoin sodium injection solution</i>	1 or 1b*	
<b>*SUCCINIMIDES*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>ethosuximide oral capsule</i>	1 or 1b*	
<i>ethosuximide oral solution</i>	1 or 1b*	
<b>*VALPROIC ACID*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>divalproex sodium er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>divalproex sodium oral capsule delayed release sprinkle</i>	1 or 1b*	
<i>divalproex sodium oral tablet delayed release</i>	1 or 1b*	
<i>valproate sodium intravenous solution</i>	1 or 1b*	
<i>valproic acid oral capsule</i>	1 or 1b*	
<i>valproic acid oral solution</i>	1 or 1b*	
<b>*ANTIDEPRESSANTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)*** - DRUGS FOR DEPRESSION</b>		
<i>mirtazapine oral tablet</i>	1 or 1b*	
<i>mirtazapine oral tablet dispersible</i>	1 or 1b*	
<b>*ANTIDEPRESSANTS - MISC.*** - DRUGS FOR DEPRESSION</b>		
<i>bupropion hcl er (sr) oral tablet extended release 12 hour</i>	1 or 1b*	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	1 or 1b*	
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg</i>	1 or 1b*	QL (1 tablet per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<i>bupropion hcl oral tablet 100 mg</i>	1 or 1b*	QL (4.5 tablet per 1 day)
<i>bupropion hcl oral tablet 75 mg</i>	1 or 1b*	
<i>maprotiline hcl oral tablet</i>	1 or 1b*	
<b>*MODIFIED CYCLICS**** - DRUGS FOR DEPRESSION</b>		
<i>nefazodone hcl oral tablet</i>	1 or 1b*	
<i>trazodone hcl oral tablet</i>	1 or 1a*	
<b>*MONOAMINE OXIDASE INHIBITORS (MAOIS)**** - DRUGS FOR DEPRESSION</b>		
<i>phenelzine sulfate oral tablet</i>	1 or 1b*	
<i>tranylcypromine sulfate oral tablet</i>	1 or 1b*	
<b>*SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**** - DRUGS FOR DEPRESSION</b>		
<i>citalopram hydrobromide oral solution</i>	1 or 1b*	QL (20 mL per 1 day)
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg</i>	1 or 1b*	
<i>citalopram hydrobromide oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>escitalopram oxalate oral solution</i>	1 or 1b*	QL (20 mL per 1 day)
<i>escitalopram oxalate oral tablet 10 mg, 5 mg</i>	1 or 1b*	
<i>escitalopram oxalate oral tablet 20 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fluoxetine hcl oral capsule 10 mg</i>	1 or 1b*	
<i>fluoxetine hcl oral capsule 20 mg</i>	1 or 1b*	QL (4 capsules per 1 day)
<i>fluoxetine hcl oral capsule 40 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>fluoxetine hcl oral capsule delayed release</i>	1 or 1b*	QL (4 capsules per 28 days)
<i>fluoxetine hcl oral solution</i>	1 or 1b*	QL (20 mL per 1 day)
<i>fluoxetine hcl oral tablet 10 mg</i>	1 or 1b*	
<i>fluoxetine hcl oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<i>fluoxetine hcl oral tablet 60 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fluvoxamine maleate er oral capsule extended release 24 hour</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>fluvoxamine maleate oral tablet 100 mg</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>fluvoxamine maleate oral tablet 25 mg, 50 mg</i>	1 or 1b*	
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg</i>	1 or 1b*	
<i>paroxetine hcl er oral tablet extended release 24 hour 25 mg, 37.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>paroxetine hcl oral tablet 10 mg, 20 mg</i>	1 or 1b*	
<i>paroxetine hcl oral tablet 30 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>paroxetine hcl oral tablet 40 mg</i>	1 or 1b*	QL (1.5 tablet per 1 day)
<i>sertraline hcl oral concentrate</i>	1 or 1b*	QL (10 mL per 1 day)
<i>sertraline hcl oral tablet 100 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>sertraline hcl oral tablet 25 mg, 50 mg</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)*** - DRUGS FOR DEPRESSION</b>		
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg</i>	1 or 1b*	
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 60 mg</i>	2	QL (2 capsules per 1 day)
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	2	
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	2	QL (3 capsule per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg</i>	1 or 1b*	
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>venlafaxine hcl er oral tablet extended release 24 hour 37.5 mg, 75 mg</i>	1 or 1b*	
<i>venlafaxine hcl oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
<b>*TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION</b>		
<i>amitriptyline hcl oral tablet</i>	1 or 1a*	
<i>amoxapine oral tablet</i>	1 or 1b*	
<i>clomipramine hcl oral capsule</i>	1 or 1b*	
<i>desipramine hcl oral tablet</i>	2	
<i>doxepin hcl oral capsule</i>	1 or 1b*	
<i>doxepin hcl oral concentrate</i>	1 or 1b*	
<i>imipramine hcl oral tablet</i>	1 or 1b*	
<i>imipramine pamoate oral capsule</i>	1 or 1b*	
<i>nortriptyline hcl oral capsule</i>	1 or 1b*	
<i>nortriptyline hcl oral solution</i>	1 or 1b*	
<i>protriptyline hcl oral tablet</i>	2	
<i>trimipramine maleate oral capsule</i>	1 or 1b*	
<b>*ANTIDIABETICS* - HORMONES</b>		
<b>*ALPHA-GLUCOSIDASE INHIBITORS*** - DRUGS FOR DIABETES</b>		
<i>acarbose oral tablet</i>	1 or 1b*	
<i>miglitol oral tablet</i>	1 or 1b*	
<b>*ANTIDIABETIC - AMYLIN ANALOGS*** - DRUGS FOR DIABETES</b>		
<b>SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> <i>(pramlintide acetate)</i>	2	
<b>SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> <i>(pramlintide acetate)</i>	2	
<b>*BIGUANIDES*** - DRUGS FOR DIABETES</b>		
<i>metformin hcl er oral tablet extended release 24 hour</i>	1 or 1b*	generic Glucophage XR
<i>metformin hcl oral tablet</i>	1 or 1b*	
<b>*DIABETIC OTHER*** - DRUGS FOR DIABETES</b>		
<b>GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED</b> <i>(glucagon hcl (rdna))</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCAGON EMERGENCY INJECTION KIT ( <i>glucagon (rdna)</i> )	2	
<b>*DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS*** - DRUGS FOR DIABETES</b>		
JANUVIA ORAL TABLET ( <i>sitagliptin phosphate</i> )	2	ST; QL (1 tablet per 1 day)
TRADJENTA ORAL TABLET ( <i>linagliptin</i> )	2	ST
<b>*DIPEPTIDYL PEPTIDASE-4 INHIBITOR-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
JANUMET ORAL TABLET ( <i>sitagliptin-metformin hcl</i> )	2	ST; QL (2 tablets per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ( <i>sitagliptin-metformin hcl</i> )	2	ST; QL (1 tablet per 1 day)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG ( <i>sitagliptin-metformin hcl</i> )	2	ST; QL (2 tablets per 1 day)
JENTADUETO ORAL TABLET ( <i>linagliptin-metformin hcl</i> )	2	ST; QL (2 tablets per 1 day)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ( <i>linagliptin-metformin hcl</i> )	2	ST; QL (2 tablets per 1 day)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ( <i>linagliptin-metformin hcl</i> )	2	ST; QL (1 tablet per 1 day)
<b>*HUMAN INSULIN*** - DRUGS FOR DIABETES</b>		
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR ( <i>insulin lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR ( <i>insulin lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR ( <i>insulin lispro prot &amp; lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION ( <i>insulin lispro prot &amp; lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR ( <i>insulin lispro prot &amp; lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION ( <i>insulin lispro prot &amp; lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION ( <i>insulin lispro</i> )	2	QL (30 mL per 30 days)
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE ( <i>insulin lispro</i> )	2	QL (30 mL per 30 days)
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR ( <i>insulin nph isophane &amp; regular</i> )	2	QL (30 mL per 30 days)
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION ( <i>insulin nph isophane &amp; regular</i> )	2	QL (30 mL per 30 days)
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR ( <i>insulin nph human (isophane)</i> )	2	QL (30 mL per 30 days)
HUMULIN N SUBCUTANEOUS SUSPENSION ( <i>insulin nph human (isophane)</i> )	2	QL (30 mL per 30 days)
HUMULIN R INJECTION SOLUTION ( <i>insulin regular human</i> )	2	QL (30 mL per 30 days)
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION ( <i>insulin regular human</i> )	2	PA; QL (20 mL per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>insulin regular human</i> )	2	PA; QL (18 mL per 30 days)
<i>insulin lispro (1 unit dial) subcutaneous solution pen-injector</i>	2	QL (30 mL per 30 days)
<i>insulin lispro subcutaneous solution</i>	2	QL (30 mL per 30 days)
<b>LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>insulin glargine</i> )	2	QL (30 mL per 30 days)
<b>LANTUS SUBCUTANEOUS SOLUTION</b> ( <i>insulin glargine</i> )	2	QL (30 mL per 30 days)
<b>LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>insulin detemir</i> )	2	QL (30 mL per 30 days)
<b>LEVEMIR SUBCUTANEOUS SOLUTION</b> ( <i>insulin detemir</i> )	2	QL (30 mL per 30 days)
<b>TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>insulin glargine</i> )	2	QL (13.5 mL per 30 days)
<b>TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>insulin glargine</i> )	2	QL (13.5 mL per 30 days)
<b>*INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)*** - DRUGS FOR DIABETES</b>		
<b>BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR</b> ( <i>exenatide</i> )	2	ST; QL (4 vial per 28 days)
<b>BYDUREON SUBCUTANEOUS PEN-INJECTOR</b> ( <i>exenatide</i> )	2	ST; QL (4 vial per 28 days)
<b>BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>exenatide</i> )	2	ST; QL (1 pens per 30 days)
<b>BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>exenatide</i> )	2	ST; QL (1 pens per 30 days)
<b>OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>semaglutide</i> )	2	ST; QL (1 pen per 28 days)
<b>OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>semaglutide</i> )	2	ST; QL (2 pens per 28 days)
<b>TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>dulaglutide</i> )	2	ST; QL (4 pens per 28 days)
<b>VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>liraglutide</i> )	2	ST; QL (1 box per 30 days)
<b>*MEGLITINIDE ANALOGUES*** - DRUGS FOR DIABETES</b>		
<i>nateglinide oral tablet</i>	2	
<i>repaglinide oral tablet</i>	2	
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS*** - DRUGS FOR DIABETES</b>		
<b>JARDIANCE ORAL TABLET</b> ( <i>empagliflozin</i> )	2	ST; QL (1 tablet per 1 day)
<b>*SULFONYLUREA-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>glipizide-metformin hcl oral tablet</i>	1 or 1b*	ST
<i>glyburide-metformin oral tablet</i>	1 or 1b*	ST
<b>*SULFONYLUREAS*** - DRUGS FOR DIABETES</b>		
<i>glimepiride oral tablet</i>	1 or 1b*	ST
<i>glipizide er oral tablet extended release 24 hour</i>	1 or 1a*	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glipizide oral tablet</i>	1 or 1a*	ST
<i>glipizide xl oral tablet extended release 24 hour</i>	1 or 1a*	ST
<i>glyburide micronized oral tablet</i>	1 or 1b*	ST
<i>glyburide oral tablet</i>	1 or 1b*	ST
<i>tolbutamide oral tablet</i>	2	ST
<b>*SULFONYLUREA-THIAZOLIDINEDIONE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>pioglitazone hcl-glimepiride oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<b>*THIAZOLIDINEDIONE-BIGUANIDE COMBINATIONS*** - DRUGS FOR DIABETES</b>		
<i>pioglitazone hcl-metformin hcl oral tablet</i>	1 or 1b*	ST; QL (3 tablets per 1 day)
<b>*THIAZOLIDINEDIONES*** - DRUGS FOR DIABETES</b>		
<i>pioglitazone hcl oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<b>*ANTIDIARRHEALS* - DRUGS FOR THE STOMACH</b>		
<b>*ANTIPERISTALTIC AGENTS*** - DRUGS FOR DIARRHEA</b>		
<i>diphenoxylate-atropine oral liquid</i>	1 or 1b*	
<i>diphenoxylate-atropine oral tablet</i>	1 or 1b*	
<i>loperamide hcl oral capsule</i>	1 or 1b*	
<b>*ANTIDOTES AND SPECIFIC ANTAGONISTS* - DRUGS FOR OVERDOSE OR POISONING</b>		
<b>*ANTIDOTES AND SPECIFIC ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING</b>		
<i>acetylcysteine intravenous solution</i>	2	
<i>fomepizole intravenous solution</i>	1 or 1b*	
<i>methylene blue injection solution</i>	1 or 1b*	
<i>sodium thiosulfate intravenous solution</i>	1 or 1b*	
<b>*ANTIDOTES* - DRUGS FOR OVERDOSE OR POISONING</b>		
<b>*ANTIDOTES - CHELATING AGENTS*** - DRUGS FOR OVERDOSE OR POISONING</b>		
<i>deferasirox oral tablet</i>	4	SP
<i>deferasirox oral tablet soluble</i>	4	PA; SP
<b>*ANTIDOTES*** - DRUGS FOR OVERDOSE OR POISONING</b>		
<i>acetylcysteine intravenous solution</i>	2	
<i>fomepizole intravenous solution</i>	1 or 1b*	
<i>methylene blue injection solution</i>	1 or 1b*	
<i>sodium thiosulfate intravenous solution</i>	1 or 1b*	
<b>*BENZODIAZEPINE ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING</b>		
<i>flumazenil intravenous solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*OPIOID ANTAGONISTS*** - DRUGS FOR OVERDOSE OR POISONING</b>		
<i>naloxone hcl injection solution</i>	1 or 1b*	QL (6 vial per 90 days)
<i>naloxone hcl injection solution cartridge</i>	1 or 1b*	QL (6 syringe per 90 days)
<i>naloxone hcl injection solution prefilled syringe</i>	1 or 1b*	QL (6 syringe per 90 days)
<i>naltrexone hcl oral tablet</i>	1 or 1b*	
<b>NARCAN NASAL LIQUID</b> ( <i>naloxone hcl</i> )	2	QL (6 nasal spray per 90 days)
<b>*ANTIEMETICS* - DRUGS FOR THE STOMACH</b>		
<b>*5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>granisetron hcl intravenous solution</i>	2	
<i>granisetron hcl oral tablet</i>	2	QL (10 tablets per 30 days)
<i>ondansetron hcl injection solution</i>	2	
<i>ondansetron hcl oral solution</i>	2	QL (8 mL per 1 day)
<i>ondansetron hcl oral tablet 24 mg</i>	2	QL (8 tablet per 30 days)
<i>ondansetron hcl oral tablet 4 mg</i>	2	QL (48 tablets per 30 days)
<i>ondansetron hcl oral tablet 8 mg</i>	2	QL (24 tablets per 30 days)
<i>ondansetron oral tablet dispersible 4 mg</i>	2	QL (48 tablets per 30 days)
<i>ondansetron oral tablet dispersible 8 mg</i>	2	QL (24 tablets per 30 days)
<i>palonosetron hcl intravenous solution</i>	2	PA
<i>palonosetron hcl intravenous solution prefilled syringe</i>	2	PA
<b>*ANTIEMETIC COMBINATIONS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>doxylamine-pyridoxine oral tablet delayed release</i>	1 or 1b*	PA; QL (4 tablet per 1 day)
<b>*ANTIEMETICS - ANTICHOLINERGIC*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>meclizine hcl oral tablet</i>	1 or 1a*	
<i>scopolamine transdermal patch 72 hour</i>	1 or 1b*	
<i>trimethobenzamide hcl oral capsule</i>	1 or 1b*	
<b>*ANTIEMETICS - MISCELLANEOUS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>dronabinol oral capsule</i>	2	
<b>*SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS*** - DRUGS FOR VOMITING AND NAUSEA</b>		
<i>aprepitant oral capsule 125 mg</i>	2	QL (5 capsules per 25 days)
<i>aprepitant oral capsule 40 mg</i>	2	QL (1 capsule per 1 fill)
<i>aprepitant oral capsule 80 &amp; 125 mg</i>	2	QL (15 capsules per 25 days)
<i>aprepitant oral capsule 80 mg</i>	2	QL (10 capsules per 25 days)
<i>fosaprepitant dimeglumine intravenous solution reconstituted</i>	2	PA; QL (5 vial per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTIFUNGALS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)*** - DRUGS FOR FUNGUS</b>		
<i>caspofungin acetate intravenous solution reconstituted</i>	2	
<b>*ANTIFUNGALS*** - DRUGS FOR FUNGUS</b>		
<i>amphotericin b intravenous solution reconstituted</i>	2	
<i>flucytosine oral capsule</i>	2	PA
<i>griseofulvin microsize oral suspension</i>	1 or 1b*	
<i>griseofulvin microsize oral tablet</i>	1 or 1b*	
<i>griseofulvin ultramicrosize oral tablet</i>	1 or 1b*	
<i>nystatin oral tablet</i>	1 or 1b*	
<i>terbinafine hcl oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<b>*IMIDAZOLES*** - DRUGS FOR FUNGUS</b>		
<i>ketoconazole oral tablet</i>	1 or 1b*	QL (2 tablets per 1 day)
<b>*TRIAZOLES*** - DRUGS FOR FUNGUS</b>		
<i>fluconazole in sodium chloride intravenous solution</i>	1 or 1b*	
<i>fluconazole oral suspension reconstituted 10 mg/ml</i>	1 or 1b*	QL (40 mL per 1 day)
<i>fluconazole oral suspension reconstituted 40 mg/ml</i>	1 or 1b*	QL (10 mL per 1 day)
<i>fluconazole oral tablet 100 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>fluconazole oral tablet 150 mg, 200 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>fluconazole oral tablet 50 mg</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>itraconazole oral capsule</i>	2	PA; QL (4.2 capsules per 1 day)
<i>itraconazole oral solution</i>	2	PA; QL (20 mL per 1 day)
<i>posaconazole oral tablet delayed release</i>	2	PA; QL (8 tablet per 1 day)
<i>voriconazole intravenous solution reconstituted</i>	2	
<i>voriconazole oral suspension reconstituted</i>	2	PA; QL (10 mL per 1 day)
<i>voriconazole oral tablet 200 mg</i>	2	PA; QL (2 tablets per 1 day)
<i>voriconazole oral tablet 50 mg</i>	2	PA; QL (4 tablet per 1 day)
<b>*ANTI-HISTAMINES* - DRUGS FOR THE LUNGS</b>		
<b>*ANTI-HISTAMINES - ALKYLAMINES*** - DRUGS FOR ALLERGIES</b>		
<i>brompheniramine tannate oral tablet chewable</i>	1 or 1b*	
<i>dexchlorpheniramine maleate oral solution</i>	1 or 1b*	
<b>RYCLORA ORAL SOLUTION (<i>dexchlorpheniramine maleate</i>)</b>	1 or 1b*	
<b>*ANTI-HISTAMINES - ETHANOLAMINES*** - DRUGS FOR ALLERGIES</b>		
<i>carbinoxamine maleate oral solution</i>	1 or 1b*	
<i>carbinoxamine maleate oral tablet</i>	1 or 1b*	
<i>clemastine fumarate oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diphenhydramine hcl injection solution</i>	2	
<b>RYVENT ORAL TABLET</b> ( <i>carbinoxamine maleate</i> )	1 or 1b*	
<b>*ANTIHISTAMINES - NON-SEDATING*** - DRUGS FOR ALLERGIES</b>		
<i>desloratadine oral tablet</i>	3	
<i>desloratadine oral tablet dispersible</i>	3	
<b>*ANTIHISTAMINES - PHENOTHIAZINES*** - DRUGS FOR ALLERGIES</b>		
<i>promethazine hcl</i> (Phenadoz Rectal Suppository)	2	
<i>promethazine hcl injection solution</i>	1 or 1a*	
<i>promethazine hcl oral syrup</i>	1 or 1a*	
<i>promethazine hcl oral tablet</i>	1 or 1a*	
<i>promethazine hcl rectal suppository</i>	2	
<i>promethazine hcl</i> (Promethegan Rectal Suppository)	2	
<b>*ANTIHISTAMINES - PIPERIDINES*** - DRUGS FOR ALLERGIES</b>		
<i>cyproheptadine hcl oral syrup</i>	1 or 1b*	
<i>cyproheptadine hcl oral tablet</i>	1 or 1b*	
<b>*ANTIHYPERLIPIDEMICS* - DRUGS FOR THE HEART</b>		
<b>*BILE ACID SEQUESTRANTS*** - DRUGS FOR CHOLESTEROL</b>		
<i>cholestyramine light oral packet</i>	2	
<i>cholestyramine light oral powder</i>	2	
<i>cholestyramine oral packet</i>	2	QL (6 packets per 1 day)
<i>cholestyramine oral powder</i>	2	QL (54 gm per 1 day)
<i>colesevelam hcl oral packet</i>	2	
<i>colesevelam hcl oral tablet</i>	2	
<i>colestipol hcl oral granules</i>	1 or 1b*	
<i>colestipol hcl oral packet</i>	1 or 1b*	
<i>colestipol hcl oral tablet</i>	1 or 1b*	
<i>cholestyramine light</i> (Prevalite Oral Packet)	2	
<i>cholestyramine light</i> (Prevalite Oral Powder)	2	
<b>WELCHOL ORAL PACKET</b> ( <i>colesevelam hcl</i> )	2	
<b>*FIBRIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL</b>		
<i>fenofibrate micronized oral capsule 130 mg, 43 mg</i>	1 or 1b*	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibrate oral capsule</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>fenofibrate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fenofibric acid oral capsule delayed release</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>gemfibrozil oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*HMG COA REDUCTASE INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	1 or 1b*; \$0	
<i>atorvastatin calcium oral tablet 40 mg</i>	1 or 1b*	
<i>atorvastatin calcium oral tablet 80 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>fluvastatin sodium er oral tablet extended release 24 hour</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>fluvastatin sodium oral capsule</i>	1 or 1b*; \$0	
<i>lovastatin oral tablet 10 mg, 20 mg</i>	1 or 1b*; \$0	
<i>lovastatin oral tablet 40 mg</i>	1 or 1b*; \$0	QL (2 tablets per 1 day)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1 or 1b*; \$0	
<i>pravastatin sodium oral tablet 80 mg</i>	1 or 1b*; \$0	QL (1 tablet per 1 day)
<i>rosuvastatin calcium oral tablet 10 mg, 5 mg</i>	2; \$0	
<i>rosuvastatin calcium oral tablet 20 mg</i>	2	
<i>rosuvastatin calcium oral tablet 40 mg</i>	2	QL (1 tablet per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1 or 1b*; \$0	
<i>simvastatin oral tablet 80 mg</i>	1 or 1b*	PA; QL (1 tablet per 1 day)
<b>*INTEST CHOLEST ABSORP INHIB-HMG COA REDUCTASE INHIB COMB*** - DRUGS FOR CHOLESTEROL</b>		
<i>ezetimibe-simvastatin oral tablet</i>	2	ST; QL (1 tablet per 1 day)
<b>*INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS*** - DRUGS FOR CHOLESTEROL</b>		
<i>ezetimibe oral tablet</i>	2	ST; QL (1 tablet per 1 day)
<b>*NICOTINIC ACID DERIVATIVES*** - DRUGS FOR CHOLESTEROL</b>		
<i>niacin (antihyperlipidemic) oral tablet</i>	1 or 1b*	QL (12 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 750 mg</i>	1 or 1b*	ST; QL (2 tablets per 1 day)
<i>niacin er (antihyperlipidemic) oral tablet extended release 500 mg</i>	1 or 1b*	ST; QL (1 tablet per 1 day)
<b>NIACOR ORAL TABLET</b> ( <i>niacin (antihyperlipidemic)</i> )	1 or 1b*	ST; QL (12 tablets per 1 day)
<b>*ANTIHYPERTENSIVES* - DRUGS FOR THE HEART</b>		
<b>*ACE INHIBITOR &amp; CALCIUM CHANNEL BLOCKER COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine besy-benazepril hcl oral capsule</i>	1 or 1b*	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg</i>	1 or 1b*	
<i>trandolapril-verapamil hcl er oral tablet extended release 2-180 mg, 2-240 mg, 4-240 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<b>*ACE INHIBITORS &amp; THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>benazepril-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>captopril-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>enalapril-hydrochlorothiazide oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fosinopril sodium-hctz oral tablet</i>	1 or 1b*	
<i>lisinopril-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>quinapril-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<b>*ACE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>benazepril hcl oral tablet</i>	1 or 1a*	
<i>captopril oral tablet</i>	1 or 1b*	
<i>enalapril maleate oral tablet</i>	1 or 1b*	
<i>enalaprilat intravenous injectable</i>	1 or 1b*	
<i>fosinopril sodium oral tablet</i>	1 or 1b*	
<i>lisinopril oral tablet</i>	1 or 1a*	
<i>moexipril hcl oral tablet</i>	1 or 1b*	
<i>perindopril erbumine oral tablet</i>	1 or 1b*	
<i>quinapril hcl oral tablet</i>	1 or 1b*	
<i>ramipril oral capsule</i>	1 or 1b*	
<i>trandolapril oral tablet</i>	1 or 1b*	
<b>*ADRENOLYTICS-CENTRAL &amp; THIAZIDE/THIAZIDE-LIKE COMB*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>methyl dopa-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<b>*AGENTS FOR PHEOCHROMOCYTOMA*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>phenoxybenzamine hcl oral capsule</i>	2	PA; QL (12 capsules per 1 day)
<i>phentolamine mesylate injection solution reconstituted</i>	1 or 1b*	
<b>*ANGIOTENSIN II RECEPTOR ANTAG &amp; CA CHANNEL BLOCKER COMB*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate-valsartan oral tablet 5-160 mg</i>	1 or 1b*	
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-olmesartan oral tablet 5-20 mg</i>	1 or 1b*	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 80-10 mg, 80-5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan-amlodipine oral tablet 40-5 mg</i>	1 or 1b*	
<b>*ANGIOTENSIN II RECEPTOR ANTAG &amp; THIAZIDE/THIAZIDE-LIKE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>candesartan cilexetil-hctz oral tablet 32-12.5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>candesartan cilexetil-hctz oral tablet 32-25 mg</i>	1 or 1b*	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg</i>	1 or 1b*	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium-hctz oral tablet 50-12.5 mg</i>	1 or 1b*	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>olmesartan medoxomil-hctz oral tablet 40-12.5 mg, 40-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>telmisartan-hctz oral tablet 40-12.5 mg</i>	1 or 1b*	
<i>telmisartan-hctz oral tablet 80-12.5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan-hctz oral tablet 80-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 80-12.5 mg</i>	1 or 1b*	
<i>valsartan-hydrochlorothiazide oral tablet 160-25 mg, 320-12.5 mg, 320-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<b>*ANGIOTENSIN II RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>candesartan cilexetil oral tablet 32 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>eprosartan mesylate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>irbesartan oral tablet 150 mg, 75 mg</i>	1 or 1b*	
<i>irbesartan oral tablet 300 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium oral tablet 100 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>losartan potassium oral tablet 25 mg, 50 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>olmesartan medoxomil oral tablet 20 mg</i>	1 or 1b*	
<i>olmesartan medoxomil oral tablet 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>olmesartan medoxomil oral tablet 5 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>telmisartan oral tablet 20 mg, 40 mg</i>	1 or 1b*	
<i>telmisartan oral tablet 80 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan oral tablet 160 mg</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>valsartan oral tablet 320 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>valsartan oral tablet 40 mg, 80 mg</i>	1 or 1b*	QL (3 tablet per 1 day)
<b>*ANGIOTENSIN II RECEPTOR ANT-CA CHANNEL BLOCKER-THIAZIDES*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-valsartan-hctz oral tablet 5-160-12.5 mg</i>	1 or 1b*	
<i>olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg</i>	1 or 1b*	
<i>olmesartan-amlodipine-hctz oral tablet 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<b>*ANTIADRENERGICS - CENTRALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>clonidine hcl oral tablet</i>	1 or 1a*	
<i>clonidine transdermal patch weekly</i>	2	
<i>guanfacine hcl oral tablet</i>	1 or 1b*	
<i>methyldopa oral tablet</i>	1 or 1b*	
<b>*ANTIADRENERGICS - PERIPHERALLY ACTING*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>doxazosin mesylate oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prazosin hcl oral capsule</i>	1 or 1b*	
<i>terazosin hcl oral capsule</i>	1 or 1b*	
<b>*BETA BLOCKER &amp; DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>atenolol-chlorthalidone oral tablet</i>	1 or 1b*	
<i>bisoprolol-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>metoprolol-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>propranolol-hctz oral tablet</i>	1 or 1b*	
<b>*DIRECT RENIN INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>aliskiren fumarate oral tablet 150 mg</i>	2	
<i>aliskiren fumarate oral tablet 300 mg</i>	2	QL (1 tablet per 1 day)
<b>*SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>eplerenone oral tablet</i>	2	
<b>*VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>hydralazine hcl injection solution</i>	2	
<i>hydralazine hcl oral tablet</i>	1 or 1b*	
<i>minoxidil oral tablet</i>	1 or 1b*	
<b>*ANTI-INFECTIVE AGENTS - MISC.* - DRUGS FOR INFECTIONS</b>		
<b>*ANTI-INFECTIVE AGENTS - MISC.*** - DRUGS FOR INFECTIONS</b>		
<i>baciiim intramuscular solution reconstituted</i>	2	
<i>bacitracin intramuscular solution reconstituted</i>	2	
<i>metronidazole in nacl intravenous solution</i>	1 or 1b*	
<i>metronidazole oral capsule</i>	1 or 1a*	
<i>metronidazole oral tablet</i>	1 or 1a*	
<b>NEBUPENT INHALATION SOLUTION RECONSTITUTED (pentamidine isethionate)</b>		
<i>pentamidine isethionate inhalation solution reconstituted</i>	2	
<i>pentamidine isethionate injection solution reconstituted</i>	2	
<i>tinidazole oral tablet</i>	1 or 1b*	
<i>trimethoprim oral tablet</i>	1 or 1a*	
<b>*ANTI-INFECTIVE MISC. - COMBINATIONS*** - ANTIBIOTICS</b>		
<i>sulfamethoxazole-trimethoprim intravenous solution</i>	2	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1 or 1a*	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1 or 1a*	
<i>sulfamethoxazole-trimethoprim (Sulfatrim Pediatric Oral Suspension)</i>	1 or 1a*	
<b>*ANTIPROTOZOAL AGENTS*** - DRUGS FOR PARASITES</b>		
<i>atovaquone oral suspension</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*CARBAPENEM COMBINATIONS*** - ANTIBIOTICS</b>		
<i>imipenem-cilastatin intravenous solution reconstituted</i>	2	
<b>*CARBAPENEMS*** - ANTIBIOTICS</b>		
<i>meropenem intravenous solution reconstituted</i>	2	
<b>*CHLORAMPHENICALS*** - ANTIBIOTICS</b>		
<i>chloramphenicol sod succinate intravenous solution reconstituted</i>	2	
<b>*CYCLIC LIPOPEPTIDES*** - ANTIBIOTICS</b>		
<i>daptomycin intravenous solution reconstituted</i>	2	
<b>*LEPROSTATICS*** - ANTIBIOTICS</b>		
<i>dapsone oral tablet</i>	2	
<b>*LINCOSAMIDES*** - ANTIBIOTICS</b>		
<i>clindamycin hcl oral capsule</i>	1 or 1b*	
<i>clindamycin palmitate hcl oral solution reconstituted</i>	1 or 1b*	
<i>clindamycin phosphate in d5w intravenous solution</i>	1 or 1b*	
<i>clindamycin phosphate injection solution</i>	1 or 1b*	
<b>*OXAZOLIDINONES*** - ANTIBIOTICS</b>		
<i>linezolid in sodium chloride intravenous solution</i>	1 or 1b*	
<i>linezolid intravenous solution</i>	1 or 1b*	
<i>linezolid oral suspension reconstituted</i>	1 or 1b*	PA; QL (900 mL per 30 days)
<i>linezolid oral tablet</i>	1 or 1b*	PA; QL (28 tablet per 30 days)
<b>*POLYMYXINS*** - ANTIBIOTICS</b>		
<i>colistimethate sodium (cba) injection solution reconstituted</i>	2	
<i>polymyxin b sulfate injection solution reconstituted</i>	2	
<b>*ANTIMALARIALS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIMALARIAL COMBINATIONS*** - DRUGS FOR PARASITES</b>		
<i>atovaquone-proguanil hcl oral tablet</i>	1 or 1b*	
<b>*ANTIMALARIALS*** - DRUGS FOR PARASITES</b>		
<i>chloroquine phosphate oral tablet</i>	1 or 1a*	
<i>hydroxychloroquine sulfate oral tablet</i>	1 or 1b*	
<i>mefloquine hcl oral tablet</i>	1 or 1b*	
<i>primaquine phosphate oral tablet</i>	1 or 1b*	
<i>quinine sulfate oral capsule</i>	1 or 1b*	PA; QL (60 capsule per 365 days)
<b>*ANTIMYASTHENIC AGENTS* - DRUGS FOR NERVES AND MUSCLES</b>		
<b>*ANTIMYASTHENIC AGENTS*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>neostigmine methylsulfate intravenous solution</i>	1 or 1b*	
<i>pyridostigmine bromide er oral tablet extended release</i>	2	
<i>pyridostigmine bromide oral solution</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pyridostigmine bromide oral tablet</i>	2	
<b>*ANTIMYASTHENIC/CHOLINERGIC AGENTS*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>neostigmine methylsulfate intravenous solution</i>	1 or 1b*	
<i>pyridostigmine bromide er oral tablet extended release</i>	2	
<i>pyridostigmine bromide oral solution</i>	2	
<i>pyridostigmine bromide oral tablet</i>	2	
<b>*ANTIMYASTHENIC/CHOLINERGIC AGENTS* - DRUGS FOR NERVES AND MUSCLES</b>		
<i>neostigmine methylsulfate intravenous solution</i>	1 or 1b*	
<i>pyridostigmine bromide er oral tablet extended release</i>	2	
<i>pyridostigmine bromide oral solution</i>	2	
<i>pyridostigmine bromide oral tablet</i>	2	
<b>*ANTIMYCOBACTERIAL AGENTS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTI TB COMBINATIONS*** - ANTIBIOTICS</b>		
<b>RIFATER ORAL TABLET</b> ( <i>isoniazid-rifamp-pyrazinamide</i> )	2	
<b>*ANTIMYCOBACTERIAL AGENTS*** - ANTIBIOTICS</b>		
<i>cycloserine oral capsule</i>	1 or 1b*	
<i>ethambutol hcl oral tablet</i>	2	
<i>isoniazid injection solution</i>	1 or 1a*	
<i>isoniazid oral syrup</i>	1 or 1a*	
<i>isoniazid oral tablet</i>	1 or 1a*	
<b>PRIFTIN ORAL TABLET</b> ( <i>rifapentine</i> )	2	
<i>pyrazinamide oral tablet</i>	2	
<i>rifabutin oral capsule</i>	2	
<i>rifampin intravenous solution reconstituted</i>	2	
<i>rifampin oral capsule</i>	2	
<b>*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES* - DRUGS FOR CANCER</b>		
<b>*ALKYLATING AGENTS*** - DRUGS FOR CANCER</b>		
<b>MYLERAN ORAL TABLET</b> ( <i>busulfan</i> )	4	
<b>*ANDROGEN BIOSYNTHESIS INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>abiraterone acetate oral tablet</i>	4	PA; SP; QL (4 tablet per 1 day)
<b>ZYTIGA ORAL TABLET</b> ( <i>abiraterone acetate</i> )	4	PA; LD; SP; QL (2 tablets per 1 day)
<b>*ANTIADRENALS*** - DRUGS FOR CANCER</b>		
<b>LYSODREN ORAL TABLET</b> ( <i>mitotane</i> )	4	LD; QL (38 tablet per 1 day)
<b>*ANTIANDROGENS*** - DRUGS FOR CANCER</b>		
<i>bicalutamide oral tablet</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ERLEADA ORAL TABLET</b> ( <i>apalutamide</i> )	4	PA; LD; SP; QL (4 tablets per 1 day)
<i>flutamide oral capsule</i>	2	
<i>nilutamide oral tablet</i>	4	QL (1 tablet per 1 day)
<b>XTANDI ORAL CAPSULE</b> ( <i>enzalutamide</i> )	4	PA; LD; SP; QL (4 capsule per 1 day)
<b>*ANTIESTROGENS*** - DRUGS FOR CANCER</b>		
<b>SOLTAMOX ORAL SOLUTION</b> ( <i>tamoxifen citrate</i> )	2; \$0	
<i>tamoxifen citrate oral tablet</i>	2; \$0	
<i>toremifene citrate oral tablet</i>	4	QL (1 tablet per 1 day)
<b>*ANTIMETABOLITES*** - DRUGS FOR CANCER</b>		
<i>capecitabine oral tablet</i>	4	PA; SP
<i>mercaptopurine oral tablet</i>	2	
<i>methotrexate oral tablet</i>	2	
<i>methotrexate sodium (pf) injection solution</i>	4	
<i>methotrexate sodium injection solution</i>	4	
<i>methotrexate sodium injection solution reconstituted</i>	4	
<i>methotrexate sodium oral tablet</i>	2	
<b>TABLOID ORAL TABLET</b> ( <i>thioguanine</i> )	2	
<b>TREXALL ORAL TABLET</b> ( <i>methotrexate sodium</i> )	2	
<b>*ANTINEOPLASTIC - BRAF KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>TAFINLAR ORAL CAPSULE</b> ( <i>dabrafenib mesylate</i> )	4	PA; LD; SP; QL (4 capsule per 1 day)
<b>ZELBORAF ORAL TABLET</b> ( <i>vemurafenib</i> )	4	PA; LD; SP; QL (8 tablet per 1 day)
<b>*ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>ERIVEDGE ORAL CAPSULE</b> ( <i>vismodegib</i> )	4	PA; LD; SP; QL (1 capsule per 1 day)
<b>*ANTINEOPLASTIC - HISTONE DEACETYLASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>ZOLINZA ORAL CAPSULE</b> ( <i>vorinostat</i> )	4	PA; SP; QL (4 capsule per 1 day)
<b>*ANTINEOPLASTIC - IMMUNOMODULATORS*** - DRUGS FOR CANCER</b>		
<b>POMALYST ORAL CAPSULE 1 MG</b> ( <i>pomalidomide</i> )	4	PA; LD; SP; QL (4 capsule per 1 day)
<b>POMALYST ORAL CAPSULE 2 MG</b> ( <i>pomalidomide</i> )	4	PA; LD; SP; QL (2 capsules per 1 day)
<b>POMALYST ORAL CAPSULE 3 MG, 4 MG</b> ( <i>pomalidomide</i> )	4	PA; LD; SP; QL (1 capsule per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTINEOPLASTIC - MEK INHIBITORS*** - DRUGS FOR CANCER</b>		
MEKINIST ORAL TABLET 0.5 MG ( <i>trametinib dimethyl sulfoxide</i> )	4	PA; LD; SP; QL (3 tablets per 1 day)
MEKINIST ORAL TABLET 2 MG ( <i>trametinib dimethyl sulfoxide</i> )	4	PA; LD; SP; QL (1 tablet per 1 day)
<b>*ANTINEOPLASTIC - MTOR KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
AFINITOR DISPERZ ORAL TABLET SOLUBLE ( <i>everolimus</i> )	4	PA; SP
AFINITOR ORAL TABLET ( <i>everolimus</i> )	4	PA; SP
<i>everolimus oral tablet</i>	4	PA; SP
<b>*ANTINEOPLASTIC - MULTIKINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
NEXAVAR ORAL TABLET ( <i>sorafenib tosylate</i> )	4	PA; LD; SP; QL (4 tablet per 1 day)
STIVARGA ORAL TABLET ( <i>regorafenib</i> )	4	PA; LD; SP; QL (4 tablet per 1 day)
SUTENT ORAL CAPSULE 12.5 MG ( <i>sunitinib malate</i> )	4	PA; SP; QL (3 capsule per 1 day)
SUTENT ORAL CAPSULE 25 MG, 37.5 MG, 50 MG ( <i>sunitinib malate</i> )	4	PA; SP; QL (1 capsule per 1 day)
<b>*ANTINEOPLASTIC - TYROSINE KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
BOSULIF ORAL TABLET 100 MG ( <i>bosutinib</i> )	4	PA; SP; QL (4 tablet per 1 day)
BOSULIF ORAL TABLET 400 MG, 500 MG ( <i>bosutinib</i> )	4	PA; SP; QL (1 tablet per 1 day)
CAPRELSA ORAL TABLET 100 MG ( <i>vandetanib</i> )	4	PA; LD; QL (3 tablet per 1 day)
CAPRELSA ORAL TABLET 300 MG ( <i>vandetanib</i> )	4	PA; LD; QL (1 tablet per 1 day)
COMETRIQ (100 MG DAILY DOSE) ORAL KIT ( <i>cabozantinib s-malate</i> )	4	PA; LD; QL (2 capsules per 1 day)
COMETRIQ (140 MG DAILY DOSE) ORAL KIT ( <i>cabozantinib s-malate</i> )	4	PA; LD; QL (4 capsule per 1 day)
COMETRIQ (60 MG DAILY DOSE) ORAL KIT ( <i>cabozantinib s-malate</i> )	4	PA; LD; QL (3 capsule per 1 day)
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	4	PA; SP; QL (1 tablet per 1 day)
<i>erlotinib hcl oral tablet 25 mg</i>	4	PA; SP; QL (3 tablets per 1 day)
GILOTRIF ORAL TABLET ( <i>afatinib dimaleate</i> )	4	PA; LD; QL (1 tablet per 1 day)
ICLUSIG ORAL TABLET 15 MG ( <i>ponatinib hcl</i> )	4	PA; LD; QL (2 tablets per 1 day)
ICLUSIG ORAL TABLET 45 MG ( <i>ponatinib hcl</i> )	4	PA; LD; QL (1 tablet per 1 day)
<i>imatinib mesylate oral tablet 100 mg</i>	4	PA; SP; QL (8 tablet per 1 day)
<i>imatinib mesylate oral tablet 400 mg</i>	4	PA; SP; QL (2 tablets per 1 day)
INLYTA ORAL TABLET 1 MG ( <i>axitinib</i> )	4	PA; LD; SP; QL (8 tablet per 1 day)
INLYTA ORAL TABLET 5 MG ( <i>axitinib</i> )	4	PA; LD; SP; QL (4 tablet per 1 day)
IRESSA ORAL TABLET ( <i>gefitinib</i> )	4	PA; LD; SP; QL (1 tablet per 1 day)
SPRYCEL ORAL TABLET ( <i>dasatinib</i> )	4	PA; SP; QL (1 tablet per 1 day)
TARCEVA ORAL TABLET 100 MG, 150 MG ( <i>erlotinib hcl</i> )	4	PA; LD; SP; QL (1 tablet per 1 day)
TARCEVA ORAL TABLET 25 MG ( <i>erlotinib hcl</i> )	4	PA; LD; SP; QL (3 tablets per 1 day)
TASIGNA ORAL CAPSULE ( <i>nilotinib hcl</i> )	4	PA; SP; QL (4 capsules per 1 day)
TYKERB ORAL TABLET ( <i>lapatinib ditosylate</i> )	4	PA; LD; SP; QL (6 tablet per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VOTRIENT ORAL TABLET ( <i>pazopanib hcl</i> )	4	PA; LD; SP; QL (4 tablet per 1 day)
XALKORI ORAL CAPSULE ( <i>crizotinib</i> )	4	PA; LD; SP; QL (2 capsules per 1 day)
<b>*ANTINEOPLASTIC COMBINATIONS*** - DRUGS FOR CANCER</b>		
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK ( <i>ribociclib-letrozole</i> )	4	PA; SP; QL (0.04 unit per 1 day)
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK ( <i>ribociclib-letrozole</i> )	4	PA; SP; QL (0.04 unit per 1 day)
KISQALI FEMARA(200 MG DOSE) ORAL TABLET THERAPY PACK ( <i>ribociclib-letrozole</i> )	4	PA; SP; QL (0.04 unit per 1 day)
<b>*ANTINEOPLASTICS MISC.*** - DRUGS FOR CANCER</b>		
ACTIMMUNE SUBCUTANEOUS SOLUTION ( <i>interferon gamma-1b</i> )	4	PA; LD; SP
<i>hydroxyurea oral capsule</i>	2	
INTRON A INJECTION SOLUTION ( <i>interferon alfa-2b</i> )	4	LD; SP
INTRON A INJECTION SOLUTION RECONSTITUTED ( <i>interferon alfa-2b</i> )	4	LD; SP
MATULANE ORAL CAPSULE ( <i>procarbazine hcl</i> )	4	LD
<b>*AROMATASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>anastrozole oral tablet</i>	2	QL (1 tablet per 1 day)
<i>exemestane oral tablet</i>	2	QL (2 tablets per 1 day)
<i>letrozole oral tablet</i>	2	QL (1 tablet per 1 day)
<b>*ESTROGENS-ANTINEOPLASTIC*** - DRUGS FOR CANCER</b>		
EMCYT ORAL CAPSULE ( <i>estramustine phosphate sodium</i> )	4	PA
<b>*FOLIC ACID ANTAGONISTS RESCUE AGENTS*** - DRUGS FOR CANCER</b>		
<i>leucovorin calcium injection solution</i>	4	
<i>leucovorin calcium injection solution reconstituted</i>	1 or 1b*	
<i>leucovorin calcium oral tablet</i>	2	
<b>*GONADOTROPIN RELEASING HORMONE (GNRH) ANTAGONISTS*** - DRUGS FOR CANCER</b>		
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG ( <i>degarelix acetate</i> )	4	PA; SP; QL (2 unit per 365 days)
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG ( <i>degarelix acetate</i> )	4	PA; SP; QL (1 kit per 28 days)
<b>*IMIDAZOTETRAZINES*** - DRUGS FOR CANCER</b>		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 250 mg</i>	4	PA; SP; QL (2 capsules per 1 day)
<i>temozolomide oral capsule 20 mg</i>	4	PA; SP; QL (4 capsule per 1 day)
<i>temozolomide oral capsule 5 mg</i>	4	PA; SP; QL (3 capsule per 1 day)
<b>*JANUS ASSOCIATED KINASE (JAK) INHIBITORS*** - DRUGS FOR CANCER</b>		
JAKAFI ORAL TABLET 10 MG ( <i>ruxolitinib phosphate</i> )	4	PA; LD; SP; QL (5 tablet per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JAKAFI ORAL TABLET 15 MG ( <i>ruxolitinib phosphate</i> )	4	PA; LD; SP; QL (100 tablets per 30 days)
JAKAFI ORAL TABLET 20 MG ( <i>ruxolitinib phosphate</i> )	4	PA; LD; SP; QL (2.5 tablet per 1 day)
JAKAFI ORAL TABLET 25 MG ( <i>ruxolitinib phosphate</i> )	4	PA; LD; SP; QL (2 tablets per 1 day)
JAKAFI ORAL TABLET 5 MG ( <i>ruxolitinib phosphate</i> )	4	PA; LD; SP; QL (10 tablet per 1 day)
<b>*LHRH ANALOGS*** - DRUGS FOR CANCER</b>		
<i>leuprolide acetate injection kit</i>	4	PA; SP
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG ( <i>triptorelin pamoate</i> )	4	PA; SP; QL (1 vial per 84 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 22.5 MG ( <i>triptorelin pamoate</i> )	4	PA; SP; QL (1 syringe per 168 days)
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 3.75 MG ( <i>triptorelin pamoate</i> )	4	PA; SP; QL (1 kit per 28 days)
<b>*MITOTIC INHIBITORS*** - DRUGS FOR CANCER</b>		
<i>etoposide oral capsule</i>	4	SP
<b>*NITROGEN MUSTARDS*** - DRUGS FOR CANCER</b>		
<i>cyclophosphamide oral capsule</i>	4	SP
LEUKERAN ORAL TABLET ( <i>chlorambucil</i> )	2	
<i>melphalan oral tablet</i>	4	SP
<b>*PROGESTINS-ANTINEOPLASTIC*** - DRUGS FOR CANCER</b>		
<i>hydroxyprogesterone caproate intramuscular solution</i>	1 or 1b*	
<i>megestrol acetate oral suspension</i>	1 or 1b*	
<i>megestrol acetate oral tablet</i>	1 or 1b*	
<b>*RETINOIDS*** - DRUGS FOR CANCER</b>		
<i>tretinoin oral capsule</i>	2	
<b>*SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR CANCER</b>		
<i>bexarotene oral capsule</i>	4	PA; SP; QL (10 capsules per 1 day)
<b>*TOPOISOMERASE I INHIBITORS*** - DRUGS FOR CANCER</b>		
HYCAMTIN ORAL CAPSULE ( <i>topotecan hcl</i> )	4	PA; SP
<b>*URINARY TRACT PROTECTIVE AGENTS*** - DRUGS FOR CANCER</b>		
<i>mesna intravenous solution</i>	1 or 1b*	PA
<b>*ANTIPARKINSON AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTIPARKINSON ANTICHOLINERGICS*** - DRUGS FOR PARKINSON</b>		
<i>benztropine mesylate injection solution</i>	1 or 1a*	
<i>benztropine mesylate oral tablet</i>	1 or 1a*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>trihexyphenidyl hcl oral solution</i>	1 or 1a*	
<i>trihexyphenidyl hcl oral tablet</i>	1 or 1a*	
<b>*ANTIPARKINSON DOPAMINERGICS*** - DRUGS FOR PARKINSON</b>		
<i>amantadine hcl oral capsule</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>amantadine hcl oral syrup</i>	1 or 1b*	
<i>amantadine hcl oral tablet</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>bromocriptine mesylate oral capsule</i>	1 or 1b*	
<i>bromocriptine mesylate oral tablet</i>	1 or 1b*	
<b>*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>rasagiline mesylate oral tablet</i>	2	
<i>selegiline hcl oral capsule</i>	2	
<i>selegiline hcl oral tablet</i>	2	
<b>*CENTRAL/PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>tolcapone oral tablet</i>	2	PA; QL (6 tablet per 1 day)
<b>*DECARBOXYLASE INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>carbidopa oral tablet</i>	2	
<b>*LEVODOPA COMBINATIONS*** - DRUGS FOR PARKINSON</b>		
<i>carbidopa-levodopa er oral tablet extended release</i>	2	
<i>carbidopa-levodopa oral tablet</i>	1 or 1b*	
<i>carbidopa-levodopa oral tablet dispersible</i>	2	
<i>carbidopa-levodopa-entacapone oral tablet</i>	2	
<b>*NONERGOLINE DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR PARKINSON</b>		
<i>pramipexole dihydrochloride er oral tablet extended release 24 hour</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>pramipexole dihydrochloride oral tablet</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>ropinirole hcl er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>ropinirole hcl oral tablet</i>	1 or 1b*	
<b>*PERIPHERAL COMT INHIBITORS*** - DRUGS FOR PARKINSON</b>		
<i>entacapone oral tablet</i>	2	QL (8 tablet per 1 day)
<b>*ANTIPSYCHOTICS/ANTIMANIC AGENTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ANTIMANIC AGENTS*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>lithium carbonate er oral tablet extended release</i>	1 or 1a*	
<i>lithium carbonate oral capsule</i>	1 or 1a*	
<i>lithium carbonate oral tablet</i>	1 or 1a*	
<i>lithium oral solution</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTIPSYCHOTICS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<b>GEODON INTRAMUSCULAR SOLUTION RECONSTITUTED</b> (ziprasidone mesylate)	2	
ziprasidone hcl oral capsule	2	
<b>*BENZISOXAZOLES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
paliperidone er oral tablet extended release 24 hour	2	
<b>RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER</b> (risperidone microspheres)	2	
risperidone oral solution	1 or 1b*	ST
risperidone oral tablet	1 or 1b*	
risperidone oral tablet dispersible	2	
<b>*BUTYROPHENONES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
haloperidol decanoate intramuscular solution	1 or 1b*	
haloperidol lactate injection solution	1 or 1b*	
haloperidol lactate oral concentrate	1 or 1b*	
haloperidol oral tablet	1 or 1b*	
<b>*DIBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
clozapine oral tablet	2	
clozapine oral tablet dispersible	2	
<b>*DIBENZOTHIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
quetiapine fumarate er oral tablet extended release 24 hour	2	
quetiapine fumarate oral tablet	2	
<b>*DIBENZOXAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
loxapine succinate oral capsule	1 or 1b*	
<b>*DIHYDROINDOLONES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
molindone hcl oral tablet	2	
<b>*PHENOTHIAZINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
chlorpromazine hcl oral tablet	1 or 1b*	
prochlorperazine (Compro Rectal Suppository)	1 or 1b*	
fluphenazine decanoate injection solution	1 or 1b*	
fluphenazine hcl injection solution	1 or 1b*	
fluphenazine hcl oral concentrate	1 or 1b*	
fluphenazine hcl oral elixir	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluphenazine hcl oral tablet</i>	1 or 1b*	
<i>perphenazine oral tablet</i>	1 or 1b*	
<i>prochlorperazine edisylate injection solution</i>	1 or 1b*	
<i>prochlorperazine maleate oral tablet</i>	1 or 1a*	
<i>prochlorperazine rectal suppository</i>	1 or 1b*	
<i>thioridazine hcl oral tablet</i>	1 or 1b*	
<i>trifluoperazine hcl oral tablet</i>	1 or 1b*	
<b>*QUINOLINONE DERIVATIVES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>aripiprazole oral solution</i>	2	
<i>aripiprazole oral tablet</i>	2	
<i>aripiprazole oral tablet dispersible</i>	2	
<b>*THIENBENZODIAZEPINES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>olanzapine intramuscular solution reconstituted</i>	2	
<i>olanzapine oral tablet</i>	2	
<i>olanzapine oral tablet dispersible</i>	2	
<b>*THIOXANTHENES*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>thiothixene oral capsule</i>	1 or 1b*	
<b>*ANTIVIRALS* - DRUGS FOR INFECTIONS</b>		
<b>*ANTIRETROVIRAL COMBINATIONS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>abacavir sulfate-lamivudine oral tablet</i>	2	
<i>abacavir-lamivudine-zidovudine oral tablet</i>	2	
<b>BIKTARVY ORAL TABLET</b> ( <i>bictegravir-emtricitab-tenofovir</i> )	4	
<b>CIMDUO ORAL TABLET</b> ( <i>lamivudine-tenofovir</i> )	4	
<b>DESCOVY ORAL TABLET</b> ( <i>emtricitabine-tenofovir af</i> )	4	ST
<b>GENVOYA ORAL TABLET</b> ( <i>elviteg-cobic-emtricit-tenofaf</i> )	4	
<b>KALETRA ORAL TABLET</b> ( <i>lopinavir-ritonavir</i> )	4	
<i>lamivudine-zidovudine oral tablet</i>	2	
<i>lopinavir-ritonavir oral solution</i>	4	
<b>STRIBILD ORAL TABLET</b> ( <i>elviteg-cobic-emtricit-tenofdf</i> )	4	
<b>SYMFI LO ORAL TABLET</b> ( <i>efavirenz-lamivudine-tenofovir</i> )	4	
<b>SYMFI ORAL TABLET</b> ( <i>efavirenz-lamivudine-tenofovir</i> )	4	
<b>TEMIXYS ORAL TABLET</b> ( <i>lamivudine-tenofovir</i> )	4	
<b>TRIUMEQ ORAL TABLET</b> ( <i>abacavir-dolutegravir-lamivud</i> )	4	
<b>TRUVADA ORAL TABLET</b> ( <i>emtricitabine-tenofovir df</i> )	4	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTIRETROVIRALS - CCR5 ANTAGONISTS (ENTRY INHIBITOR)*** - DRUGS FOR VIRAL INFECTIONS</b>		
SELZENTRY ORAL TABLET ( <i>maraviroc</i> )	4	
<b>*ANTIRETROVIRALS - FUSION INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED ( <i>enfuvirtide</i> )	4	
<b>*ANTIRETROVIRALS - INTEGRASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
ISENTRESS ORAL TABLET ( <i>raltegravir potassium</i> )	4	
ISENTRESS ORAL TABLET CHEWABLE ( <i>raltegravir potassium</i> )	4	
TIVICAY ORAL TABLET ( <i>dolutegravir sodium</i> )	4	
<b>*ANTIRETROVIRALS - PROTEASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
APTIVUS ORAL CAPSULE ( <i>tipranavir</i> )	4	
APTIVUS ORAL SOLUTION ( <i>tipranavir</i> )	4	
<i>atazanavir sulfate oral capsule</i>	4	
<i>fosamprenavir calcium oral tablet</i>	4	
NORVIR ORAL SOLUTION ( <i>ritonavir</i> )	4	
PREZISTA ORAL SUSPENSION ( <i>darunavir ethanolate</i> )	4	
PREZISTA ORAL TABLET ( <i>darunavir ethanolate</i> )	4	
REYATAZ ORAL PACKET ( <i>atazanavir sulfate</i> )	4	
<i>ritonavir oral tablet</i>	4	
<b>*ANTIRETROVIRALS - RTI-NON-NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
EDURANT ORAL TABLET ( <i>rilpivirine hcl</i> )	4	
<i>efavirenz oral capsule</i>	4	
<i>efavirenz oral tablet</i>	4	
INTELENCE ORAL TABLET ( <i>etravirine</i> )	4	
<i>nevirapine er oral tablet extended release 24 hour</i>	4	
<i>nevirapine oral suspension</i>	4	
<i>nevirapine oral tablet</i>	4	
<b>*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PURINES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>abacavir sulfate oral solution</i>	4	
<i>abacavir sulfate oral tablet</i>	4	
<i>didanosine oral capsule delayed release</i>	4	
<b>*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-PYRIMIDINES*** - DRUGS FOR VIRAL INFECTIONS</b>		
EMTRIVA ORAL CAPSULE ( <i>emtricitabine</i> )	4	
EMTRIVA ORAL SOLUTION ( <i>emtricitabine</i> )	4	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamivudine oral tablet</i>	4	
<b>*ANTIRETROVIRALS - RTI-NUCLEOSIDE ANALOGUES-THYMIDINES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>stavudine oral capsule</i>	4	
<i>zidovudine oral capsule</i>	4	
<i>zidovudine oral syrup</i>	4	
<i>zidovudine oral tablet</i>	4	
<b>*ANTIRETROVIRALS - RTI-NUCLEOTIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>tenofovir disoproxil fumarate oral tablet</i>	4	
<b>VIREAD ORAL TABLET</b> ( <i>tenofovir disoproxil fumarate</i> )	4	
<b>*CMV AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>valganciclovir hcl oral solution reconstituted</i>	4	
<i>valganciclovir hcl oral tablet</i>	4	
<b>*HEPATITIS B AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>adefovir dipivoxil oral tablet</i>	4	SP
<b>BARACLUDE ORAL SOLUTION</b> ( <i>entecavir</i> )	4	
<i>entecavir oral tablet</i>	4	
<b>*HEPATITIS C AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>ribavirin oral capsule</i>	4	SP
<i>ribavirin oral tablet</i>	4	SP
<b>*HERPES AGENTS - PURINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>acyclovir oral capsule</i>	1 or 1b*	
<i>acyclovir oral suspension</i>	1 or 1b*	
<i>acyclovir oral tablet</i>	1 or 1b*	
<i>acyclovir sodium intravenous solution</i>	1 or 1b*	
<i>valacyclovir hcl oral tablet</i>	1 or 1b*	
<b>*HERPES AGENTS - THYMIDINE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>famciclovir oral tablet</i>	1 or 1b*	
<b>*INFLUENZA AGENTS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>rimantadine hcl oral tablet</i>	1 or 1b*	
<b>*NEURAMINIDASE INHIBITORS*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>oseltamivir phosphate oral capsule 30 mg</i>	1 or 1b*	QL (20 capsule per 90 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	1 or 1b*	QL (10 capsule per 90 days)
<i>oseltamivir phosphate oral suspension reconstituted</i>	1 or 1b*	QL (20 ML per 90 days)
<b>RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED</b> ( <i>zanamivir</i> )	2	QL (1 package per 90 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*RSV AGENTS - NUCLEOSIDE ANALOGUES*** - DRUGS FOR VIRAL INFECTIONS</b>		
<i>ribavirin inhalation solution reconstituted</i>	2	
<b>*ASSORTED CLASSES* - VITAMINS AND MINERALS</b>		
<b>*ANTILEPTOTICS*** - VITAMINS AND MINERALS</b>		
<b>THALOMID ORAL CAPSULE 100 MG, 50 MG</b> ( <i>thalidomide</i> )	4	PA; SP; QL (1 capsule per 1 day)
<b>THALOMID ORAL CAPSULE 150 MG, 200 MG</b> ( <i>thalidomide</i> )	4	PA; SP; QL (2 capsules per 1 day)
<b>*CHELATING AGENTS*** - VITAMINS AND MINERALS</b>		
<i>trientine hcl</i> (Clovique Oral Capsule)	4	PA; SP
<i>penicillamine oral capsule</i>	2	PA
<i>trientine hcl oral capsule</i>	4	PA; SP
<b>*CYCLOSPORINE ANALOGS*** - VITAMINS AND MINERALS</b>		
<i>cyclosporine modified oral capsule</i>	4	
<i>cyclosporine modified oral solution</i>	4	
<i>cyclosporine oral capsule</i>	4	
<i>cyclosporine modified</i> (Gengraf Oral Capsule)	4	
<i>cyclosporine modified</i> (Gengraf Oral Solution)	4	
<b>*IMMUNOMODULATORS FOR MYELODYSPLASTIC SYNDROMES*** - VITAMINS AND MINERALS</b>		
<b>REVLIMID ORAL CAPSULE</b> ( <i>lenalidomide</i> )	4	PA; LD; SP; QL (1 capsule per 1 day)
<b>*INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS*** - VITAMINS AND MINERALS</b>		
<i>mycophenolate mofetil oral capsule</i>	4	
<i>mycophenolate mofetil oral suspension reconstituted</i>	4	
<i>mycophenolate mofetil oral tablet</i>	4	
<i>mycophenolate sodium oral tablet delayed release</i>	4	
<b>*IRRIGATION SOLUTIONS*** - VITAMINS AND MINERALS</b>		
<i>lactated ringers irrigation solution</i>	1 or 1b*	
<i>irrigation solns physiological</i> (Physiolyte Irrigation Solution)	1 or 1b*	
<i>irrigation solns physiological</i> (Physiosol Irrigation Irrigation Solution)	1 or 1b*	
<i>ringers irrigation irrigation solution</i>	1 or 1b*	
<i>sterile water for irrigation irrigation solution</i>	1 or 1b*	
<i>ringers irrigation</i> (Tis-U-Sol Irrigation Solution)	1 or 1b*	
<i>water for irrigation, sterile irrigation solution</i>	1 or 1b*	
<b>*MACROLIDE IMMUNOSUPPRESSANTS*** - VITAMINS AND MINERALS</b>		
<i>sirolimus oral solution</i>	4	
<i>sirolimus oral tablet</i>	4	
<i>tacrolimus oral capsule</i>	4	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ZORTRESS ORAL TABLET</b> ( <i>everolimus</i> )	4	
<b>*POTASSIUM REMOVING RESINS*** - VITAMINS AND MINERALS</b>		
<i>sodium polystyrene sulfonate</i> (Kionex Oral Suspension)	2	
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sodium polystyrene sulfonate oral suspension</i>	2	
<i>sodium polystyrene sulfonate rectal suspension 30 gm/120ml</i>	2	
<i>sodium polystyrene sulfonate rectal suspension 50 gm/200ml</i>	1 or 1b*	
<i>sodium polystyrene sulfonate</i> (Sps Oral Suspension)	2	
<b>*PROSTAGLANDINS*** - VITAMINS AND MINERALS</b>		
<i>alprostadil injection solution</i>	1 or 1b*	
<b>*PURINE ANALOGS*** - VITAMINS AND MINERALS</b>		
<b>AZASAN ORAL TABLET</b> ( <i>azathioprine</i> )	2	
<i>azathioprine oral tablet</i>	1 or 1b*	
<b>*SCLEROSING AGENTS*** - VITAMINS AND MINERALS</b>		
<i>sodium tetradecyl sulfate intravenous solution</i>	2	
<i>sodium tetradecyl sulfate</i> (Sotradecol Intravenous Solution)	2	
<b>*BETA BLOCKERS* - DRUGS FOR THE HEART</b>		
<b>*ALPHA-BETA BLOCKERS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>carvedilol oral tablet</i>	1 or 1b*	
<i>carvedilol phosphate er oral capsule extended release 24 hour</i>	2	
<i>labetalol hcl intravenous solution</i>	1 or 1b*	
<i>labetalol hcl oral tablet</i>	1 or 1b*	
<b>*BETA BLOCKERS CARDIO-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>acebutolol hcl oral capsule</i>	1 or 1b*	
<i>atenolol oral tablet</i>	1 or 1a*	
<i>betaxolol hcl oral tablet</i>	1 or 1b*	
<i>bisoprolol fumarate oral tablet</i>	1 or 1b*	
<b>BYSTOLIC ORAL TABLET</b> ( <i>nebivolol hcl</i> )	3	
<i>esmolol hcl intravenous solution</i>	1 or 1b*	
<i>metoprolol succinate er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>metoprolol tartrate intravenous solution</i>	1 or 1a*	
<i>metoprolol tartrate intravenous solution cartridge</i>	1 or 1a*	
<i>metoprolol tartrate oral tablet</i>	1 or 1a*	
<b>*BETA BLOCKERS NON-SELECTIVE*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>nadolol oral tablet</i>	2	
<i>pindolol oral tablet</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>propranolol hcl er oral capsule extended release 24 hour</i>	1 or 1b*	
<i>propranolol hcl intravenous solution</i>	1 or 1b*	
<i>propranolol hcl oral solution</i>	1 or 1b*	
<i>propranolol hcl oral tablet</i>	1 or 1b*	
<i>sotalol hcl (Sorine Oral Tablet)</i>	2	
<i>sotalol hcl (af) oral tablet</i>	2	
<i>sotalol hcl oral tablet</i>	2	
<i>sotalol hydrochloride oral tablet</i>	2	
<i>timolol maleate oral tablet</i>	1 or 1b*	
<b>*CALCIUM CHANNEL BLOCKERS* - DRUGS FOR THE HEART</b>		
<b>*CALCIUM CHANNEL BLOCKERS**** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amlodipine besylate oral tablet 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine besylate oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	
<i>diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg)</i>	1 or 1b*	
<i>diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 240 Mg, 300 Mg)</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg</i>	1 or 1b*	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 240 mg, 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg</i>	1 or 1b*	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg, 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er coated beads oral tablet extended release 24 hour 180 mg</i>	1 or 1b*	
<i>diltiazem hcl er coated beads oral tablet extended release 24 hour 240 mg, 300 mg, 360 mg, 420 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>diltiazem hcl er oral capsule extended release 12 hour</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>diltiazem hcl intravenous solution</i>	1 or 1b*	
<i>diltiazem hcl oral tablet 120 mg</i>	1 or 1b*	QL (3 tablet per 1 day)
<i>diltiazem hcl oral tablet 30 mg, 60 mg, 90 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg</i>	1 or 1b*	
<i>dilt-xr oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>felodipine er oral tablet extended release 24 hour 10 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>felodipine er oral tablet extended release 24 hour 2.5 mg, 5 mg</i>	1 or 1b*	
<i>isradipine oral capsule 2.5 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>isradipine oral capsule 5 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>diltiazem hcl coated beads (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg)</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl coated beads</i> (Matzim La Oral Tablet Extended Release 24 Hour 240 Mg, 300 Mg, 360 Mg, 420 Mg)	1 or 1b*	QL (1 tablet per 1 day)
<i>nicardipine hcl intravenous solution</i>	1 or 1b*	
<i>nicardipine hcl oral capsule 20 mg</i>	1 or 1b*	QL (6 capsule per 1 day)
<i>nicardipine hcl oral capsule 30 mg</i>	1 or 1b*	QL (4 capsule per 1 day)
<i>nifedipine er oral tablet extended release 24 hour 30 mg</i>	2	
<i>nifedipine er oral tablet extended release 24 hour 60 mg, 90 mg</i>	2	QL (1 tablet per 1 day)
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg</i>	2	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 60 mg, 90 mg</i>	2	QL (1 tablet per 1 day)
<i>nifedipine oral capsule</i>	2	QL (4 capsule per 1 day)
<i>nimodipine oral capsule</i>	2	QL (12 capsule per 1 day)
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 8.5 mg</i>	1 or 1b*	
<i>nisoldipine er oral tablet extended release 24 hour 25.5 mg, 30 mg, 34 mg, 40 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>diltiazem hcl er beads</i> (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg)	1 or 1b*	
<i>diltiazem hcl er beads</i> (Taztia Xt Oral Capsule Extended Release 24 Hour 240 Mg, 300 Mg, 360 Mg)	1 or 1b*	QL (1 capsule per 1 day)
<i>diltiazem hcl er beads</i> (Tiadylt Er Oral Capsule Extended Release 24 Hour)	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg</i>	1 or 1b*	
<i>verapamil hcl er oral capsule extended release 24 hour 200 mg, 300 mg, 360 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<i>verapamil hcl er oral capsule extended release 24 hour 240 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>verapamil hcl er oral tablet extended release</i>	1 or 1b*	QL (2 tablets per 1 day)
<i>verapamil hcl intravenous solution</i>	1 or 1b*	
<i>verapamil hcl oral tablet 120 mg, 80 mg</i>	1 or 1b*	QL (4 tablet per 1 day)
<i>verapamil hcl oral tablet 40 mg</i>	1 or 1b*	QL (3 tablet per 1 day)
<b>*CARDIOTONICS* - DRUGS FOR THE HEART</b>		
<b>*CARDIAC GLYCOSIDES*** - DRUGS FOR THE HEART</b>		
<i>digoxin</i> (Digitek Oral Tablet)	1 or 1b*	
<i>digoxin</i> (Digox Oral Tablet)	1 or 1b*	
<i>digoxin injection solution</i>	1 or 1b*	
<i>digoxin oral solution</i>	1 or 1b*	
<i>digoxin oral tablet</i>	1 or 1b*	
<b>LANOXIN ORAL TABLET</b> ( <i>digoxin</i> )	2	
<b>LANOXIN PEDIATRIC INJECTION SOLUTION</b> ( <i>digoxin</i> )	2	
<b>*PHOSPHODIESTERASE INHIBITORS*** - DRUGS FOR THE HEART</b>		
<i>milrinone lactate in dextrose intravenous solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>milrinone lactate intravenous solution</i>	1 or 1b*	
<b>*CARDIOVASCULAR AGENTS - MISC.* - DRUGS FOR THE HEART</b>		
<b>*CALCIUM CHANNEL BLOCKER &amp; HMG COA REDUCTASE INHIBIT COMB*** - DRUGS FOR CHOLESTEROL</b>		
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 5-80 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1 or 1b*	
<b>*NITRATE &amp; VASODILATOR COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<b>BIDIL ORAL TABLET</b> ( <i>isosorb dinitrate-hydralazine</i> )	2	
<b>*PERIPHERAL VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>papaverine hcl injection solution</i>	1 or 1b*	
<b>*PROSTAGLANDIN VASODILATORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>treprostinil injection solution</i>	4	PA; LD; SP
<b>VENTAVIS INHALATION SOLUTION</b> ( <i>iloprost</i> )	4	PA; LD; SP; QL (9 mL per 1 day)
<b>*PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>ambrisentan oral tablet</i>	4	PA; LD; SP; QL (1 tablet per 1 day)
<i>bosentan oral tablet</i>	4	PA; SP; QL (2 tablets per 1 day)
<b>LETAIRIS ORAL TABLET</b> ( <i>ambrisentan</i> )	4	PA; LD; SP; QL (1 tablet per 1 day)
<b>TRACLEER ORAL TABLET</b> ( <i>bosentan</i> )	4	PA; LD; SP; QL (2 tablets per 1 day)
<b>TRACLEER ORAL TABLET SOLUBLE</b> ( <i>bosentan</i> )	4	PA; LD; SP; QL (2 tablets per 1 day)
<b>*PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>tadalafil (pah)</i> (Alyq Oral Tablet)	4	PA; SP; QL (2 tablets per 1 day)
<i>sildenafil citrate oral suspension reconstituted</i>	4	PA; SP; QL (6 mL per 1 day)
<i>sildenafil citrate oral tablet</i>	4	PA; SP; QL (3 tablets per 1 day)
<i>tadalafil (pah) oral tablet</i>	4	PA; SP; QL (2 tablets per 1 day)
<b>*SELECTIVE CGMP PHOSPHODIESTERASE TYPE 5 INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>sildenafil citrate oral tablet</i>	1 or 1b*	PA
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1 or 1b*	PA
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1 or 1b*	PA; QL (30 tablets per 30 days)
<i>vardenafil hcl oral tablet</i>	1 or 1b*	PA
<i>vardenafil hcl oral tablet dispersible</i>	1 or 1b*	PA

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*CEPHALOSPORINS* - DRUGS FOR INFECTIONS</b>		
<b>*CEPHALOSPORINS - 1ST GENERATION*** - ANTIBIOTICS</b>		
<i>cefadroxil oral capsule</i>	1 or 1b*	
<i>cefadroxil oral suspension reconstituted</i>	1 or 1b*	
<i>cefadroxil oral tablet</i>	1 or 1b*	
<i>cefazolin sodium injection solution reconstituted</i>	2	
<i>cefazolin sodium intravenous solution reconstituted</i>	2	
<i>cephalexin oral capsule</i>	1 or 1a*	
<i>cephalexin oral suspension reconstituted</i>	1 or 1a*	
<i>cephalexin oral tablet</i>	1 or 1a*	
<b>*CEPHALOSPORINS - 2ND GENERATION*** - ANTIBIOTICS</b>		
<i>cefaclor er oral tablet extended release 12 hour</i>	2	
<i>cefaclor oral capsule</i>	1 or 1b*	
<i>cefaclor oral suspension reconstituted</i>	1 or 1b*	
<i>cefotetan disodium injection solution reconstituted</i>	2	
<i>cefoxitin sodium injection solution reconstituted</i>	2	
<i>cefoxitin sodium intravenous solution reconstituted</i>	2	
<i>cefprozil oral suspension reconstituted</i>	1 or 1b*	
<i>cefprozil oral tablet</i>	1 or 1b*	
<i>cefuroxime axetil oral tablet</i>	1 or 1b*	
<i>cefuroxime sodium injection solution reconstituted</i>	2	
<i>cefuroxime sodium intravenous solution reconstituted</i>	2	
<b>*CEPHALOSPORINS - 3RD GENERATION*** - ANTIBIOTICS</b>		
<i>cefdinir oral capsule</i>	1 or 1b*	
<i>cefdinir oral suspension reconstituted</i>	1 or 1b*	
<i>cefditoren pivoxil oral tablet</i>	1 or 1b*	
<i>cefixime oral capsule</i>	2	
<i>cefixime oral suspension reconstituted</i>	2	
<i>cefotaxime sodium injection solution reconstituted</i>	2	
<i>cefpodoxime proxetil oral suspension reconstituted</i>	2	
<i>cefpodoxime proxetil oral tablet</i>	2	
<i>ceftazidime injection solution reconstituted</i>	2	
<i>ceftriaxone sodium in dextrose intravenous solution</i>	2	
<i>ceftriaxone sodium injection solution reconstituted</i>	2	
<i>ceftriaxone sodium intravenous solution reconstituted</i>	2	
<i>ceftazidime (Tazicef Injection Solution Reconstituted)</i>	2	
<b>TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED</b> <i>(ceftazidime)</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*CEPHALOSPORINS - 4TH GENERATION*** - ANTIBIOTICS</b>		
<i>cefepime hcl injection solution reconstituted</i>	2	
<b>*CONTRACEPTIVES* - DRUGS FOR WOMEN</b>		
<b>*BIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>desogestrel-ethinyl estradiol (Azurette Oral Tablet)</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol (Bekyree Oral Tablet)</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol (Kariva Oral Tablet)</i>	1 or 1b*; \$0	
<b>LO LOESTRIN FE ORAL TABLET (norethin-eth estrad-fe biphas)</b>	2; \$0	
<i>desogestrel-ethinyl estradiol (Pimtree Oral Tablet)</i>	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol (Simliya Oral Tablet)</i>	1 or 1b*; \$0	
<i>viorele oral tablet</i>	1 or 1b*; \$0	
<b>*COMBINATION CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>levonorgestrel-ethinyl estrad (Afirmelle Oral Tablet)</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Altavera Oral Tablet)</i>	1 or 1a*; \$0	
<i>alyacen 1/35 oral tablet</i>	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol (Apri Oral Tablet)</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Aubra Eq Oral Tablet)</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Aubra Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est (Aurovela 1.5/30 Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est (Aurovela 1/20 Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Aurovela 24 Fe Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Aurovela Fe 1.5/30 Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Aurovela Fe 1/20 Oral Tablet)</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Aviane Oral Tablet)</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Ayuna Oral Tablet)</i>	1 or 1a*; \$0	
<b>BALCOLTRA ORAL TABLET (levonorgest-eth estrad-fe bisg)</b>	2; \$0	
<i>norethindrone-eth estradiol (Balziva Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Blisovi 24 Fe Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Blisovi Fe 1.5/30 Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe (Blisovi Fe 1/20 Oral Tablet)</i>	1 or 1a*; \$0	
<i>briellyn oral tablet</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Chateal Eq Oral Tablet)</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad (Chateal Oral Tablet)</i>	1 or 1a*; \$0	
<i>norgestrel-ethinyl estradiol (Cryselle-28 Oral Tablet)</i>	1 or 1a*; \$0	
<i>norethindrone-eth estradiol (Cyclafem 1/35 Oral Tablet)</i>	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet)</i>	1 or 1a*; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desogestrel-ethinyl estradiol</i> (Cyred Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Delyla Oral Tablet)	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol oral tablet</i>	1 or 1a*; \$0	
<i>drospiren-eth estrad-levomefol oral tablet</i>	1 or 1b*; \$0	
<i>drospirenone-ethinyl estradiol oral tablet</i>	1 or 1b*; \$0	
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet)	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Emoquette Oral Tablet)	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet)	1 or 1a*; \$0	
<i>ethynodiol diac-eth estradiol oral tablet</i>	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Femynor Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Gianvi Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Oral Tablet)	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet)	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable)	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet)	1 or 1a*; \$0	
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet)	1 or 1a*; \$0	
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Larissia Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe</i> (Layolis Fe Oral Tablet Chewable)	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet</i>	1 or 1a*; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Lillow Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet)	1 or 1b*; \$0	
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet)	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet)	1 or 1a*; \$0	
<i>marlissa oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Melodetta 24 Fe Oral Tablet Chewable)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable)	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet)	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe oral tablet</i>	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe oral tablet chewable</i>	1 or 1a*; \$0	
<i>norethindrone acet-ethinyl est oral tablet</i>	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe oral tablet chewable</i>	1 or 1b*; \$0	
<i>norgestimate-eth estradiol oral tablet</i>	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Ocella Oral Tablet)	1 or 1b*; \$0	
<b>OGESTREL ORAL TABLET</b> ( <i>norgestrel-ethinyl estradiol</i> )	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Orsythia Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Pirmella 1/35 Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Previfem Oral Tablet)	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet)	1 or 1a*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet)	1 or 1a*; \$0	
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet)	1 or 1b*; \$0	
<i>norethin ace-eth estrad-fe</i> (Tarina 24 Fe Oral Tablet)	1 or 1a*; \$0	
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet)	1 or 1a*; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Oral Tablet)	1 or 1a*; \$0	
<b>TAYTULLA ORAL CAPSULE</b> ( <i>norethin ace-eth estrad-fe</i> )	2; \$0	
<i>drosipren-eth estrad-levomefol</i> (Tydemy Oral Tablet)	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad</i> (Vienva Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet)	1 or 1a*; \$0	
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet)	1 or 1a*; \$0	
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable)	1 or 1b*; \$0	
<i>drosiprenone-ethinyl estradiol</i> (Zarah Oral Tablet)	1 or 1b*; \$0	
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35E (28) Oral Tablet)	1 or 1a*; \$0	
<i>drosiprenone-ethinyl estradiol</i> (Zumandimine Oral Tablet)	1 or 1b*; \$0	
<b>*COMBINATION CONTRACEPTIVES - TRANSDERMAL*** - BIRTH CONTROL PILLS</b>		
<b>XULANE TRANSDERMAL PATCH WEEKLY</b> ( <i>norelgestromin-eth estradiol</i> )	1 or 1b*; \$0	
<b>*COMBINATION CONTRACEPTIVES - VAGINAL*** - BIRTH CONTROL PILLS</b>		
<b>ANNOVERA VAGINAL RING</b> ( <i>segesterone-ethinyl estradiol</i> )	2; \$0	
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring)	1 or 1b*; \$0	
<i>etonogestrel-ethinyl estradiol vaginal ring</i>	1 or 1b*; \$0	
<b>NUVARING VAGINAL RING</b> ( <i>etonogestrel-ethinyl estradiol</i> )	2	
<b>*CONTINUOUS CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet)	1 or 1b*; \$0	
<i>levonorgestrel-ethinyl estrad oral tablet</i>	1 or 1b*; \$0	
<b>*EMERGENCY CONTRACEPTIVES*** - BIRTH CONTROL PILLS</b>		
<b>ELLA ORAL TABLET</b> ( <i>ulipristal acetate</i> )	2; \$0	
<b>*EXTENDED-CYCLE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>levonorgest-eth estrad 91-day</i> (Amethia Lo Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Amethia Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Ashlyna Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Daysee Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Fayosim Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth est &amp; eth est oral tablet</i>	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day oral tablet</i>	1 or 1b*; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet)	1 or 1b*; \$0	
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet)	1 or 1b*; \$0	
<b>*FOUR PHASE CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<b>NATAZIA ORAL TABLET</b> ( <i>estradiol valerate-dienogest</i> )	2; \$0	
<b>*PROGESTIN CONTRACEPTIVES - INJECTABLE*** - BIRTH CONTROL PILLS</b>		
<b>DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE</b> ( <i>medroxyprogesterone acetate</i> )	2; \$0	
<i>medroxyprogesterone acetate intramuscular suspension</i>	1 or 1b*; \$0	
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe</i>	1 or 1b*; \$0	
<b>*PROGESTIN CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>norethindrone</i> (Camila Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Deblitane Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Errin Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Heather Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Incassia Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Jencycla Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Lyza Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Nora-Be Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone oral tablet</i>	1 or 1b*; \$0	
<i>norethindrone</i> (Norlyda Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Norlyroc Oral Tablet)	1 or 1b*; \$0	
<i>norethindrone</i> (Sharobel Oral Tablet)	1 or 1b*; \$0	
<b>SLYND ORAL TABLET</b> ( <i>drospirenone</i> )	2; \$0	
<i>norethindrone</i> (Tulana Oral Tablet)	1 or 1b*; \$0	
<b>*TRIPHASIC CONTRACEPTIVES - ORAL*** - BIRTH CONTROL PILLS</b>		
<i>alyacen 7/7/7 oral tablet</i>	1 or 1a*; \$0	
<i>norethin-eth estrad triphasic</i> (Aranelle Oral Tablet)	1 or 1a*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Caziant Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estrad triphasic</i> (Cyclafem 7/7/7 Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Oral Tablet)	1 or 1a*; \$0	
<i>levonorg-eth estrad triphasic</i> (Enpresse-28 Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estrad triphasic</i> (Leena Oral Tablet)	1 or 1a*; \$0	
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet)	1 or 1a*; \$0	
<i>levonorg-eth estrad triphasic oral tablet</i>	1 or 1a*; \$0	
<i>norgestim-eth estrad triphasic oral tablet</i>	1 or 1b*; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet)	1 or 1a*; \$0	
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Oral Tablet)	1 or 1a*; \$0	
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri Femynor Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Oral Tablet)	1 or 1b*; \$0	
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Previfem Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet)	1 or 1b*; \$0	
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet)	1 or 1a*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet)	1 or 1b*; \$0	
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet)	1 or 1b*; \$0	
<i>desogestrel-ethinyl estradiol</i> (Velivet Oral Tablet)	1 or 1a*; \$0	
<b>*CORTICOSTEROIDS* - HORMONES</b>		
<b>*GLUCOCORTICOSTEROIDS*** - DRUGS FOR INFLAMMATION</b>		
<i>budesonide er oral tablet extended release 24 hour</i>	2	QL (1 tablet per 1 day)
<i>budesonide oral capsule delayed release particles</i>	2	QL (3 capsule per 1 day)
<i>cortisone acetate oral tablet</i>	1 or 1b*	
<i>dexamethasone</i> (Decadron Oral Tablet)	1 or 1a*	
<b>DEXAMETHASONE INTENSOL ORAL CONCENTRATE</b> ( <i>dexamethasone</i> )	2	
<i>dexamethasone oral elixir</i>	1 or 1a*	
<i>dexamethasone oral solution</i>	1 or 1a*	
<i>dexamethasone oral tablet</i>	1 or 1a*	
<i>dexamethasone oral tablet therapy pack</i>	1 or 1b*	
<i>dexamethasone sod phosphate pf injection solution</i>	1 or 1b*	
<i>dexamethasone sodium phosphate injection solution</i>	1 or 1b*	
<i>dexamethasone</i> (Dexpak 10 Day Oral Tablet Therapy Pack)	1 or 1b*	
<i>dexamethasone</i> (Dexpak 13 Day Oral Tablet Therapy Pack)	1 or 1b*	
<i>dexamethasone</i> (Dexpak 6 Day Oral Tablet Therapy Pack)	1 or 1b*	
<i>hydrocortisone oral tablet</i>	1 or 1b*	
<i>methylprednisolone acetate injection suspension</i>	1 or 1b*	
<i>methylprednisolone oral tablet</i>	1 or 1a*	
<i>methylprednisolone oral tablet therapy pack</i>	1 or 1a*	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylprednisolone sodium succ injection solution reconstituted</i>	1 or 1b*	
<i>prednisolone oral solution</i>	1 or 1a*	
<i>prednisolone sodium phosphate oral solution</i>	1 or 1a*	
<i>prednisolone sodium phosphate oral tablet dispersible</i>	1 or 1a*	
<i>prednisone oral solution</i>	1 or 1a*	
<i>prednisone oral tablet</i>	1 or 1a*	
<i>prednisone oral tablet therapy pack</i>	1 or 1a*	
<b>TAPERDEX 12-DAY ORAL TABLET THERAPY PACK (dexamethasone)</b>	1 or 1b*	
<i>dexamethasone (Taperdex 6-Day Oral Tablet Therapy Pack)</i>	1 or 1b*	
<b>TAPERDEX 7-DAY ORAL TABLET THERAPY PACK (dexamethasone)</b>	1 or 1b*	
<i>triamcinolone acetonide injection suspension</i>	1 or 1b*	
<b>*MINERALOCORTICOID*** - DRUGS FOR INFLAMMATION</b>		
<i>fludrocortisone acetate oral tablet</i>	1 or 1b*	
<b>*STEROID COMBINATIONS*** - DRUGS FOR INFLAMMATION</b>		
<i>betamethasone sod phos &amp; acet injection suspension</i>	1 or 1b*	
<b>*COUGH/COLD/ALLERGY* - DRUGS FOR THE LUNGS</b>		
<b>*ANTITUSSIVE - NONNARCOTIC*** - DRUGS FOR ALLERGIES</b>		
<i>benzonatate oral capsule</i>	1 or 1b*	
<b>*ANTITUSSIVE - OPIOID*** - DRUGS FOR COUGH AND COLD</b>		
<i>hydrocodone-homatropine oral syrup</i>	1 or 1a*	
<i>hydrocodone-homatropine oral tablet</i>	1 or 1a*	
<i>hydromet oral syrup</i>	1 or 1a*	
<b>*ANTITUSSIVE-EXPECTORANT*** - DRUGS FOR COUGH AND COLD</b>		
<i>g tussin ac oral solution</i>	1 or 1a*	
<i>guaiaatussin ac oral syrup</i>	1 or 1a*	
<i>guaifenesin ac oral syrup</i>	1 or 1a*	
<i>trymine cg oral liquid</i>	1 or 1a*	
<i>virtussin a/c oral solution</i>	1 or 1a*	
<b>*ANTITUSSIVE-EXPECTORANTS-DECONGESTANT*** - DRUGS FOR COUGH AND COLD</b>		
<i>guaifenesin dac oral solution</i>	1 or 1b*	
<i>virtussin dac oral solution</i>	1 or 1b*	
<b>*DECONGESTANT &amp; ANTIHISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>promethazine-phenylephrine oral syrup</i>	1 or 1b*	
<b>*MISC. RESPIRATORY INHALANTS*** - DRUGS FOR ALLERGIES</b>		
<i>sodium chloride (Nebusal Inhalation Nebulization Solution)</i>	2	
<i>sodium chloride (Pulmosal Inhalation Nebulization Solution)</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium chloride inhalation nebulization solution</i>	2	
<b>*MUCOLYTICS*** - DRUGS FOR THE LUNGS</b>		
<i>acetylcysteine inhalation solution</i>	2	
<b>*NON-NARC ANTITUSSIVE-ANTIHIISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>promethazine-dm oral syrup</i>	1 or 1a*	
<b>*NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHIISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>pseudoeph-bromphen-dm (Bromfed Dm Oral Syrup)</i>	1 or 1b*	
<i>pseudoeph-bromphen-dm oral syrup</i>	1 or 1b*	
<b>*OPIOID ANTITUSSIVE-ANTIHIISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>hydrocod polst-cpm polst er oral suspension extended release</i>	1 or 1b*	
<i>promethazine-codeine oral solution</i>	1 or 1a*	
<i>promethazine-codeine oral syrup</i>	1 or 1a*	
<b>TUSSICAPS ORAL CAPSULE EXTENDED RELEASE 12 HOUR</b> <i>(hydrocod polst-chlorphen polst)</i>	2	
<b>*OPIOID ANTITUSSIVE-DECONGESTANT-ANTIHIISTAMINE*** - DRUGS FOR COUGH AND COLD</b>		
<i>poly-tussin ac oral liquid</i>	2	
<i>promethazine-phenyleph-codeine oral syrup</i>	1 or 1b*	
<b>*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>*CYCLIN-DEPENDENT KINASES (CDK) INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>IBRANCE ORAL CAPSULE</b> ( <i>palbociclib</i> )	4	PA; LD; SP; QL (1 capsule per 1 day)
<b>KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK</b> ( <i>ribociclib succinate</i> )	4	PA; SP; QL (3 tablets per 1 day)
<b>KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK</b> ( <i>ribociclib succinate</i> )	4	PA; SP; QL (3 tablets per 1 day)
<b>KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK</b> ( <i>ribociclib succinate</i> )	4	PA; SP; QL (3 tablets per 1 day)
<b>*DERMATOLOGICALS* - DRUGS FOR THE SKIN</b>		
<b>*ACNE ANTIBIOTICS*** - DRUGS FOR THE SKIN</b>		
<i>clindamycin phosphate (Clindacin Etz External Swab)</i>	1 or 1b*	
<i>clindamycin phosphate (Clindacin-P External Swab)</i>	1 or 1b*	
<i>clindamycin phosphate external foam</i>	1 or 1b*	
<i>clindamycin phosphate external gel</i>	1 or 1b*	
<i>clindamycin phosphate external lotion</i>	1 or 1b*	
<i>clindamycin phosphate external solution</i>	1 or 1b*	
<i>clindamycin phosphate external swab</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dapsone external gel</i>	1 or 1b*	ST
<i>ery external pad</i>	1 or 1b*	
<i>erythromycin external gel</i>	1 or 1b*	
<i>erythromycin external solution</i>	1 or 1b*	
<i>sulfacetamide sodium (acne) external lotion</i>	1 or 1b*	
<b>*ACNE COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>adapalene-benzoyl peroxide external gel</i>	1 or 1b*	
<i>benzoyl peroxide-erythromycin external gel</i>	1 or 1b*	
<i>bp 10-1 external emulsion</i>	1 or 1b*	
<i>bp cleansing wash external emulsion</i>	1 or 1b*	
<i>clindamycin phos-benzoyl perox external gel</i>	1 or 1b*	
<i>clindamycin-tretinoin external gel</i>	1 or 1b*	
<i>clindamycin-benzoyl per (refr) (Neuac External Gel)</i>	1 or 1b*	
<i>sss 10-5 external cream</i>	1 or 1b*	
<i>sss 10-5 external foam</i>	1 or 1b*	
<i>sulfacetamide sodium-sulfur external cream</i>	1 or 1b*	
<i>sulfacetamide sodium-sulfur external emulsion</i>	1 or 1b*	
<i>sulfacetamide sodium-sulfur external liquid 9-4 %</i>	1 or 1b*	PA
<i>sulfacetamide sodium-sulfur external liquid 9-4.5 %</i>	1 or 1b*	
<i>sulfacetamide sodium-sulfur external lotion</i>	1 or 1b*	
<i>sulfacetamide sodium-sulfur external pad</i>	1 or 1b*	
<i>sulfacetamide sodium-sulfur external suspension</i>	1 or 1b*	
<i>sulfacetamide sod-sulfur wash external kit</i>	1 or 1b*	
<b>*ACNE PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>adapalene external cream</i>	1 or 1b*	PA
<i>adapalene external gel</i>	1 or 1b*	PA
<i>adapalene external pad</i>	1 or 1b*	PA
<i>isotretinoin (Amnesteem Oral Capsule)</i>	2	PA
<i>tretinoin (Avita External Cream)</i>	1 or 1b*	PA
<i>tretinoin (Avita External Gel)</i>	1 or 1b*	PA
<b>BENZIQ WASH EXTERNAL LIQUID (benzoyl peroxide)</b>	1 or 1b*	
<i>bp wash external liquid</i>	1 or 1b*	
<i>isotretinoin (Claravis Oral Capsule)</i>	2	PA
<i>isotretinoin oral capsule</i>	2	PA
<i>isotretinoin (Myorisan Oral Capsule)</i>	2	PA
<i>tretinoin external cream</i>	1 or 1b*	PA
<i>tretinoin external gel</i>	1 or 1b*	PA
<i>tretinoin microsphere external gel</i>	1 or 1b*	PA

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tretinoin microsphere pump external gel</i>	1 or 1b*	PA
<i>isotretinoin</i> (Zenatane Oral Capsule)	2	PA
<b>*AGENTS FOR FACIAL WRINKLES - RETINOIDS*** - DRUGS FOR THE SKIN</b>		
<b>REFISSA EXTERNAL CREAM</b> ( <i>tretinoin (facial wrinkles)</i> )	1 or 1b*	PA
<i>tretinoin (emollient) external cream</i>	1 or 1b*	PA
<b>*ANTIBIOTICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<b>ALTABAX EXTERNAL OINTMENT</b> ( <i>retapamulin</i> )	2	
<i>gentamicin sulfate external cream</i>	1 or 1b*	
<i>gentamicin sulfate external ointment</i>	1 or 1b*	
<i>mupirocin calcium external cream</i>	1 or 1b*	
<i>mupirocin external ointment</i>	1 or 1b*	
<b>*ANTIFUNGALS - TOPICAL COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>clotrimazole-betamethasone external cream</i>	1 or 1b*	
<i>clotrimazole-betamethasone external lotion</i>	1 or 1b*	
<i>nystatin-triamcinolone external cream</i>	1 or 1b*	
<i>nystatin-triamcinolone external ointment</i>	1 or 1b*	
<b>*ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>ciclopirox external gel</i>	1 or 1b*	
<i>ciclopirox external shampoo</i>	1 or 1b*	
<i>ciclopirox external solution</i>	1 or 1b*	
<i>ciclopirox olamine external cream</i>	1 or 1b*	
<i>ciclopirox olamine external suspension</i>	1 or 1b*	
<i>naftifine hcl external cream</i>	2	ST
<i>naftifine hcl external gel</i>	1 or 1b*	ST
<i>nystatin</i> (Nyamyc External Powder)	1 or 1b*	
<i>nystatin external cream</i>	1 or 1b*	
<i>nystatin external ointment</i>	1 or 1b*	
<i>nystatin external powder</i>	1 or 1b*	
<i>nystatin</i> (Nystop External Powder)	1 or 1b*	
<b>*ANTI-INFLAMMATORY AGENTS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>diclofenac epolamine transdermal patch</i>	2	ST; QL (2 patch per 1 day)
<i>diclofenac sodium transdermal gel</i>	2	QL (1000 gm per 30 days)
<b>*ANTI-INFLAMMATORY COMBINATIONS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>sure result dss premium pack combination therapy pack</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<b>CARAC EXTERNAL CREAM</b> ( <i>fluorouracil</i> )	2	QL (30 gm per 365 days)
<i>fluorouracil external cream</i>	1 or 1b*	QL (40 gm per 365 days)
<i>fluorouracil external solution</i>	1 or 1b*	QL (10 mL per 365 days)
<b>*ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S*** - DRUGS FOR THE SKIN</b>		
<i>diclofenac sodium transdermal gel</i>	2	PA; QL (300 gm per 365 days)
<b>*ANTIPRURITICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>doxepin hcl external cream</i>	2	
<b>*ANTIPSORIATICS - SYSTEMIC*** - DRUGS FOR THE SKIN</b>		
<i>acitretin oral capsule</i>	2	
<b>COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>secukinumab</i> )	4	PA; LD; SP; QL (2 syringes per 28 days)
<b>COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> ( <i>secukinumab</i> )	4	PA; LD; SP; QL (2 pens per 28 days)
<b>COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> ( <i>secukinumab</i> )	4	PA; LD; SP; QL (2 pens per 28 days)
<b>COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>secukinumab</i> )	4	PA; LD; SP; QL (2 syringes per 28 days)
<i>methoxsalen rapid oral capsule</i>	4	SP
<b>SKYRIZI (150 MG DOSE) SUBCUTANEOUS PREFILLED SYRINGE KIT</b> ( <i>risankizumab-rzaa</i> )	4	PA; SP; QL (2 syringes per 84 days)
<b>STELARA SUBCUTANEOUS SOLUTION</b> ( <i>ustekinumab</i> )	4	PA; SP; QL (1 vial per 84 days)
<b>STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>ustekinumab</i> )	4	PA; SP; QL (1 syringe per 84 days)
<b>TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>guselkumab</i> )	4	PA; SP; QL (1 syringe per 47 days)
<b>TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>guselkumab</i> )	4	PA; SP; QL (1 syringe per 47 days)
<b>*ANTIPSORIATICS*** - DRUGS FOR THE SKIN</b>		
<i>calcipotriene external cream</i>	1 or 1b*	
<i>calcipotriene external ointment</i>	1 or 1b*	
<i>calcipotriene external solution</i>	1 or 1b*	
<i>calcipotriene</i> (Calcitrene External Ointment)	1 or 1b*	
<i>calcitriol external ointment</i>	1 or 1b*	
<i>tazarotene external cream</i>	1 or 1b*	
<b>TAZORAC EXTERNAL CREAM</b> ( <i>tazarotene</i> )	2	
<b>TAZORAC EXTERNAL GEL</b> ( <i>tazarotene</i> )	2	
<b>*ANTISEBORRHEIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>sodium sulfacetamide wash external liquid</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ANTISEBORRHEIC PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>selenium sulfide external lotion</i>	1 or 1a*	
<i>sodium sulfacetamide external shampoo</i>	1 or 1b*	
<i>sulfacetamide sodium external gel</i>	1 or 1b*	
<i>sulfacetamide sodium external liquid</i>	1 or 1b*	
<b>*ANTIVIRALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>acyclovir external cream</i>	1 or 1b*	PA; QL (5 gm per 30 days)
<i>acyclovir external ointment</i>	1 or 1b*	QL (30 gm per 30 days)
<b>*BURN PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>mafenide acetate external packet</i>	2	
<i>silver sulfadiazine external cream</i>	1 or 1a*	
<i>silver sulfadiazine (Ssd External Cream)</i>	1 or 1a*	
<b>*CORTICOSTEROIDS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>ala-cort external cream</i>	1 or 1a*	
<i>alclometasone dipropionate external cream</i>	1 or 1b*	
<i>alclometasone dipropionate external ointment</i>	1 or 1b*	
<i>amcinonide external cream</i>	1 or 1b*	ST
<i>amcinonide external lotion</i>	1 or 1b*	ST
<i>fluticasone propionate (Beser External Lotion)</i>	1 or 1b*	ST
<i>betamethasone dipropionate aug external cream</i>	1 or 1b*	
<i>betamethasone dipropionate aug external gel</i>	1 or 1b*	ST
<i>betamethasone dipropionate aug external lotion</i>	1 or 1b*	ST
<i>betamethasone dipropionate aug external ointment</i>	1 or 1b*	
<i>betamethasone dipropionate external cream</i>	1 or 1b*	ST
<i>betamethasone dipropionate external lotion</i>	1 or 1b*	ST
<i>betamethasone dipropionate external ointment</i>	1 or 1b*	ST
<i>betamethasone valerate external cream</i>	1 or 1b*	ST
<i>betamethasone valerate external foam</i>	1 or 1b*	ST
<i>betamethasone valerate external lotion</i>	1 or 1b*	ST
<i>betamethasone valerate external ointment</i>	1 or 1b*	ST
<i>clobetasol prop emollient base external cream</i>	1 or 1b*	
<i>clobetasol propionate e external cream</i>	1 or 1b*	
<i>clobetasol propionate emulsion external foam</i>	1 or 1b*	
<i>clobetasol propionate external cream</i>	1 or 1b*	
<i>clobetasol propionate external foam</i>	1 or 1b*	
<i>clobetasol propionate external gel</i>	1 or 1b*	
<i>clobetasol propionate external liquid</i>	1 or 1b*	
<i>clobetasol propionate external lotion</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobetasol propionate external ointment</i>	1 or 1b*	
<i>clobetasol propionate external shampoo</i>	1 or 1b*	
<i>clobetasol propionate external solution</i>	1 or 1b*	
<i>clocortolone pivalate external cream</i>	1 or 1b*	ST
<i>clobetasol propionate (Clodan External Shampoo)</i>	1 or 1b*	
<i>desonide external cream</i>	1 or 1b*	ST
<i>desonide external lotion</i>	1 or 1b*	ST
<i>desonide external ointment</i>	1 or 1b*	ST
<i>desoximetasone external cream</i>	1 or 1b*	ST
<i>desoximetasone external gel</i>	1 or 1b*	ST
<i>desoximetasone external liquid</i>	1 or 1b*	ST
<i>desoximetasone external ointment</i>	1 or 1b*	ST
<i>diflorasone diacetate external cream</i>	1 or 1b*	ST
<i>diflorasone diacetate external ointment</i>	1 or 1b*	ST
<i>fluocinolone acetonide body external oil</i>	1 or 1b*	ST
<i>fluocinolone acetonide external cream</i>	1 or 1b*	ST
<i>fluocinolone acetonide external ointment</i>	1 or 1b*	ST
<i>fluocinolone acetonide external solution</i>	1 or 1b*	ST
<i>fluocinolone acetonide scalp external oil</i>	1 or 1b*	ST
<i>fluocinonide emulsified base external cream</i>	1 or 1b*	
<i>fluocinonide external cream</i>	1 or 1b*	
<i>fluocinonide external gel</i>	1 or 1b*	ST
<i>fluocinonide external ointment</i>	1 or 1b*	
<i>fluocinonide external solution</i>	1 or 1b*	
<i>flurandrenolide external cream</i>	1 or 1b*	ST
<i>flurandrenolide external lotion</i>	1 or 1b*	ST
<i>flurandrenolide external ointment</i>	1 or 1b*	ST
<i>fluticasone propionate external cream</i>	1 or 1b*	ST
<i>fluticasone propionate external lotion</i>	1 or 1b*	ST
<i>fluticasone propionate external ointment</i>	1 or 1b*	ST
<i>halcinonide external cream</i>	2	ST
<i>halobetasol propionate external cream</i>	1 or 1b*	
<i>halobetasol propionate external ointment</i>	1 or 1b*	
<i>hydrocortisone butyr lipo base external cream</i>	1 or 1b*	ST
<i>hydrocortisone butyrate external cream</i>	1 or 1b*	ST
<i>hydrocortisone butyrate external lotion</i>	1 or 1b*	ST
<i>hydrocortisone butyrate external ointment</i>	1 or 1b*	ST
<i>hydrocortisone butyrate external solution</i>	1 or 1b*	ST

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone external cream</i>	1 or 1a*	
<i>hydrocortisone external lotion</i>	1 or 1a*	
<i>hydrocortisone external ointment</i>	1 or 1a*	
<i>hydrocortisone valerate external cream</i>	1 or 1b*	ST
<i>hydrocortisone valerate external ointment</i>	1 or 1b*	ST
<i>mometasone furoate external cream</i>	1 or 1b*	
<i>mometasone furoate external ointment</i>	1 or 1b*	
<i>mometasone furoate external solution</i>	1 or 1b*	
<i>flurandrenolide (Nolix External Cream)</i>	1 or 1b*	ST
<i>flurandrenolide (Nolix External Lotion)</i>	1 or 1b*	ST
<i>prednicarbate external cream</i>	1 or 1b*	ST
<i>prednicarbate external ointment</i>	1 or 1b*	ST
<i>clobetasol propionate emulsion (Tovet External Foam)</i>	1 or 1b*	
<i>triamcinolone acetonide external aerosol solution</i>	1 or 1a*	ST
<i>triamcinolone acetonide external cream</i>	1 or 1a*	
<i>triamcinolone acetonide external lotion</i>	1 or 1a*	
<i>triamcinolone acetonide external ointment</i>	1 or 1a*	
<i>triamcinolone acetonide (Triderm External Cream)</i>	1 or 1a*	ST
<b>*DEPIGMENTING AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>hydroquinone (Blanche External Cream)</i>	1 or 1b*	
<i>melpaque hp external cream</i>	1 or 1b*	
<i>hydroquinone (Remergent Hq External Cream)</i>	1 or 1b*	
<i>tl hydroquinone external cream</i>	1 or 1b*	
<b>*EMOLLIENT COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>lactic acid e external cream</i>	1 or 1b*	
<b>*EMOLLIENT/KERATOLYTIC AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>urea (Cerovel External Lotion)</i>	1 or 1b*	
<i>urea external cream</i>	1 or 1b*	
<i>urea external suspension</i>	1 or 1b*	
<i>urea nail external gel</i>	1 or 1b*	
<i>urea-c40 external lotion</i>	1 or 1b*	
<b>*EMOLLIENT/KERATOLYTIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>urea hydrating external foam</i>	1 or 1b*	
<b>*EMOLLIENTS*** - DRUGS FOR THE SKIN</b>		
<i>ammonium lactate external cream</i>	1 or 1b*	
<i>ammonium lactate external lotion</i>	1 or 1b*	
<i>lactic acid external lotion</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium hyaluronate external gel</i>	1 or 1b*	
<b>*IMIDAZOLE-RELATED ANTIFUNGALS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>clotrimazole external solution</i>	1 or 1b*	
<i>econazole nitrate external cream</i>	1 or 1b*	
<i>ketoconazole external cream</i>	1 or 1b*	
<i>ketoconazole external foam</i>	1 or 1b*	
<i>ketoconazole external shampoo</i>	1 or 1b*	
<i>ketoconazole (Ketodan External Foam)</i>	1 or 1b*	
<i>luliconazole external cream</i>	1 or 1b*	ST
<i>oxiconazole nitrate external cream</i>	1 or 1b*	ST
<b>*IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>imiquimod external cream</i>	1 or 1b*	QL (48 packet per 365 days)
<i>imiquimod pump external cream</i>	1 or 1b*	ST; QL (2 bottle per 365 days)
<b>*KERATOLYTIC/ANTIMITOTIC AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>podofilox external solution</i>	1 or 1b*	
<i>salicylic acid external cream</i>	1 or 1b*	
<i>salicylic acid external foam</i>	1 or 1b*	
<i>salicylic acid external gel</i>	1 or 1b*	
<i>salicylic acid external lotion</i>	1 or 1b*	
<i>salicylic acid external shampoo</i>	1 or 1b*	
<i>salicylic acid external solution</i>	1 or 1b*	
<b>*LOCAL ANESTHETICS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>lidocaine hcl (Glydo External Prefilled Syringe)</i>	2	
<i>lidocaine external ointment</i>	2	QL (5 grams per 1 day)
<i>lidocaine external patch</i>	2	QL (3 patches per 1 day)
<i>lidocaine hcl external lotion</i>	2	
<i>lidocaine hcl external solution</i>	2	QL (10 mL per 1 day)
<i>lidocaine hcl urethral/mucosal external gel</i>	2	
<i>lidocaine hcl urethral/mucosal external prefilled syringe</i>	2	
<i>lidocaine hcl (Lido-Sorb External Lotion)</i>	2	
<i>pramoxine hcl (Pramox External Gel)</i>	1 or 1b*	
<b>*MACROLIDE IMMUNOSUPPRESSANTS - TOPICAL*** - DRUGS FOR THE SKIN</b>		
<i>pimecrolimus external cream</i>	1 or 1b*	ST
<i>tacrolimus external ointment</i>	1 or 1b*	ST
<b>*ROSACEA AGENTS*** - DRUGS FOR THE SKIN</b>		
<i>azelaic acid external gel</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**\*=Drugs with the lowest cost share **Tier 1 or 1b**\*=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ivermectin external cream</i>	2	
<i>metronidazole external cream</i>	1 or 1b*	
<i>metronidazole external gel</i>	1 or 1b*	
<i>metronidazole external lotion</i>	1 or 1b*	
<i>metronidazole (Rosadan External Cream)</i>	1 or 1b*	
<i>metronidazole (Rosadan External Gel)</i>	1 or 1b*	
<b>*SCABICIDES &amp; PEDICULICIDES*** - DRUGS FOR THE SKIN</b>		
<b>CROTAN EXTERNAL LOTION (<i>crotamiton</i>)</b>	2	
<i>lindane external shampoo</i>	1 or 1b*	
<i>malathion external lotion</i>	1 or 1b*	
<i>permethrin external cream</i>	1 or 1b*	
<i>spinosad external suspension</i>	1 or 1b*	
<b>*SKIN PROTECTANTS*** - DRUGS FOR THE SKIN</b>		
<i>benzoin compound external tincture</i>	1 or 1b*	
<b>*STEROID-LOCAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<b>PRAMOSONE EXTERNAL CREAM (<i>pramoxine-hc</i>)</b>	2	
<b>PRAMOSONE EXTERNAL LOTION (<i>pramoxine-hc</i>)</b>	2	
<b>*TAR PRODUCTS*** - DRUGS FOR THE SKIN</b>		
<i>coal tar external solution</i>	1 or 1b*	
<b>*TOPICAL ANESTHETIC COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>lidocaine-prilocaine external cream</i>	2	QL (30 grams per 30 days)
<i>lidocaine-prilocaine external kit</i>	2	
<i>prilovix ultralite external kit</i>	2	
<i>prilovix ultralite plus external kit</i>	2	
<b>*TOPICAL SELECTIVE RETINOID X RECEPTOR AGONISTS*** - DRUGS FOR THE SKIN</b>		
<b>TARGRETIN EXTERNAL GEL (<i>bexarotene</i>)</b>	4	PA; SP
<b>*TOPICAL STEROID COMBINATIONS*** - DRUGS FOR THE SKIN</b>		
<i>calcipotriene-betameth diprop external ointment</i>	1 or 1b*	
<i>triamcinolone-dimeth-silicone (Nutriarx Creampak External Kit)</i>	1 or 1b*	
<b>*TYPE II 5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE SKIN</b>		
<i>finasteride oral tablet</i>	1 or 1b*	
<b>*WOUND DRESSINGS*** - DRUGS FOR THE SKIN</b>		
<b>ACTICOAT 7 EXTERNAL PAD (<i>silver</i>)</b>	2	
<b>ACTICOAT 7 EXTERNAL SHEET (<i>silver</i>)</b>	2	
<b>ACTICOAT ANTIMICROBIAL EXTERNAL PAD (<i>silver</i>)</b>	2	
<b>ACTICOAT EXTERNAL SHEET (<i>silver</i>)</b>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACTICOAT FLEX 3 4"X4" EXTERNAL PAD (wound dressings)	2	
ACTICOAT FLEX 3 EXTERNAL SHEET (silver)	2	
ACTICOAT FLEX 7 EXTERNAL SHEET (silver)	2	
ALLEVYN AG ADHESIVE EXTERNAL PAD (silver)	2	
BIOSTEP AG EXTERNAL SHEET (collagen matrix-silver)	2	
BIOSTEP EXTERNAL SHEET (collagen matrix (porcine))	2	
HYDROFERA BLUE 4"X4" EXTERNAL PAD (wound dressings)	2	
HYDROFERA BLUE 6"X6" EXTERNAL PAD (wound dressings)	2	
HYDROFERA BLUE FOAM DRESSING EXTERNAL PAD (wound dressings)	2	
HYDROFERA BLUE FOAM/TUNNELING EXTERNAL PAD (wound dressings)	2	
HYDROFERA BLUE MRF DRESSING EXTERNAL PAD (wound dressings)	2	
HYDROFERA BLUE READY FOAM EXTERNAL PAD (wound dressings)	2; \$0	
RESTORE SILVER DRESSING EXTERNAL PAD (calcium alginate-silver)	2	
<b>*DIAGNOSTIC PRODUCTS*</b>		
<b>*DIAGNOSTIC TESTS***</b>		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
ACCU-CHEK COMPACT PLUS IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
ACCU-CHEK GUIDE IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
ACCU-CHEK SMARTVIEW IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
ACCUTREND GLUCOSE IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
ONETOUCH ULTRA BLUE IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
ONETOUCH VERIO IN VITRO STRIP (glucose blood)	2	QL (204 strips per 30 days)
<b>*DIGESTIVE AIDS* - DRUGS FOR THE STOMACH</b>		
<b>*DIGESTIVE ENZYMES*** - DRUGS FOR THE STOMACH</b>		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES (pancrelipase (lip-prot-amyl))	2	
VIOKACE ORAL TABLET (pancrelipase (lip-prot-amyl))	3	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES (pancrelipase (lip-prot-amyl))	2	
<b>*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<b>*DIRECT-ACTING P2Y12 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
BRILINTA ORAL TABLET (ticagrelor)	2	QL (2 tablets per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*DIURETICS* - DRUGS FOR THE HEART</b>		
<b>*CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>acetazolamide er oral capsule extended release 12 hour</i>	1 or 1b*	
<i>acetazolamide oral tablet</i>	1 or 1b*	
<i>acetazolamide sodium injection solution reconstituted</i>	1 or 1b*	
<i>methazolamide oral tablet</i>	2	
<b>*DIURETIC COMBINATIONS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amiloride-hydrochlorothiazide oral tablet</i>	1 or 1b*	
<i>spironolactone-hctz oral tablet</i>	1 or 1b*	
<i>triamterene-hctz oral capsule</i>	1 or 1a*	
<i>triamterene-hctz oral tablet</i>	1 or 1a*	
<b>*LOOP DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>bumetanide injection solution</i>	1 or 1b*	
<i>bumetanide oral tablet</i>	1 or 1b*	
<i>ethacrynic acid oral tablet</i>	2	
<i>furosemide injection solution</i>	1 or 1a*	
<i>furosemide oral solution</i>	1 or 1a*	
<i>furosemide oral tablet</i>	1 or 1a*	
<i>toremide oral tablet</i>	1 or 1b*	
<b>*OSMOTIC DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>mannitol intravenous solution</i>	1 or 1b*	
<b>OSMITROL INTRAVENOUS SOLUTION</b> ( <i>mannitol</i> )	1 or 1b*	
<b>*POTASSIUM SPARING DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>amiloride hcl oral tablet</i>	2	
<i>spironolactone oral tablet</i>	1 or 1a*	
<i>triamterene oral capsule</i>	2	
<b>*THIAZIDES AND THIAZIDE-LIKE DIURETICS*** - DRUGS FOR HIGH BLOOD PRESSURE</b>		
<i>chlorothiazide oral tablet</i>	1 or 1b*	
<i>chlorothiazide sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>chlorthalidone oral tablet</i>	1 or 1a*	
<i>hydrochlorothiazide oral capsule</i>	1 or 1a*	
<i>hydrochlorothiazide oral tablet</i>	1 or 1a*	
<i>indapamide oral tablet</i>	1 or 1b*	
<i>metolazone oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ENDOCRINE AND METABOLIC AGENTS - MISC.* - HORMONES</b>		
<b>*ABORTIFACIENT - PROGESTERONE RECEPTOR ANTAGONISTS*** - DRUGS FOR WOMEN</b>		
<i>mifepristone oral tablet</i>	1 or 1a*	
<b>*BISPHOSPHONATES*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>alendronate sodium oral solution</i>	1 or 1b*	
<i>alendronate sodium oral tablet 10 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
<b>FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT</b> ( <i>alendronate-cholecalciferol</i> )	2	QL (4 tablets per 28 days)
<b>FOSAMAX PLUS D ORAL TABLET 70-5600 MG-UNIT</b> ( <i>alendronate-cholecalciferol</i> )	2	
<i>ibandronate sodium oral tablet</i>	1 or 1b*	ST; QL (1 tablet per 28 days)
<i>risedronate sodium oral tablet 150 mg</i>	1 or 1b*	QL (1 tablet per 30 days)
<i>risedronate sodium oral tablet 30 mg, 5 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>risedronate sodium oral tablet 35 mg</i>	1 or 1b*	QL (4 tablets per 28 days)
<i>risedronate sodium oral tablet delayed release</i>	1 or 1b*	QL (4 tablets per 28 days)
<b>*CALCIMIMETIC AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	4	PA; QL (2 tablets per 1 day)
<i>cinacalcet hcl oral tablet 90 mg</i>	4	PA; QL (4 tablets per 1 day)
<b>*CALCITONINS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>calcitonin (salmon) nasal solution</i>	2	QL (1 bottle per 30 days)
<b>*CARNITINE REPLENISHER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>levocarnitine oral solution</i>	2	
<i>levocarnitine oral tablet</i>	2	
<i>levocarnitine sf oral solution</i>	2	
<b>*DOPAMINE RECEPTOR AGONISTS*** - DRUGS FOR WOMEN</b>		
<i>cabergoline oral tablet</i>	1 or 1b*	
<b>*GROWTH HORMONE RECEPTOR ANTAGONISTS*** - DRUGS FOR GROWTH</b>		
<b>SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED</b> ( <i>pegvisomant</i> )	4	PA; LD; SP; QL (1 vial per 1 day)
<b>*GROWTH HORMONES*** - DRUGS FOR GROWTH</b>		
<b>HUMATROPE INJECTION SOLUTION RECONSTITUTED</b> ( <i>somatropin</i> )	4	PA; SP
<b>NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION</b> ( <i>somatropin</i> )	4	PA; SP
<b>NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION</b> ( <i>somatropin</i> )	4	PA; SP
<b>NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION</b> ( <i>somatropin</i> )	4	PA; SP

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*HEREDITARY TYROSINEMIA TYPE 1 (HT-1) TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>nitisinone oral capsule</i>	4	PA
<b>ORFADIN ORAL CAPSULE</b> ( <i>nitisinone</i> )	4	PA; LD
<b>*HOMOCYSTINURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<b>CYSTADANE ORAL POWDER</b> ( <i>betaine</i> )	4	LD
<b>*HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>calcitriol intravenous solution</i>	1 or 1b*	PA
<i>calcitriol oral capsule</i>	1 or 1b*	PA
<i>calcitriol oral solution</i>	2	PA
<i>doxercalciferol intravenous solution</i>	2	PA
<i>doxercalciferol oral capsule</i>	2	PA
<i>paricalcitol oral capsule</i>	2	PA
<b>*LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS*** - DRUGS FOR WOMEN</b>		
<b>SYNAREL NASAL SOLUTION</b> ( <i>nafarelin acetate</i> )	4	PA; SP; QL (5 bottle per 30 days)
<b>*OVULATION STIMULANTS-GONADOTROPINS*** - DRUGS FOR WOMEN</b>		
<b>GONAL-F INJECTION SOLUTION RECONSTITUTED</b> ( <i>follitropin alfa</i> )	4	PA; SP
<b>GONAL-F RFF REDJECT SUBCUTANEOUS SOLUTION</b> ( <i>follitropin alfa</i> )	4	PA; SP
<b>GONAL-F RFF SUBCUTANEOUS SOLUTION RECONSTITUTED</b> ( <i>follitropin alfa</i> )	4	PA; SP
<b>NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 10000 UNIT</b> ( <i>chorionic gonadotropin</i> )	4	PA; SP
<b>NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT</b> ( <i>chorionic gonadotropin</i> )	4	SP
<b>*OVULATION STIMULANTS-SYNTHETIC*** - DRUGS FOR WOMEN</b>		
<i>clomiphene citrate oral tablet</i>	1 or 1b*	PA
<b>*PARATHYROID HORMONE AND DERIVATIVES*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<b>FORTEO SUBCUTANEOUS SOLUTION</b> ( <i>teriparatide (recombinant)</i> )	4	PA; SP; QL (1 pen per 28 days)
<b>*PHENYLKETONURIA TREATMENT - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<b>KUVAN ORAL TABLET SOLUBLE</b> ( <i>sapropterin dihydrochloride</i> )	4	PA; LD; SP
<b>*RANK LIGAND (RANKL) INHIBITORS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<b>PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>denosumab</i> )	4	PA; SP; QL (2 injections per 365 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>raloxifene hcl oral tablet</i>	1 or 1b*; \$0	
<b>*SOMATOSTATIC AGENTS*** - DRUGS FOR GROWTH</b>		
<b>SOMATULINE DEPOT SUBCUTANEOUS SOLUTION</b> ( <i>lanreotide acetate</i> )	4	PA; LD; SP; QL (1 syringe/vial per 28 days)
<b>*UREA CYCLE DISORDER - AGENTS*** - DRUGS FOR MENOPAUSE AND BONE LOSS</b>		
<i>sodium phenylbutyrate oral powder</i>	4	PA; QL (25 GM per 1 day)
<i>sodium phenylbutyrate oral tablet</i>	4	PA; QL (40 tablets per 1 day)
<b>*VASOPRESSIN*** - HORMONES</b>		
<i>desmopressin ace spray refrig nasal solution</i>	1 or 1b*	
<i>desmopressin acetate injection solution</i>	1 or 1b*	
<i>desmopressin acetate oral tablet</i>	1 or 1b*	
<i>desmopressin acetate spray nasal solution</i>	1 or 1b*	
<b>*ESTROGENS* - HORMONES</b>		
<b>*ESTROGEN &amp; PROGESTIN*** - DRUGS FOR WOMEN</b>		
<i>estradiol-norethindrone acet</i> (Amabelz Oral Tablet)	1 or 1b*	
<b>CLIMARA PRO TRANSDERMAL PATCH WEEKLY</b> ( <i>estradiol-levonorgestrel</i> )	2	QL (4 patch per 28 days)
<b>COMBIPATCH TRANSDERMAL PATCH TWICE WEEKLY</b> ( <i>estradiol-norethindrone acet</i> )	2	QL (8 patch per 28 days)
<i>estradiol-norethindrone acet oral tablet</i>	1 or 1b*	
<i>norethindrone-eth estradiol</i> (Fyavolv Oral Tablet)	1 or 1b*	
<i>norethindrone-eth estradiol</i> (Jinteli Oral Tablet)	1 or 1b*	
<i>estradiol-norethindrone acet</i> (Lopreeza Oral Tablet)	1 or 1b*	
<i>estradiol-norethindrone acet</i> (Mimvey Oral Tablet)	1 or 1b*	
<i>norethindrone-eth estradiol oral tablet</i>	1 or 1b*	
<b>PREMPHASE ORAL TABLET</b> ( <i>conj estrog-medroxyprogest ace</i> )	2	
<b>PREMPRO ORAL TABLET</b> ( <i>conj estrog-medroxyprogest ace</i> )	2	
<b>*ESTROGENS*** - DRUGS FOR WOMEN</b>		
<b>DIVIGEL TRANSDERMAL GEL</b> ( <i>estradiol</i> )	2	QL (1 packet per 1 day)
<i>estradiol</i> (Dotti Transdermal Patch Twice Weekly)	1 or 1b*	QL (8 patch per 28 days)
<i>estradiol oral tablet</i>	1 or 1b*	
<i>estradiol transdermal patch twice weekly</i>	1 or 1b*	QL (8 patch per 28 days)
<i>estradiol transdermal patch weekly</i>	1 or 1b*	
<i>estradiol valerate intramuscular oil</i>	1 or 1b*	
<b>EVAMIST TRANSDERMAL SOLUTION</b> ( <i>estradiol</i> )	2	QL (2 bottles per 30 days)
<b>MENEST ORAL TABLET</b> ( <i>esterified estrogens</i> )	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMARIN INJECTION SOLUTION RECONSTITUTED ( <i>estrogens conjugated</i> )	2	
PREMARIN ORAL TABLET ( <i>estrogens conjugated</i> )	2	QL (1 tablet per 1 day)
<b>*FLUOROQUINOLONES* - DRUGS FOR INFECTIONS</b>		
<b>*FLUOROQUINOLONES*** - ANTIBIOTICS</b>		
<i>ciprofloxacin hcl oral tablet</i>	1 or 1b*	QL (28 tablets per 30 days)
<i>ciprofloxacin in d5w intravenous solution</i>	2	
<i>levofloxacin in d5w intravenous solution</i>	2	
<i>levofloxacin intravenous solution</i>	2	
<i>levofloxacin oral solution</i>	2	QL (480 mL per 30 days)
<i>levofloxacin oral tablet</i>	1 or 1b*	QL (14 tablets per 30 days)
<i>moxifloxacin hcl oral tablet</i>	2	QL (21 tablet per 30 days)
<i>ofloxacin oral tablet</i>	1 or 1b*	QL (28 tablet per 30 days)
<b>*GASTROINTESTINAL AGENTS - MISC.* - DRUGS FOR THE STOMACH</b>		
<b>*GALLSTONE SOLUBILIZING AGENTS*** - DRUGS FOR THE STOMACH</b>		
<i>ursodiol oral capsule</i>	2	
<i>ursodiol oral tablet</i>	2	
<b>*GASTROINTESTINAL ANTIALLERGY AGENTS*** - DRUGS FOR THE STOMACH</b>		
<i>cromolyn sodium oral concentrate</i>	1 or 1b*	
<b>*GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
AMITIZA ORAL CAPSULE ( <i>lubiprostone</i> )	2	
<b>*GASTROINTESTINAL STIMULANTS*** - DRUGS FOR THE STOMACH</b>		
<i>metoclopramide hcl injection solution</i>	1 or 1a*	
<i>metoclopramide hcl oral solution</i>	1 or 1a*	
<i>metoclopramide hcl oral tablet</i>	1 or 1a*	
<i>metoclopramide hcl oral tablet dispersible</i>	1 or 1a*	
<b>*IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
LINZESS ORAL CAPSULE ( <i>linaclotide</i> )	2	
<b>*IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS*** - DRUGS FOR IRRITABLE BOWEL SYNDROME</b>		
<i>alosetron hcl oral tablet</i>	2	PA; QL (2 tablets per 1 day)
<b>*INFLAMMATORY BOWEL AGENTS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE</b>		
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR ( <i>mesalamine</i> )	2	QL (4 capsule per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>balsalazide disodium oral capsule</i>	1 or 1b*	QL (9 capsule per 1 day)
<i>mesalamine er oral capsule extended release 24 hour</i>	2	QL (4 capsules per 1 day)
<i>mesalamine oral capsule delayed release</i>	2	QL (6 tablets per 1 day)
<i>mesalamine oral tablet delayed release 1.2 gm</i>	2	QL (4 tablets per 1 day)
<i>mesalamine oral tablet delayed release 800 mg</i>	2	QL (6 tablet per 1 day)
<i>mesalamine rectal enema</i>	2	QL (60 mL per 1 day)
<i>mesalamine rectal suppository</i>	2	QL (1 suppository per 1 day)
<i>mesalamine-cleanser rectal kit</i>	2	QL (1 kit per 28 days)
<b>PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG (mesalamine)</b>	2	QL (16 capsule per 1 day)
<b>PENTASA ORAL CAPSULE EXTENDED RELEASE 500 MG (mesalamine)</b>	2	QL (8 capsule per 1 day)
<i>sulfasalazine oral tablet</i>	1 or 1b*	QL (8 tablet per 1 day)
<i>sulfasalazine oral tablet delayed release</i>	1 or 1b*	QL (8 tablet per 1 day)
<b>*INTESTINAL ACIDIFIERS*** - DRUGS FOR THE STOMACH</b>		
<i>enulose oral solution</i>	1 or 1b*	
<i>generlac oral solution</i>	1 or 1b*	
<i>lactulose encephalopathy oral solution</i>	1 or 1b*	
<b>*PHOSPHATE BINDER AGENTS*** - DRUGS FOR THE STOMACH</b>		
<i>calcium acetate (phos binder) oral capsule</i>	2	
<i>calcium acetate (phos binder) oral tablet</i>	2	
<i>calcium acetate oral tablet</i>	2	
<i>lanthanum carbonate oral tablet chewable</i>	2	
<i>sevelamer carbonate oral packet</i>	2	
<i>sevelamer carbonate oral tablet</i>	2	
<i>sevelamer hcl oral tablet</i>	2	
<b>*TUMOR NECROSIS FACTOR ALPHA BLOCKERS*** - DRUGS FOR INFLAMMATORY BOWEL DISEASE</b>		
<b>REMICADE INTRAVENOUS SOLUTION RECONSTITUTED (infliximab)</b>	4	PA; SP
<b>*GENERAL ANESTHETICS* - DRUGS FOR PAIN AND FEVER</b>		
<b>*ANESTHETICS - MISC.*** - DRUGS FOR SEDATION</b>		
<i>etomidate intravenous solution</i>	1 or 1b*	
<i>fresenius propoven intravenous emulsion</i>	1 or 1b*	
<i>ketamine hcl injection solution</i>	1 or 1b*	
<i>propofol intravenous emulsion</i>	1 or 1b*	
<b>*VOLATILE ANESTHETICS*** - DRUGS FOR SEDATION</b>		
<i>desflurane inhalation solution</i>	1 or 1b*	
<i>isoflurane inhalation solution</i>	1 or 1b*	
<i>sevoflurane inhalation solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>isoflurane</i> (Terrell Inhalation Solution)	1 or 1b*	
<b>*GENITOURINARY AGENTS - MISCELLANEOUS* - DRUGS FOR THE URINARY SYSTEM</b>		
<b>*5-ALPHA REDUCTASE INHIBITORS*** - DRUGS FOR THE PROSTATE</b>		
<i>dutasteride oral capsule</i>	1 or 1b*	
<i>finasteride oral tablet</i>	1 or 1b*	
<b>*ALPHA 1-ADRENOCEPTOR ANTAGONISTS*** - DRUGS FOR THE PROSTATE</b>		
<i>alfuzosin hcl er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>silodosin oral capsule</i>	2	
<i>tamsulosin hcl oral capsule</i>	1 or 1b*	
<b>*ANTI-INFECTIVE GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM</b>		
<i>neomycin-polymyxin b gu irrigation solution</i>	2	
<b>*CITRATES*** - DRUGS FOR INFECTIONS</b>		
<i>pot &amp; sod cit-cit ac oral solution</i>	1 or 1b*	
<i>potassium citrate er oral tablet extended release</i>	1 or 1b*	
<i>potassium citrate-citric acid oral solution</i>	1 or 1b*	
<i>sod citrate-citric acid oral solution</i>	1 or 1b*	
<i>potassium citrate-citric acid</i> (Taron-Crystals Oral Packet)	1 or 1b*	
<i>tricitrates oral solution</i>	1 or 1b*	
<b>*GENITOURINARY IRRIGANTS*** - DRUGS FOR THE URINARY SYSTEM</b>		
<i>acetic acid irrigation solution</i>	1 or 1b*	
<i>aminoacetic acid irrigation solution</i>	1 or 1b*	
<i>glycine irrigation solution</i>	1 or 1b*	
<i>glycine urologic irrigation solution</i>	1 or 1b*	
<i>sodium chloride irrigation solution</i>	2	
<b>*PROSTATIC HYPERTROPHY AGENT COMBINATIONS*** - DRUGS FOR THE PROSTATE</b>		
<i>dutasteride-tamsulosin hcl oral capsule</i>	1 or 1b*	
<b>*GLYCOPEPTIDES*** - DRUGS FOR INFECTIONS</b>		
<b>*GLYCOPEPTIDES*** - DRUGS FOR INFECTIONS</b>		
<i>vancomycin hcl intravenous solution reconstituted</i>	2	
<i>vancomycin hcl oral capsule</i>	2	PA
<b>*GOUT AGENTS* - DRUGS FOR PAIN AND FEVER</b>		
<b>*GOUT AGENT COMBINATIONS*** - GOUT DRUGS</b>		
<i>colchicine-probenecid oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*GOUT AGENTS*** - GOUT DRUGS</b>		
<i>allopurinol oral tablet</i>	1 or 1a*	
<i>allopurinol sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>colchicine oral tablet</i>	2	QL (2.3 tablet per 1 day)
<b>COLCRYS ORAL TABLET</b> ( <i>colchicine</i> )	2	QL (2.3 tablet per 1 day)
<i>febuxostat oral tablet</i>	2	ST; QL (1 tablet per 1 day)
<b>*URICOSURICS*** - GOUT DRUGS</b>		
<i>probenecid oral tablet</i>	1 or 1b*	
<b>*HEMATOLOGICAL AGENTS - MISC.* - DRUGS FOR THE BLOOD</b>		
<b>*BRADYKININ B2 RECEPTOR ANTAGONISTS*** - DRUGS FOR THE BLOOD</b>		
<b>FIRAZYR SUBCUTANEOUS SOLUTION</b> ( <i>icatibant acetate</i> )	4	PA; LD; SP
<i>icatibant acetate subcutaneous solution</i>	4	PA; SP
<b>*C1 INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<b>BERINERT INTRAVENOUS KIT</b> ( <i>c1 esterase inhibitor (human)</i> )	4	PA; LD; SP
<b>HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT</b> ( <i>c1 esterase inhibitor (human)</i> )	4	PA; LD; SP; QL (24 vials per 28 days)
<b>HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT</b> ( <i>c1 esterase inhibitor (human)</i> )	4	PA; LD; SP; QL (16 vials per 28 days)
<b>RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED</b> ( <i>c1 esterase inhibitor (recomb)</i> )	4	PA; LD; SP
<b>*CYCLOPENTYLTRIAZOLOPYRIMIDINE (CPTP) DERIVATIVES*** - DRUGS FOR THE BLOOD</b>		
<b>BRILINTA ORAL TABLET</b> ( <i>ticagrelor</i> )	2	QL (2 tablets per 1 day)
<b>*GLYCOPROTEIN IIB/IIIA RECEPTOR INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<i>eptifibatid intravenous solution</i>	2	
<b>*HEMATORHEOLOGIC AGENTS*** - DRUGS FOR THE BLOOD</b>		
<i>pentoxifylline er oral tablet extended release</i>	1 or 1b*	
<b>*PHOSPHODIESTERASE III INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<i>cilostazol oral tablet</i>	2	
<b>*PLASMA EXPANDERS*** - DRUGS FOR THE BLOOD</b>		
<i>hetastarch-nacl intravenous solution</i>	1 or 1b*	
<b>LMD IN D5W INTRAVENOUS SOLUTION</b> ( <i>dextran 40 in d5w</i> )	1 or 1b*	
<b>LMD IN NAACL INTRAVENOUS SOLUTION</b> ( <i>dextran 40 in saline</i> )	1 or 1b*	
<b>*PLASMA KALLIKREIN INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<b>KALBITOR SUBCUTANEOUS SOLUTION</b> ( <i>ecallantide</i> )	4	PA; LD; SP
<b>*PLASMA PROTEINS*** - DRUGS FOR THE BLOOD</b>		
<i>albumin human</i> (Albuked 25 Intravenous Solution)	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>albumin human</i> (Albuked 5 Intravenous Solution)	1 or 1b*	
<i>albumin human intravenous solution</i>	1 or 1b*	
<i>albumin-zlb intravenous solution</i>	1 or 1b*	
<i>alburx intravenous solution</i>	1 or 1b*	
<i>albumin human</i> (Albutein Intravenous Solution)	1 or 1b*	
<i>albumin human</i> (Flexbumin Intravenous Solution)	1 or 1b*	
<i>albumin human</i> (Human Albumin Grifols Intravenous Solution)	1 or 1b*	
<i>kedbumin intravenous solution</i>	1 or 1b*	
<i>albumin human</i> (Plasbumin-25 Intravenous Solution)	1 or 1b*	
<i>albumin human</i> (Plasbumin-5 Intravenous Solution)	1 or 1b*	
<b>*PLATELET AGGREGATION INHIBITOR COMBINATIONS*** - DRUGS FOR THE BLOOD</b>		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour</i>	1 or 1b*	QL (2 capsules per 1 day)
<b>*PLATELET AGGREGATION INHIBITORS*** - DRUGS FOR THE BLOOD</b>		
<i>dipyridamole oral tablet</i>	2	
<b>*PROTAMINE*** - DRUGS FOR THE BLOOD</b>		
<i>protamine sulfate intravenous solution</i>	1 or 1b*	
<b>*QUINAZOLINE AGENTS*** - DRUGS FOR THE BLOOD</b>		
<i>anagrelide hcl oral capsule</i>	1 or 1b*	
<b>*THIENOPYRIDINE DERIVATIVES*** - DRUGS FOR THE BLOOD</b>		
<i>clopidogrel bisulfate oral tablet 300 mg</i>	1 or 1b*	
<i>clopidogrel bisulfate oral tablet 75 mg</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>prasugrel hcl oral tablet 10 mg</i>	2	QL (1 tablet per 1 day)
<i>prasugrel hcl oral tablet 5 mg</i>	2	
<b>*HEMATOPOIETIC AGENTS* - DRUGS FOR NUTRITION</b>		
<b>*AGENTS FOR GAUCHER DISEASE*** - DRUGS FOR NUTRITION</b>		
<i>miglustat oral capsule</i>	4	PA; SP
<b>*COBALAMINS*** - DRUGS FOR NUTRITION</b>		
<i>cyanocobalamin injection solution</i>	1 or 1a*	
<i>hydroxocobalamin acetate intramuscular solution</i>	1 or 1b*	
<b>*CYTOTOXIC AGENTS*** - DRUGS FOR NUTRITION</b>		
<b>DROXIA ORAL CAPSULE</b> ( <i>hydroxyurea</i> )	2	
<b>*ERYTHROPOIESIS-STIMULATING AGENTS (ESAS)*** - DRUGS FOR NUTRITION</b>		
<b>ARANESP (ALBUMIN FREE) INJECTION SOLUTION</b> ( <i>darbepoetin alfa</i> )	4	PA; SP
<b>ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE</b> ( <i>darbepoetin alfa</i> )	4	PA; SP
<b>PROCRIT INJECTION SOLUTION</b> ( <i>epoetin alfa</i> )	4	PA; SP

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RETACRIT INJECTION SOLUTION ( <i>epoetin alfa-epbx</i> )	4	PA; SP
<b>*ERYTHROPOIETINS*** - DRUGS FOR NUTRITION</b>		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION ( <i>darbepoetin alfa</i> )	4	PA; SP
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE ( <i>darbepoetin alfa</i> )	4	PA; SP
PROCRIT INJECTION SOLUTION ( <i>epoetin alfa</i> )	4	PA; SP
RETACRIT INJECTION SOLUTION ( <i>epoetin alfa-epbx</i> )	4	PA; SP
<b>*FOLIC ACID/FOLATE COMBINATIONS*** - DRUGS FOR NUTRITION</b>		
<i>folic acid-vit b6-vit b12</i> (Airavite Oral Tablet)	1 or 1b*	
<i>bp vit 3 oral capsule</i>	2	
<i>fabb oral tablet</i>	1 or 1b*	
<i>fa-vitamin b-6-vitamin b-12 oral tablet</i>	1 or 1b*	
<i>folbee oral tablet</i>	1 or 1b*	
<i>folplex 2.2 oral tablet</i>	1 or 1b*	
<i>folic acid-vit b6-vit b12</i> (Nufol Oral Tablet)	1 or 1b*	
TALIVA ORAL CAPSULE ( <i>fa-b6-b12-omega 3-phytosterols</i> )	2	
<i>tl gard rx oral tablet</i>	1 or 1b*	
<i>folic acid-vit b6-vit b12</i> (Virt-Gard Oral Tablet)	1 or 1b*	
<i>westab one oral tablet</i>	1 or 1b*	
<b>*FOLIC ACID/FOLATES*** - DRUGS FOR NUTRITION</b>		
<i>folic acid injection solution</i>	1 or 1a*	
<i>folic acid oral tablet</i>	1 or 1a*	
<b>*GRANULOCYTE COLONY-STIMULATING FACTORS (G-CSF)*** - DRUGS FOR NUTRITION</b>		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE ( <i>pegfilgrastim-jmdb</i> )	4	PA; SP; QL (2 syringes per 30 days)
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT ( <i>pegfilgrastim</i> )	4	PA; SP; QL (2 injectors/kits per 28 days)
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE ( <i>pegfilgrastim</i> )	4	PA; SP; QL (2 syringes per 28 days)
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE ( <i>filgrastim-sndz</i> )	4	PA; SP
<b>*IRON COMBINATIONS*** - DRUGS FOR NUTRITION</b>		
<i>iron combinations</i> (Chromagen Oral Capsule)	1 or 1b*	
<i>iron-folic acid-c-b6-b12-zinc</i> (Corvita 150 Oral Tablet)	1 or 1b*	
<i>ferocon oral capsule</i>	1 or 1b*	
<i>ferottrinsic oral capsule</i>	1 or 1b*	
<i>fe fum-fa-b cmp-c-zn-mg-mn-cu</i> (Ferrocite Plus Oral Tablet)	1 or 1b*	
<i>foltrin oral capsule</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hematinic plus vit/minerals oral tablet</i>	1 or 1b*	
<i>fe fum-vit c-vit b12-fa</i> (Hematogen Forte Oral Capsule)	1 or 1b*	
<i>iron combinations</i> (Hematogen Oral Capsule)	1 or 1b*	
<i>polysaccharide iron forte oral capsule</i>	1 or 1b*	
<i>purevit dualfe plus oral capsule</i>	1 or 1b*	
<i>se-tan plus oral capsule</i>	1 or 1b*	
<i>tl-hem 150 oral tablet</i>	1 or 1b*	
<i>fe fumarate-b12-vit c-fa-ifc</i> (Tricon Oral Capsule)	1 or 1b*	
<i>trigels-f forte oral capsule</i>	1 or 1b*	
<b>*IRON W/ FOLIC ACID*** - DRUGS FOR NUTRITION</b>		
<i>hematinic/folic acid oral tablet</i>	1 or 1b*	
<i>ferrous fumarate-folic acid</i> (Hemocyte-F Oral Tablet)	1 or 1b*	
<b>*IRON*** - DRUGS FOR NUTRITION</b>		
<i>na ferric gluc cplx in sucrose intravenous solution</i>	1 or 1b*	
<b>*THROMBOPOIETIN (TPO) RECEPTOR AGONISTS*** - DRUGS FOR NUTRITION</b>		
<b>PROMACTA ORAL TABLET</b> ( <i>eltrombopag olamine</i> )	4	PA; LD; SP
<b>*HEMOSTATICS* - DRUGS FOR THE BLOOD</b>		
<b>*HEMOSTATICS - SYSTEMIC*** - DRUGS TO PREVENT BLEEDING</b>		
<i>aminocaproic acid intravenous solution</i>	1 or 1b*	
<i>aminocaproic acid oral solution</i>	2	
<i>aminocaproic acid oral tablet</i>	2	
<i>tranexamic acid intravenous solution</i>	2	
<i>tranexamic acid oral tablet</i>	1 or 1b*	
<b>*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR INFECTIONS</b>		
<b>*HEPATITIS C AGENT - COMBINATIONS*** - DRUGS FOR INFECTIONS</b>		
<b>MAVYRET ORAL TABLET</b> ( <i>glecaprevir-pibrentasvir</i> )	4	PA; SP; QL (3 tablets per 1 day)
<i>sofosbuvir-velpatasvir oral tablet</i>	4	PA; SP; QL (1 tablet per 1 day)
<b>VOSEVI ORAL TABLET</b> ( <i>sofosbuv-velpatasv-voxilaprev</i> )	4	PA; SP; QL (1 tablet per 1 day)
<b>*HYPNOTICS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*BARBITURATE HYPNOTICS*** - DRUGS FOR INSOMNIA</b>		
<i>pentobarbital sodium injection solution</i>	1 or 1b*	
<i>phenobarbital oral solution</i>	1 or 1b*	
<i>phenobarbital oral tablet</i>	1 or 1b*	
<i>phenobarbital sodium injection solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*BENZODIAZEPINE HYPNOTICS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>estazolam oral tablet</i>	1 or 1b*	
<i>flurazepam hcl oral capsule</i>	1 or 1b*	
<i>midazolam hcl (pf) injection solution</i>	1 or 1b*	
<i>midazolam hcl injection solution</i>	1 or 1b*	
<i>midazolam hcl oral syrup</i>	1 or 1b*	
<i>quazepam oral tablet</i>	1 or 1b*	
<i>temazepam oral capsule</i>	1 or 1b*	
<i>triazolam oral tablet</i>	1 or 1b*	
<b>*NON-BENZODIAZEPINE - GABA-RECEPTOR MODULATORS*** - DRUGS FOR INSOMNIA</b>		
<i>eszopiclone oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zaleplon oral capsule</i>	1 or 1b*	ST; QL (1 capsule per 1 day)
<i>zolpidem tartrate oral tablet</i>	1 or 1b*	QL (1 tablet per 1 day)
<i>zolpidem tartrate sublingual tablet sublingual</i>	2	ST; QL (1 tablet per 1 day)
<b>*SELECTIVE ALPHA2-ADRENORECEPTOR AGONIST SEDATIVES*** - DRUGS FOR INSOMNIA</b>		
<i>dexmedetomidine hcl in nacl intravenous solution</i>	1 or 1b*	
<i>dexmedetomidine hcl intravenous solution</i>	1 or 1b*	
<b>*SELECTIVE MELATONIN RECEPTOR AGONISTS*** - DRUGS FOR INSOMNIA</b>		
<i>ramelteon oral tablet</i>	2	ST; QL (1 tablet per 1 day)
<b>*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH</b>		
<b>*INTEGRIN RECEPTOR ANTAGONISTS*** - DRUGS FOR THE STOMACH</b>		
<b>ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED (vedolizumab)</b>	4	PA; SP; QL (1 vial per 56 days)
<b>*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR THE STOMACH</b>		
<b>*INTERLEUKIN ANTAGONISTS*** - DRUGS FOR THE STOMACH</b>		
<b>STELARA INTRAVENOUS SOLUTION (ustekinumab)</b>	4	PA; SP; QL (4 vial per 365 days)
<b>*LAXATIVES* - DRUGS FOR THE STOMACH</b>		
<b>*BOWEL EVACUANT COMBINATIONS*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-C Oral Solution Reconstituted)</i>	1 or 1a*; \$0	
<i>peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted)</i>	1 or 1a*; \$0	
<i>bisacodyl-peg-kcl-nabicar-nacl (Gavilyte-H Oral Kit)</i>	1 or 1b*; \$0	
<i>peg 3350-kcl-na bicarb-nacl (Gavilyte-N With Flavor Pack Oral Solution Reconstituted)</i>	1 or 1a*; \$0	
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted</i>	1 or 1a*; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>peg-3350/electrolytes oral solution reconstituted</i>	1 or 1a*; \$0	
<i>bisacodyl-peg-kcl-nabicar-nacl</i> (Peg-Prep Oral Kit)	1 or 1b*; \$0	
<b>SUPREP BOWEL PREP KIT ORAL SOLUTION</b> ( <i>na sulfate-k sulfate-mg sulf</i> )	2	
<i>peg 3350-kcl-na bicarb-nacl</i> (Trilyte Oral Solution Reconstituted)	1 or 1a*; \$0	
<b>*LAXATIVES - MISCELLANEOUS*** - DRUGS TO PREVENT CONSTIPATION</b>		
<i>constulose oral solution</i>	1 or 1b*	
<i>lactulose oral packet</i>	2	
<i>lactulose oral solution</i>	1 or 1b*	
<b>*LOCAL ANESTHETICS-PARENTERAL* - DRUGS FOR PAIN AND FEVER</b>		
<b>*LOCAL ANESTHETIC &amp; SYMPATHOMIMETIC*** - DRUGS FOR SEDATION</b>		
<i>bupivacaine-epinephrine (pf) injection solution</i>	1 or 1b*	
<i>bupivacaine-epinephrine injection solution</i>	1 or 1b*	
<i>lidocaine-epinephrine injection solution</i>	1 or 1b*	
<i>bupivacaine-epinephrine</i> (Sensorcaine/Epinephrine Injection Solution)	1 or 1b*	
<i>bupivacaine-epinephrine</i> (Sensorcaine-Mpf/Epinephrine Injection Solution)	1 or 1b*	
<i>lidocaine-epinephrine</i> (Xylocaine Dental Injection Solution)	1 or 1b*	
<b>*LOCAL ANESTHETICS - AMIDES*** - DRUGS FOR SEDATION</b>		
<i>bupivacaine hcl (pf) injection solution</i>	1 or 1b*	
<i>bupivacaine hcl injection solution</i>	1 or 1b*	
<i>bupivacaine in dextrose intrathecal solution</i>	1 or 1b*	
<i>bupivacaine spinal intrathecal solution</i>	1 or 1b*	
<i>lidocaine hcl (pf) injection solution</i>	1 or 1b*	
<i>lidocaine hcl injection solution</i>	1 or 1b*	
<i>lidocaine hcl intradermal jet-injector</i>	1 or 1b*	
<i>mepivacaine hcl</i> (Polocaine Injection Solution)	1 or 1b*	
<i>mepivacaine hcl</i> (Polocaine-Mpf Injection Solution)	1 or 1b*	
<i>ropivacaine hcl injection solution</i>	1 or 1b*	
<i>bupivacaine hcl</i> (Sensorcaine Injection Solution)	1 or 1b*	
<i>bupivacaine hcl</i> (Sensorcaine-Mpf Injection Solution)	1 or 1b*	
<b>*LOCAL ANESTHETICS - ESTERS*** - DRUGS FOR SEDATION</b>		
<i>chloroprocaine hcl (pf) injection solution</i>	1 or 1b*	
<b>*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - DRUGS FOR THE EYE</b>		
<b>*LYMPHOCYTE FUNCTION-ASSOCIATED ANTIGEN-1 (LFA-1) ANTAG*** - DRUGS FOR THE EYE</b>		
<b>XIIDRA OPTHALMIC SOLUTION</b> ( <i>lifitegrast</i> )	3	PA; QL (2 vial per 1 day)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*MACROLIDES* - DRUGS FOR INFECTIONS</b>		
<b>*AZITHROMYCIN*** - ANTIBIOTICS</b>		
<i>azithromycin intravenous solution reconstituted</i>	2	
<i>azithromycin oral packet</i>	1 or 1b*	QL (2 packets per 30 days)
<i>azithromycin oral suspension reconstituted 100 mg/5ml</i>	1 or 1b*	QL (15 ML per 30 days)
<i>azithromycin oral suspension reconstituted 200 mg/5ml</i>	1 or 1b*	QL (15 mL per 30 days)
<i>azithromycin oral tablet 250 mg</i>	1 or 1b*	QL (6 tablets per 30 days)
<i>azithromycin oral tablet 500 mg</i>	1 or 1b*	QL (3 tablets per 30 days)
<i>azithromycin oral tablet 600 mg</i>	1 or 1b*	QL (8 tablet per 28 days)
<b>*CLARITHROMYCIN*** - ANTIBIOTICS</b>		
<i>clarithromycin er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>clarithromycin oral suspension reconstituted</i>	1 or 1b*	
<i>clarithromycin oral tablet</i>	1 or 1b*	
<b>*ERYTHROMYCINS*** - ANTIBIOTICS</b>		
<b>E.E.S. 400 ORAL TABLET</b> ( <i>erythromycin ethylsuccinate</i> )	1 or 1b*	
<i>erythromycin base</i> (Ery-Tab Oral Tablet Delayed Release)	1 or 1b*	
<b>ERYTHROCIN STEARATE ORAL TABLET</b> ( <i>erythromycin stearate</i> )	1 or 1b*	
<i>erythromycin base oral capsule delayed release particles</i>	1 or 1b*	
<i>erythromycin base oral tablet</i>	1 or 1b*	
<i>erythromycin base oral tablet delayed release</i>	1 or 1b*	
<i>erythromycin ethylsuccinate oral suspension reconstituted</i>	2	
<i>erythromycin ethylsuccinate oral tablet</i>	1 or 1b*	
<i>erythromycin oral tablet delayed release</i>	1 or 1b*	
<b>*MEDICAL DEVICES* - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<b>*CERVICAL CAPS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<b>FEMCAP VAGINAL DEVICE</b> ( <i>cervical caps</i> )	2; \$0	
<b>*DIAPHRAGMS*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<b>CAYA VAGINAL DIAPHRAGM</b> ( <i>diaphragm arc-spring</i> )	2; \$0	
<b>WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM</b> ( <i>diaphragm wide seal</i> )	2; \$0	
<b>WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM</b> ( <i>diaphragm wide seal</i> )	2; \$0	
<b>WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM</b> ( <i>diaphragm wide seal</i> )	2; \$0	
<b>WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM</b> ( <i>diaphragm wide seal</i> )	2; \$0	
<b>WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM</b> ( <i>diaphragm wide seal</i> )	2; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM ( <i>diaphragm wide seal</i> )	2; \$0	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM ( <i>diaphragm wide seal</i> )	2; \$0	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM ( <i>diaphragm wide seal</i> )	2; \$0	
<b>*GLUCOSE MONITORING TEST SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
ACCU-CHEK FASTCLIX LANCET KIT ( <i>lancets misc.</i> )	2	
ACCU-CHEK FASTCLIX LANCETS ( <i>lancets</i> )	2	
ACCU-CHEK MULTICLIX LANCET DEV KIT ( <i>lancets misc.</i> )	2	
ACCU-CHEK MULTICLIX LANCETS ( <i>lancets</i> )	2	
ACCU-CHEK SAFE-T PRO LANCETS ( <i>lancets</i> )	2	
ACCU-CHEK SOFTCLIX LANCET DEV KIT ( <i>lancets misc.</i> )	2	
ACCU-CHEK SOFTCLIX LANCETS ( <i>lancets</i> )	2	
COAGUCHEK LANCETS ( <i>lancets</i> )	2	
LIFESCAN UNISTIK 2 ( <i>lancets</i> )	2	
LIFESCAN UNISTIK II LANCETS ( <i>lancets</i> )	2	
ONETOUCH CLUB LANCETS FINE PT ( <i>lancets</i> )	2	
ONETOUCH DELICA LANCETS 30G ( <i>lancets</i> )	2	
ONETOUCH DELICA LANCETS 33G ( <i>lancets</i> )	2	
ONETOUCH DELICA LANCING DEV ( <i>lancet devices</i> )	2	
ONETOUCH DELICA PLUS LANCET30G ( <i>lancets</i> )	2	
ONETOUCH DELICA PLUS LANCET33G ( <i>lancets</i> )	2	
ONETOUCH DELICA PLUS LANCING ( <i>lancet devices</i> )	2	
ONETOUCH FINEPOINT LANCETS ( <i>lancets</i> )	2	
ONETOUCH SURESOFT LANCING DEV ( <i>lancets misc.</i> )	2	
ONETOUCH ULTRASOFT LANCETS ( <i>lancets</i> )	2	
PENLET II BLOOD SAMPLER KIT ( <i>lancets misc.</i> )	2	
PENLET II REPLACEMENT CAP ( <i>lancets misc.</i> )	2	
<b>*NEEDLES &amp; SYRINGES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<i>1st tier unifine pentips</i>	3	ST
<i>1st tier unifine pentips plus</i>	3	ST
ADVOCATE INSULIN PEN NEEDLES ( <i>insulin pen needle</i> )	3	ST
ADVOCATE INSULIN SYRINGE ( <i>insulin syringe-needle u-100</i> )	3	ST
ASSURE ID INSULIN SAFETY SYR ( <i>insulin syringe-needle u-100</i> )	3	ST
ASSURE ID SAFETY PEN NEEDLES ( <i>insulin pen needle</i> )	3	ST
<i>aurora pen needles</i>	3	ST
<i>aurora unifine pentips</i>	3	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BD AUTOSHIELD</b> ( <i>insulin pen needle</i> )	2	
<b>BD AUTOSHIELD DUO</b> ( <i>insulin pen needle</i> )	2	
<b>BD INSULIN SYR ULTRAFINE II</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD INSULIN SYRINGE</b> ( <i>insulin syringes (disposable)</i> )	2	
<b>BD INSULIN SYRINGE MICROFINE</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD INSULIN SYRINGE U/F</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD INSULIN SYRINGE U/F 1/2UNIT</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD INSULIN SYRINGE U-500</b> ( <i>insulin syringe/needle u-500</i> )	2	
<b>BD INSULIN SYRINGE ULTRAFINE</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD PEN NEEDLE MICRO U/F</b> ( <i>insulin pen needle</i> )	2	
<b>BD PEN NEEDLE MINI U/F</b> ( <i>insulin pen needle</i> )	2	
<b>BD PEN NEEDLE NANO 2ND GEN</b> ( <i>insulin pen needle</i> )	2	
<b>BD PEN NEEDLE NANO U/F</b> ( <i>insulin pen needle</i> )	2	
<b>BD PEN NEEDLE ORIGINAL U/F</b> ( <i>insulin pen needle</i> )	2	
<b>BD PEN NEEDLE SHORT U/F</b> ( <i>insulin pen needle</i> )	2	
<b>BD SAFETYGLIDE INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD SAFETY-LOK INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>BD VEO INSULIN SYRINGE U/F</b> ( <i>insulin syringe-needle u-100</i> )	2	
<b>CAREFINE PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<i>careone insulin syringe</i>	3	ST
<i>careone unifine pentips</i>	3	ST
<i>careone unifine pentips plus</i>	3	ST
<b>CARETOUCH INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>CARETOUCH PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>CLEVER CHOICE COMFORT EZ</b> ( <i>insulin pen needle</i> )	3	ST
<b>CLICKFINE PEN NEEDLES 31G X 5 MM</b> ( <i>insulin pen needle</i> )	3	ST
<i>clickfine pen needles 31g x 6 mm , 31g x 8 mm , 32g x 4 mm</i>	3	ST
<b>COMFORT ASSIST INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>COMFORT EZ INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>COMFORT EZ MICRO PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>COMFORT EZ PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>COMFORT EZ SHORT PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 1/2" 0.3 ML, 30G X 1/2" 0.5 ML, 30G X 1/2" 1 ML, 30G X 15/64" 0.3 ML, 30G X 15/64" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 15/64" 0.3 ML, 31G X 15/64" 0.5 ML, 31G X 15/64" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML</b> ( <i>insulin syringe-needle u-100</i> )	3	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DROPLET PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<i>dropsafe safety pen needles</i>	3	ST
<i>drug mart unifine pentips</i>	3	ST
<i>drug mart unifine pentips plus</i>	3	ST
<i>easy comfort insulin syringe</i>	3	ST
<i>easy comfort pen needles</i>	3	ST
<i>easy glide pen needles</i>	3	ST
<b>EASY TOUCH FLIPLOCK INSULIN SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>EASY TOUCH INSULIN SAFETY SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>EASY TOUCH INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>EASY TOUCH PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>EASY TOUCH SHEATHLOCK SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>eql insulin syringe</i>	3	ST
<b>EXEL COMFORT POINT INSULIN SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>EXEL COMFORT POINT PEN NEEDLE</b> ( <i>insulin pen needle</i> )	3	ST
<b>FIFTY50 PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>FIFTY50 SUPERIOR COMFORT SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>freds pharmacy unifine pentip+</i>	3	ST
<i>freds pharmacy unifine pentips</i>	3	ST
<b>FREESTYLE PRECISION INS SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>global ease inject pen needles</i>	3	ST
<i>global easy glide insulin syr 31g x 15/64" 0.3 ml, 31g x 15/64" 0.5 ml, 31g x 5/16" 0.3 ml</i>	3	ST
<i>global easy glide insulin syr 31g x 15/64" 1 ml</i>	3	
<i>global easy glide pen needles</i>	3	ST
<i>global inject ease insulin syr</i>	3	ST
<i>global insulin syringes</i>	3	ST
<b>GLUCOPRO INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>gnp clickfine pen needles</i>	3	ST
<i>gnp insulin syringe</i>	3	ST
<i>gnp ultra com insulin syringe</i>	3	ST
<i>goodsense clickfine pen needle</i>	3	ST
<b>GOODSENSE PEN NEEDLE PENFINE</b> ( <i>insulin pen needle</i> )	3	ST
<i>healthwise insulin syr/needle</i>	3	ST
<i>healthwise micron pen needles</i>	3	ST
<i>healthwise mini pen needles</i>	3	ST
<i>healthwise pen needles</i>	3	ST
<i>healthwise short pen needles</i>	3	ST
<i>healthwise unifine pentips</i>	3	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>healthy accents unifine pentip</i>	3	ST
<i>h-e-b incontrol pen needles</i>	3	ST
<b>H-E-B INCONTROL UNIFINE PENTIP</b> ( <i>insulin pen needle</i> )	3	ST
<i>insulin syringe 27g x 1/2" 0.5 ml, 27g x 1/2" 1 ml, 28g x 1/2" 0.5 ml, 29g x 1/2" 0.3 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 30g x 1/2" 0.5 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml</i>	3	ST
<i>insulin syringe 29g x 1" 0.3 ml</i>	3	
<i>insulin syringe/needle</i>	3	ST
<i>insulin syringe-needle u-100</i>	3	ST
<i>insupen pen needles</i>	3	ST
<b>INSUPEN SENSITIVE</b> ( <i>insulin pen needle</i> )	3	ST
<b>INSUPEN ULTRAFIN</b> ( <i>insulin pen needle</i> )	3	ST
<i>kinray insulin syringe</i>	3	ST
<i>kmart valu insulin syringe 29g</i>	3	ST
<i>kmart valu insulin syringe 30g</i>	3	ST
<i>kroger insulin syringe</i>	3	ST
<i>kroger pen needles</i>	3	ST
<i>leader insulin syringe</i>	3	ST
<b>LEADER UNIFINE PENTIPS</b> ( <i>insulin pen needle</i> )	3	ST
<b>LEADER UNIFINE PENTIPS PLUS</b> ( <i>insulin pen needle</i> )	3	ST
<b>LITETOUCH INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>LITETOUCH PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<i>longs insulin syringe</i>	3	ST
<b>MAGELLAN INSULIN SAFETY SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>MARATHON MEDICAL PENTIPS</b> ( <i>insulin pen needle</i> )	3	ST
<b>MAXICOMFORT II PEN NEEDLE</b> ( <i>insulin pen needle</i> )	3	ST
<b>MAXI-COMFORT INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>MAXI-COMFORT SAFETY PEN NEEDLE</b> ( <i>insulin pen needle</i> )	3	ST
<b>MAXICOMFORT SYR 27G X 1/2"</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>medicine shoppe pen needles</i>	3	ST
<i>meijer pen needles</i>	3	ST
<i>mm insulin syringe/needle</i>	3	ST
<b>MM PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>MONOJECT INSULIN SYRINGE</b> ( <i>insulin syringes (disposable)</i> )	3	ST
<b>MONOJECT ULTRA COMFORT SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>ms insulin syringe</i>	3	ST
<b>NOVOFINE</b> ( <i>insulin pen needle</i> )	3	ST
<b>NOVOFINE AUTOCOVER</b> ( <i>insulin pen needle</i> )	3	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NOVOFINE PLUS</b> ( <i>insulin pen needle</i> )	3	ST
<b>NOVOTWIST</b> ( <i>insulin pen needle</i> )	3	ST
<i>pc unifine pentips</i>	3	ST
<i>pen needles</i>	3	ST
<i>pen needles 1/2"</i>	3	ST
<i>pen needles 3/16"</i>	3	ST
<i>pen needles 5/16"</i>	3	ST
<b>PENTIPS</b> ( <i>insulin pen needle</i> )	3	ST
<b>PRECISION SUREDOSE PLUS SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>PRECISION SURE-DOSE SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.5 ML, 30G X 5/16" 0.3 ML</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>PRECISION SURE-DOSE SYRINGE 30G X 3/8" 0.5 ML</b> ( <i>insulin syringe-needle u-100</i> )	3	
<i>preferred plus insulin syringe</i>	3	ST
<i>preferred plus unifine pentips</i>	3	ST
<b>PRO COMFORT INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>pro comfort pen needles</i>	3	ST
<b>PRODIGY INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>px extra short pen needles</i>	3	ST
<i>px insulin syringe</i>	3	ST
<i>px mini pen needles</i>	3	ST
<i>px pen needle</i>	3	ST
<i>px shortlength pen needles</i>	3	ST
<i>qc pen needles</i>	3	ST
<i>qc unifine pentips</i>	3	ST
<i>ra insulin syringe</i>	3	ST
<i>ra pen needles</i>	3	ST
<i>reality insulin syringe</i>	3	ST
<b>RELION INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>RELI-ON INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>RELION MINI PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>RELION PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>RELION SHORT PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>SAFESNAP INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>sb insulin syringe</i>	3	ST
<b>SHOPKO UNIFINE PENTIPS</b> ( <i>insulin pen needle</i> )	3	ST
<b>SHOPKO UNIFINE PENTIPS PLUS</b> ( <i>insulin pen needle</i> )	3	ST
<i>sure comfort insulin syringe</i>	3	ST
<i>sure comfort pen needles</i>	3	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SURE-FINE PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>SURE-JECT INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<i>techlite insulin syringe</i>	3	ST
<b>TECHLITE PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<i>today's health mini pen needles</i>	3	ST
<i>today's health pen needles</i>	3	ST
<i>today's health short pen needle</i>	3	ST
<i>topcare clickfine pen needles</i>	3	ST
<i>topcare ultra comfort ins syr</i>	3	ST
<i>true comfort insulin syringe</i>	3	ST
<i>true comfort pen needles</i>	3	ST
<b>TRUEPLUS 5-BEVEL PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	
<b>TRUEPLUS INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>TRUEPLUS PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>ULTICARE INSULIN SAFETY SYR</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>ULTICARE INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>ULTICARE MICRO PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>ULTICARE MINI PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>ULTICARE PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>ULTICARE SHORT PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<i>ultiguard safepack pen needle</i>	3	ST
<b>ULTILET PEN NEEDLE</b> ( <i>insulin pen needle</i> )	3	ST
<i>ultra comfort insulin syringe</i>	3	ST
<b>ULTRA THIN PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<i>ultracare insulin syringe</i>	3	ST
<i>ultracare pen needles</i>	3	ST
<i>ultra-comfort insulin syringe</i>	3	ST
<b>ULTRA-THIN II INS SYR SHORT</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>ULTRA-THIN II INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>ULTRA-THIN II MINI PEN NEEDLE</b> ( <i>insulin pen needle</i> )	3	ST
<b>ULTRA-THIN II PEN NEEDLE SHORT</b> ( <i>insulin pen needle</i> )	3	ST
<b>ULTRA-THIN II PEN NEEDLES</b> ( <i>insulin pen needle</i> )	3	ST
<b>UNIFINE PENTIPS</b> ( <i>insulin pen needle</i> )	3	ST
<b>UNIFINE PENTIPS PLUS</b> ( <i>insulin pen needle</i> )	3	ST
<i>value health insulin syringe</i>	3	ST
<i>valumark pen needles</i>	3	ST
<b>VANISHPOINT INSULIN SYRINGE</b> ( <i>insulin syringe-needle u-100</i> )	3	ST
<b>VIDA MIA UNIFINE PENTIPS</b> ( <i>insulin pen needle</i> )	3	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>vp insulin syringe</i>	3	ST
<i>wegmans unifine pentips plus</i>	3	ST
<b>*OSTOMY SUPPLIES*** - MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT</b>		
<b>KANGAROO BALLOON 12FR/0.8CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/1.2CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/1.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/1.7CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/1CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/2.3CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/2.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/2.7CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/2CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/3.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/3CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/4.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/4CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 12FR/5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/0.8CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/1.2CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/1.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/1.7CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/2.3CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/2.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/2.7CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/3.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/3CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/4.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 14FR/5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/0.8CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/1.2CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/1.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/1.7CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/1CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/2.3CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/2.7CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/2CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/3.5CM KIT</b> ( <i>ostomy supplies</i> )	2	
<b>KANGAROO BALLOON 16FR/3CM KIT</b> ( <i>ostomy supplies</i> )	2	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KANGAROO BALLOON 16FR/4.5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 16FR/4CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 16FR/5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/0.8CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/1.2CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/1.5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/1.7CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/1CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/2.3CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/2.5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/2.7CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/2CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/3.5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/3CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/4.5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/4CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 18FR/5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/0.8CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/1.2CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/1.5CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/1.7CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/1CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/2.3CM KIT (ostomy supplies)	2	
KANGAROO BALLOON 20FR/2CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 20FR/2.5CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 20FR/2.7CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 20FR/3.5CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 20FR/4.5CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 20FR/4CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 20FR/5CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/0.8CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/1.2CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/1.5CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/1.7CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/1CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/2.3CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/2.5CM KIT (ostomy supplies)	2	
NUTRIPOINT BALLOON 24FR/2.7CM KIT (ostomy supplies)	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUTRIPOINT BALLOON 24FR/2CM KIT ( <i>ostomy supplies</i> )	2	
NUTRIPOINT BALLOON 24FR/3.5CM KIT ( <i>ostomy supplies</i> )	2	
NUTRIPOINT BALLOON 24FR/3CM KIT ( <i>ostomy supplies</i> )	2	
NUTRIPOINT BALLOON 24FR/4.5CM KIT ( <i>ostomy supplies</i> )	2	
<b>*MIGRAINE PRODUCTS* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ERGOT COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>ergotamine-caffeine oral tablet</i>	1 or 1b*	
MIGERGOT RECTAL SUPPOSITORY ( <i>ergotamine-caffeine</i> )	1 or 1b*	
<b>*MIGRAINE PRODUCTS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>dihydroergotamine mesylate injection solution</i>	1 or 1b*	PA
<i>dihydroergotamine mesylate nasal solution</i>	2	QL (8 bottles per 30 days)
<b>*SELECTIVE SEROTONIN AGONIST-NSAID COMBINATIONS*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>sumatriptan-naproxen sodium oral tablet</i>	2	ST; QL (9 tablets per 30 days)
<b>*SELECTIVE SEROTONIN AGONISTS 5-HT(1)*** - DRUGS FOR MIGRAINE HEADACHES</b>		
<i>almotriptan malate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>eletriptan hydrobromide oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>frovatriptan succinate oral tablet</i>	1 or 1b*	ST; QL (9 tablets per 30 days)
<i>naratriptan hcl oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>rizatriptan benzoate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>rizatriptan benzoate oral tablet dispersible</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>sumatriptan nasal solution</i>	1 or 1b*	QL (6 nasal inhalers per 30 days)
<i>sumatriptan succinate oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge</i>	2	QL (6 cartridges per 30 days)
<i>sumatriptan succinate subcutaneous solution</i>	2	QL (5 vials per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	2	QL (6 syringes (2 ML) per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	2	QL (6 cartridges (2ml) per 30 days)
<i>sumatriptan succinate subcutaneous solution prefilled syringe</i>	2	QL (2 syringes per 30 days)
<i>zolmitriptan oral tablet</i>	1 or 1b*	QL (9 tablets per 30 days)
<i>zolmitriptan oral tablet dispersible</i>	1 or 1b*	QL (9 tablets per 30 days)
<b>*MINERALS &amp; ELECTROLYTES* - DRUGS FOR NUTRITION</b>		
<b>*BICARBONATES*** - DRUGS FOR NUTRITION</b>		
<i>sodium acetate intravenous solution</i>	1 or 1b*	
<i>sodium bicarbonate intravenous solution</i>	2	
<i>sodium bicarbonate-dextrose intravenous solution</i>	2	
<b>*CALCIUM*** - DRUGS FOR NUTRITION</b>		
<i>calcium chloride intravenous solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a**\*=Drugs with the lowest cost share **Tier 1 or 1b**\*=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcium gluconate intravenous solution</i>	1 or 1b*	
<b>*ELECTROLYTES &amp; DEXTROSE*** - DRUGS FOR NUTRITION</b>		
<i>dextrose in lactated ringers intravenous solution</i>	1 or 1b*	
<i>dextrose-nacl intravenous solution</i>	1 or 1b*	
<i>kcl in dextrose-nacl intravenous solution</i>	1 or 1b*	
<i>potassium chloride in dextrose intravenous solution</i>	1 or 1b*	
<b>*ELECTROLYTES PARENTERAL*** - DRUGS FOR NUTRITION</b>		
<b>HYPERLYTE-CR INTRAVENOUS SOLUTION</b> ( <i>parenteral electrolytes</i> )	1 or 1b*	
<i>lactated ringers intravenous solution</i>	1 or 1b*	
<i>potassium chloride in nacl intravenous solution</i>	1 or 1b*	
<i>ringers intravenous solution</i>	1 or 1b*	
<b>*FLUORIDE*** - DRUGS FOR NUTRITION</b>		
<i>fluritab oral solution</i>	1 or 1a*	
<i>fluritab oral tablet chewable</i>	1 or 1a*; \$0	
<b>FLURA-DROPS ORAL SOLUTION</b> ( <i>sodium fluoride</i> )	1 or 1a*	
<i>sodium fluoride</i> (Ludent Oral Tablet Chewable)	1 or 1a*; \$0	
<i>sodium fluoride</i> (Nafrinse Drops Oral Solution)	1 or 1a*	
<i>sodium fluoride</i> (Nafrinse Oral Tablet Chewable)	1 or 1a*; \$0	
<i>sodium fluoride oral solution</i>	1 or 1a*; \$0	
<i>sodium fluoride oral tablet</i>	1 or 1a*	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 2.2 (1 f) mg</i>	1 or 1a*; \$0	
<i>sodium fluoride oral tablet chewable 1.1 (0.5 f) mg</i>	1 or 1a*	
<b>*MAGNESIUM*** - DRUGS FOR NUTRITION</b>		
<i>magnesium chloride injection solution</i>	1 or 1b*	
<i>magnesium sulfate in d5w intravenous solution</i>	1 or 1b*	
<i>magnesium sulfate injection solution</i>	2	
<i>magnesium sulfate intravenous solution</i>	2	
<b>*MANGANESE*** - DRUGS FOR NUTRITION</b>		
<i>manganese chloride intravenous solution</i>	1 or 1b*	
<i>manganese sulfate intravenous solution</i>	1 or 1b*	
<b>*PHOSPHATE*** - DRUGS FOR NUTRITION</b>		
<i>k phos mono-sod phos di &amp; mono</i> (Phospha 250 Neutral Oral Tablet)	1 or 1b*	
<i>phosphorous oral tablet</i>	1 or 1b*	
<i>sodium phosphates intravenous solution</i>	1 or 1b*	
<i>virt-phos 250 neutral oral tablet</i>	1 or 1b*	
<b>*POTASSIUM COMBINATIONS*** - DRUGS FOR NUTRITION</b>		
<i>pot bicarb-pot chloride oral tablet effervescent</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*POTASSIUM*** - DRUGS FOR NUTRITION</b>		
<i>potassium bicarbonate</i> (Effer-K Oral Tablet Effervescent)	1 or 1b*	
<i>potassium chloride</i> (Klor-Con 10 Oral Tablet Extended Release)	1 or 1b*	
<i>potassium chloride crys er</i> (Klor-Con M10 Oral Tablet Extended Release)	1 or 1a*	
<b>KLOR-CON M15 ORAL TABLET EXTENDED RELEASE</b> ( <i>potassium chloride crys er</i> )	1 or 1a*	
<i>potassium chloride crys er</i> (Klor-Con M20 Oral Tablet Extended Release)	1 or 1a*	
<i>potassium chloride</i> (Klor-Con Oral Packet)	1 or 1b*	
<i>potassium chloride</i> (Klor-Con Oral Tablet Extended Release)	1 or 1b*	
<i>potassium chloride</i> (Klor-Con Sprinkle Oral Capsule Extended Release)	1 or 1b*	
<i>potassium bicarbonate</i> (Klor-Con/Ef Oral Tablet Effervescent)	1 or 1b*	
<i>potassium bicarbonate</i> (K-Prime Oral Tablet Effervescent)	1 or 1b*	
<i>potassium acetate intravenous solution</i>	1 or 1b*	
<i>potassium bicarbonate oral tablet effervescent</i>	1 or 1b*	
<i>potassium chloride crys er oral tablet extended release</i>	1 or 1a*	
<i>potassium chloride er oral capsule extended release</i>	1 or 1b*	
<i>potassium chloride er oral tablet extended release</i>	1 or 1b*	
<i>potassium chloride intravenous solution</i>	1 or 1b*	
<i>potassium chloride oral packet</i>	1 or 1b*	
<i>potassium chloride oral solution</i>	1 or 1b*	
<b>*SODIUM*** - DRUGS FOR NUTRITION</b>		
<i>sodium chloride flush</i> (Monoject Flush Syringe Intravenous Solution)	2	
<i>sodium chloride flush</i> (Monoject Sodium Chloride Flush Intravenous Solution)	2	
<i>normal saline flush intravenous solution</i>	2	
<i>saline flush intravenous solution</i>	2	
<i>sodium chloride flush</i> (Saline Flush Zr Intravenous Solution)	2	
<i>sodium chloride (pf) injection solution</i>	2	
<i>sodium chloride flush intravenous solution</i>	2	
<i>sodium chloride injection solution</i>	2	
<i>sodium chloride intravenous solution</i>	2	
<i>sodium chloride flush</i> (Swabflush Saline Flush Intravenous Solution)	2	
<b>*TRACE MINERAL COMBINATIONS*** - DRUGS FOR NUTRITION</b>		
<i>multitrace-4 concentrate intravenous solution</i>	1 or 1b*	
<i>multitrace-5 concentrate intravenous solution</i>	1 or 1b*	
<b>*TRACE MINERALS*** - DRUGS FOR NUTRITION</b>		
<i>chromic chloride intravenous solution</i>	1 or 1b*	
<i>copper chloride intravenous solution</i>	1 or 1b*	
<i>selenium intravenous solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*ZINC*** - DRUGS FOR NUTRITION</b>		
<i>zinc sulfate intravenous solution</i>	1 or 1b*	
<b>*MONOBACTAMS*** - DRUGS FOR INFECTIONS</b>		
<b>*MONOBACTAMS*** - DRUGS FOR INFECTIONS</b>		
<i>aztreonam injection solution reconstituted</i>	2	
<b>*MOUTH/THROAT/DENTAL AGENTS* - DRUGS FOR THE MOUTH AND THROAT</b>		
<b>*ANESTHETICS TOPICAL ORAL*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>lidocaine hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
<i>lidocaine viscous hcl mouth/throat solution</i>	1 or 1a*	QL (10 mL per 1 day)
<b>*ANTI-INFECTIVES - THROAT*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>clotrimazole mouth/throat lozenge</i>	1 or 1b*	QL (5 tablet per 1 day)
<i>clotrimazole mouth/throat troche</i>	1 or 1b*	QL (5 tablet per 1 day)
<i>nystatin mouth/throat suspension</i>	1 or 1b*	
<b>*ANTISEPTICS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>chlorhexidine gluconate mouth/throat solution</i>	1 or 1a*	
<i>chlorhexidine gluconate (Paroex Mouth/Throat Solution)</i>	1 or 1a*	
<i>chlorhexidine gluconate (Periogard Mouth/Throat Solution)</i>	1 or 1a*	
<b>*FLUORIDE DENTAL PRODUCTS*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>sodium fluoride (Cavarest Dental Gel)</i>	1 or 1b*	
<i>sodium fluoride (Dentagel Dental Gel)</i>	1 or 1a*	
<b>EASYGEL DENTAL GEL</b> ( <i>stannous fluoride</i> )	1 or 1b*	
<i>neutral sodium fluoride mouth/throat solution</i>	1 or 1a*	
<i>sf dental gel</i>	1 or 1a*	
<b>*SALIVA STIMULANTS*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>cevimeline hcl oral capsule</i>	2	
<i>pilocarpine hcl oral tablet</i>	2	
<b>*STERIODS - MOUTH/THROAT*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>triamcinolone acetonide (Oralene Mouth/Throat Paste)</i>	1 or 1b*	
<i>triamcinolone acetonide mouth/throat paste</i>	1 or 1b*	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*MULTIPLE SCLEROSIS AGENTS - ANTIMETABOLITES*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK (cladribine)	4	PA; LD; SP; QL (2 packs per 46 weekss)
<b>*MULTIVITAMINS* - DRUGS FOR NUTRITION</b>		
<b>*B-COMPLEX W/ C &amp; FOLIC ACID*** - DRUGS FOR NUTRITION</b>		
<i>b-plex oral tablet</i>	1 or 1b*	
<i>b complex-c-folic acid</i> (Dexifol Oral Tablet)	1 or 1b*	
<i>b complex-c-folic acid</i> (Dialyvite Oral Tablet)	1 or 1b*	
<i>folbee plus oral tablet</i>	1 or 1b*	
<i>b complex-c-folic acid</i> (Genicin Vita-S Oral Tablet)	1 or 1b*	
<i>hylavite oral tablet</i>	1 or 1b*	
<i>lorid oral tablet</i>	1 or 1b*	
<i>mynephrocaps oral capsule</i>	1 or 1b*	
<i>b complex-c-folic acid</i> (Mynephron Oral Capsule)	1 or 1b*	
<i>b complex-c-folic acid</i> (Nephronex Oral Tablet)	1 or 1b*	
<i>b complex-c-folic acid</i> (Renal Oral Capsule)	1 or 1b*	
<i>reno caps oral capsule</i>	1 or 1b*	
<i>triphrocaps oral capsule</i>	1 or 1b*	
<i>tronvite oral tablet</i>	1 or 1b*	
<i>virt-caps oral capsule</i>	1 or 1b*	
<i>vp-vite rx oral tablet</i>	1 or 1b*	
<b>*MULTIPLE VITAMINS W/ MINERALS &amp; FOLIC ACID*** - DRUGS FOR NUTRITION</b>		
CORVITA ORAL TABLET ( <i>multiple vitamins-minerals-fa</i> )	1 or 1b*	
<b>*MULTIPLE VITAMINS W/ MINERALS*** - DRUGS FOR NUTRITION</b>		
<i>biocel oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>b-plex plus oral tablet</i>	1 or 1b*	
<i>multiple vitamins-minerals (Corvite Free Oral Tablet)</i>	1 or 1b*	
<i>multiple vitamins-minerals (Lysiplex Plus Oral Tablet)</i>	1 or 1b*	
<b>NICAZEL FORTE ORAL TABLET</b> ( <i>multiple vitamins-minerals</i> )	2	
<b>NICAZEL ORAL TABLET</b> ( <i>multiple vitamins-minerals</i> )	2	
<i>multiple vitamins-minerals (Nutrifac Zx Oral Tablet)</i>	1 or 1b*	
<i>v-c forte oral capsule</i>	1 or 1b*	
<i>multiple vitamins-minerals (Vic-Forte Oral Capsule)</i>	1 or 1b*	
<i>multiple vitamins-minerals (Vita S Forte Oral Tablet)</i>	1 or 1b*	
<b>*PED MULTI VITAMINS W/FL &amp; FE*** - DRUGS FOR NUTRITION</b>		
<i>multi-vit/iron/fluoride oral solution</i>	1 or 1b*	
<i>multivitamin/fluoride/iron oral solution</i>	1 or 1b*	
<i>multi-vitamin/fluoride/iron oral solution</i>	1 or 1b*	
<b>*PED MULTIPLE VITAMINS W/ MINERALS &amp; C*** - DRUGS FOR NUTRITION</b>		
<i>pediatric multivit-minerals-c (Vitamax Pediatric Oral Solution)</i>	1 or 1b*	
<b>*PED MV W/ FLUORIDE*** - DRUGS FOR NUTRITION</b>		
<i>multivitamin/fluoride oral solution</i>	1 or 1b*; \$0	
<i>multi-vitamin/fluoride oral solution</i>	1 or 1b*; \$0	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg</i>	1 or 1b*; \$0	
<i>multivitamin/fluoride oral tablet chewable 1 mg</i>	1 or 1b*	
<i>multivitamins/fluoride oral tablet chewable</i>	1 or 1b*; \$0	
<i>pediatric multivitamins-fl (Mvc-Fluoride Oral Tablet Chewable 0.25 Mg, 0.5 Mg)</i>	1 or 1b*; \$0	
<i>pediatric multivitamins-fl (Mvc-Fluoride Oral Tablet Chewable 1 Mg)</i>	1 or 1b*	
<b>*PED VITAMINS ACD W/ FLUORIDE*** - DRUGS FOR NUTRITION</b>		
<i>tri-vitamin/fluoride oral solution</i>	1 or 1b*; \$0	
<i>tri-vite/fluoride oral solution</i>	1 or 1b*; \$0	
<i>vitamins acd-fluoride oral solution</i>	1 or 1b*; \$0	
<b>*PRENATAL MV &amp; MIN W/FE-FA*** - DRUGS FOR NUTRITION</b>		
<i>completenate oral tablet chewable</i>	2	
<b>ELITE-OB ORAL TABLET</b> ( <i>prenatal vit-iron carbonyl-fa</i> )	1 or 1b*	
<b>FOLIVANE-OB ORAL CAPSULE</b> ( <i>prenat w/o a vit-fefum-fepo-fa</i> )	2	
<b>INATAL GT ORAL TABLET</b> ( <i>prenatal vit-dss-fe cbn-fa</i> )	1 or 1b*	
<i>mynatal plus oral tablet</i>	2	
<i>mynatal-z oral tablet</i>	2	
<i>mynate 90 plus oral tablet extended release</i>	2	
<i>pnv prenatal plus multivitamin oral tablet</i>	2	
<i>pnv tabs 29-1 oral tablet</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PRENATABS RX ORAL TABLET</b> ( <i>prenatal vit-iron carbonyl-fa</i> )	1 or 1a*	
<i>prenatal oral tablet</i>	2	
<i>prenatal plus iron oral tablet</i>	2	
<i>prenatal vitamin plus low iron oral tablet</i>	2	
<b>PRENATAL-U ORAL CAPSULE</b> ( <i>prenatal w/o a vit-fe fum-fa</i> )	2	
<i>preplus oral tablet</i>	2	
<i>pretab oral tablet</i>	2	
<i>se-natal 19 oral tablet</i>	2	
<i>se-natal 19 oral tablet chewable</i>	2	
<i>thrivite 19 oral tablet</i>	2	
<i>trinatal rx 1 oral tablet</i>	2	
<b>TRINATE ORAL TABLET</b> ( <i>prenatal vit-fe fumarate-fa</i> )	1 or 1a*	
<b>VINATE II ORAL TABLET</b> ( <i>prenatal vit w/ fe bisg-fa</i> )	2	
<b>VINATE M ORAL TABLET</b> ( <i>prenatal vit-sel-fe fum-fa</i> )	2	
<b>VINATE ONE ORAL TABLET</b> ( <i>prenatal vit-fe fumarate-fa</i> )	2	
<i>vol-plus oral tablet</i>	2	
<i>vol-tab rx oral tablet</i>	2	
<b>*PRENATAL MV &amp; MIN W/FE-FA-CA-OMEGA 3 FISH OIL*** - DRUGS FOR NUTRITION</b>		
<b>PR NATAL 400 EC ORAL</b> ( <i>prenat-febis-fepro-fa-ca-omega</i> )	2	
<b>PR NATAL 400 ORAL</b> ( <i>prenat-febis-fepro-fa-ca-omega</i> )	2	
<b>PR NATAL 430 EC ORAL</b> ( <i>prenat-febis-fepro-fa-ca-omega</i> )	2	
<b>PR NATAL 430 ORAL</b> ( <i>prenat-febis-fepro-fa-ca-omega</i> )	2	
<b>TRIVEEN-DUO DHA ORAL</b> ( <i>prenat-febis-fepro-fa-ca-omega</i> )	2	
<b>*PRENATAL VITAMINS*** - DRUGS FOR NUTRITION</b>		
<i>prenal oral tablet chewable</i>	2	
<b>*MUSCULOSKELETAL THERAPY AGENTS* - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<b>*CENTRAL MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<i>baclofen intrathecal solution</i>	4	
<i>baclofen oral tablet</i>	1 or 1b*	
<i>carisoprodol oral tablet</i>	1 or 1b*	
<i>chlorzoxazone oral tablet 375 mg, 750 mg</i>	1 or 1b*	ST
<i>chlorzoxazone oral tablet 500 mg</i>	1 or 1b*	
<i>cyclobenzaprine hcl oral tablet</i>	1 or 1b*	
<b>FEXMID ORAL TABLET</b> ( <i>cyclobenzaprine hcl</i> )	1 or 1b*	ST
<i>chlorzoxazone</i> (Lorzone Oral Tablet)	1 or 1b*	ST
<i>metaxalone oral tablet</i>	1 or 1b*	ST

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methocarbamol injection solution</i>	1 or 1b*	
<i>methocarbamol oral tablet</i>	1 or 1b*	
<i>orphenadrine citrate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>orphenadrine citrate injection solution</i>	1 or 1b*	
<i>tizanidine hcl oral capsule</i>	1 or 1b*	
<i>tizanidine hcl oral tablet</i>	1 or 1b*	
<b>*DIRECT MUSCLE RELAXANTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<i>dantrolene sodium intravenous solution reconstituted</i>	1 or 1b*	
<i>dantrolene sodium oral capsule</i>	2	
<i>dantrolene sodium</i> (Revonto Intravenous Solution Reconstituted)	1 or 1b*	
<b>*MUSCLE RELAXANT COMBINATIONS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<i>carisoprodol-aspirin oral tablet</i>	1 or 1b*	
<i>carisoprodol-aspirin-codeine oral tablet</i>	1 or 1b*	
<b>ORPHENGESIC FORTE ORAL TABLET</b> ( <i>orphenadrine-aspirin-caffeine</i> )	1 or 1b*	ST
<b>*VISCOSUPPLEMENTS*** - DRUGS FOR MUSCLES, LIGAMENTS, TENDONS, AND BONES</b>		
<b>MONOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE</b> ( <i>hyaluronan</i> )	4	PA; SP
<b>ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE</b> ( <i>hyaluronan</i> )	4	PA; SP
<b>SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE</b> ( <i>hylan</i> )	4	PA; SP
<b>SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE</b> ( <i>hylan</i> )	4	PA; SP
<b>*NASAL AGENTS - SYSTEMIC AND TOPICAL* - DRUGS FOR THE NOSE</b>		
<b>*ANTI HISTAMINE-STEROID*** - ALLERGY</b>		
<b>DYMISTA NASAL SUSPENSION</b> ( <i>azelastine-fluticasone</i> )	2	QL (1 bottle per 30 days)
<b>*NASAL ANTICHOLINERGICS*** - ALLERGY</b>		
<i>ipratropium bromide nasal solution 0.03 %</i>	1 or 1b*	QL (2 bottles per 30 days)
<i>ipratropium bromide nasal solution 0.06 %</i>	1 or 1b*	QL (1 mL per 1 day)
<b>*NASAL ANTIHISTAMINES*** - ALLERGY</b>		
<i>azelastine hcl nasal solution 0.1 %, 137 mcg/spray</i>	1 or 1b*	QL (1 package per 25 days)
<i>azelastine hcl nasal solution 0.15 %</i>	1 or 1b*	QL (1 bottle per 25 days)
<i>olopatadine hcl nasal solution</i>	1 or 1b*	QL (1 bottle per 30 days)
<b>*NASAL STEROIDS*** - ALLERGY</b>		
<i>mometasone furoate nasal suspension</i>	3	ST; QL (1 bottle per 30 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR THE HEART</b>		
<b>*NEPRILYSIN INHIB (ARNI)-ANGIOTENSIN II RECEPT ANTAG COMB*** - DRUGS FOR THE HEART</b>		
ENTRESTO ORAL TABLET ( <i>sacubitril-valsartan</i> )	3	PA; QL (2 tablets per 1 day)
<b>*NEUROMUSCULAR AGENTS* - DRUGS FOR NERVES AND MUSCLES</b>		
<b>*BENZATHIAZOLES*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>riluzole oral tablet</i>	4	SP
<b>*DEPOLARIZING MUSCLE RELAXANTS*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>succinylcholine chloride injection solution</i>	1 or 1b*	
<b>*NONDEPOLARIZING MUSCLE RELAXANTS*** - DRUGS FOR NERVES AND MUSCLES</b>		
<i>atracurium besylate intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate (pf) intravenous solution</i>	1 or 1b*	
<i>cisatracurium besylate intravenous solution</i>	1 or 1b*	
<i>pancuronium bromide intravenous solution</i>	1 or 1b*	
<i>rocuronium bromide intravenous solution</i>	1 or 1b*	
<i>vecuronium bromide intravenous solution reconstituted</i>	1 or 1b*	
<b>*NUTRIENTS* - DRUGS FOR NUTRITION</b>		
<b>*AMINO ACID MIXTURES*** - DRUGS FOR NUTRITION</b>		
<i>amino acids (Aminoreliefrms Oral Capsule)</i>	1 or 1b*	
<i>amino acid infusion (Clinisol Sf Intravenous Solution)</i>	1 or 1b*	
<b>HEPATAMINE INTRAVENOUS SOLUTION (<i>amino acid infusion</i>)</b>	1 or 1b*	
<i>amino acid infusion (Plenammine Intravenous Solution)</i>	1 or 1b*	
<b>*AMINO ACIDS-SINGLE*** - DRUGS FOR NUTRITION</b>		
<i>n-acetyl-l-cysteine oral capsule</i>	1 or 1b*	
<b>*CARBOHYDRATES*** - DRUGS FOR NUTRITION</b>		
<i>alcohol injection solution</i>	1 or 1b*	
<i>dextrose intravenous solution</i>	1 or 1b*	
<b>*MISC. NUTRITIONAL SUBSTANCES COMBINATIONS*** - DRUGS FOR NUTRITION</b>		
<b>CARDIOVID PLUS ORAL CAPSULE (<i>dha-epa-vit b6-b12-folic acid</i>)</b>	2	
<b>*OPHTHALMIC AGENTS* - DRUGS FOR THE EYE</b>		
<b>*ALPHA ADRENERGIC AGONIST &amp; CARBONIC ANHYDRASE INHIB COMB*** - DRUGS FOR GLAUCOMA</b>		
<b>SIMBRINZA OPTHALMIC SUSPENSION (<i>brinzolamide-brimonidine</i>)</b>	2	
<b>*BETA-BLOCKERS - OPTHALMIC COMBINATIONS*** - DRUGS FOR GLAUCOMA</b>		
<b>COMBIGAN OPTHALMIC SOLUTION (<i>brimonidine tartrate-timolol</i>)</b>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dorzolamide hcl-timolol mal ophthalmic solution</i>	1 or 1b*	
<i>dorzolamide hcl-timolol mal pf ophthalmic solution</i>	1 or 1b*	
<b>*BETA-BLOCKERS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA</b>		
<i>betaxolol hcl ophthalmic solution</i>	1 or 1b*	
<b>BETOPTIC-S OPHTHALMIC SUSPENSION</b> ( <i>betaxolol hcl</i> )	2	
<i>carteolol hcl ophthalmic solution</i>	1 or 1a*	
<i>levobunolol hcl ophthalmic solution</i>	1 or 1b*	
<i>timolol maleate ophthalmic gel forming solution</i>	1 or 1b*	
<i>timolol maleate ophthalmic solution</i>	1 or 1b*	
<b>*CYCLOPLEGIC MYDRIATICS*** - DRUGS FOR THE EYE</b>		
<i>phenylephrine hcl</i> (Altafrin Ophthalmic Solution)	1 or 1b*	
<i>cyclopentolate hcl ophthalmic solution</i>	1 or 1b*	
<i>phenylephrine hcl ophthalmic solution</i>	1 or 1b*	
<i>tropicamide ophthalmic solution</i>	1 or 1b*	
<b>*MIOTICS - DIRECT ACTING*** - DRUGS FOR GLAUCOMA</b>		
<i>pilocarpine hcl ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC ANTIALLERGIC*** - DRUGS FOR ITCHY EYE</b>		
<i>azelastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 24 days)
<i>cromolyn sodium ophthalmic solution</i>	1 or 1a*	QL (1 bottle per 30 days)
<i>epinastine hcl ophthalmic solution</i>	1 or 1b*	QL (1 bottle per 30 days)
<i>olopatadine hcl ophthalmic solution 0.1 %</i>	1 or 1b*	ST; QL (1 bottle per 30 days)
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	1 or 1b*	ST; QL (1 mL per 1 day)
<b>*OPHTHALMIC ANTIBIOTICS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>bacitracin ophthalmic ointment</i>	1 or 1b*	
<i>ciprofloxacin hcl ophthalmic solution</i>	1 or 1a*	
<i>erythromycin ophthalmic ointment</i>	1 or 1a*	
<i>gatifloxacin ophthalmic solution</i>	1 or 1b*	
<b>GENTAK OPHTHALMIC OINTMENT</b> ( <i>gentamicin sulfate</i> )	1 or 1a*	
<i>gentamicin sulfate ophthalmic solution</i>	1 or 1a*	
<i>levofloxacin ophthalmic solution</i>	1 or 1b*	
<i>moxifloxacin hcl ophthalmic solution</i>	2	
<i>ofloxacin ophthalmic solution</i>	1 or 1a*	
<i>tobramycin ophthalmic solution</i>	1 or 1a*	
<b>*OPHTHALMIC ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>ak-poly-bac ophthalmic ointment</i>	1 or 1a*	
<i>bacitracin-polymyxin b ophthalmic ointment</i>	1 or 1a*	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-polymyxin-gramicidin ophthalmic solution</i>	1 or 1b*	
<i>neomycin-bacitracin zn-polymyx (Neo-Polycin Ophthalmic Ointment)</i>	1 or 1b*	
<i>bacitracin-polymyxin b (Polycin Ophthalmic Ointment)</i>	1 or 1a*	
<i>polymyxin b-trimethoprim ophthalmic solution</i>	1 or 1a*	
<b>*OPHTHALMIC ANTIVIRALS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>trifluridine ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC CARBONIC ANHYDRASE INHIBITORS*** - DRUGS FOR GLAUCOMA</b>		
<b>AZOPT OPHTHALMIC SUSPENSION (<i>brinzolamide</i>)</b>	2	
<i>dorzolamide hcl ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC DIAGNOSTIC PRODUCTS*** - DRUGS FOR THE EYE</b>		
<i>ak-fluor intravenous solution</i>	1 or 1b*	
<i>altafluor benox ophthalmic solution</i>	1 or 1b*	
<i>fluorescein-benoxinate ophthalmic solution</i>	1 or 1b*	
<i>fluorescein sodium (Fluor-I-Strips A.T. Ophthalmic Strip)</i>	1 or 1b*	
<i>fluorescein sodium (Glostrips Ophthalmic Strip)</i>	1 or 1b*	
<i>lissamine green ophthalmic strip</i>	1 or 1b*	
<i>proparacaine-fluorescein ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC IMMUNOMODULATORS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<b>RESTASIS OPHTHALMIC EMULSION (<i>cyclosporine</i>)</b>	3	PA
<b>*OPHTHALMIC IRRIGATION SOLUTIONS*** - DRUGS FOR THE EYE</b>		
<i>balanced salt intraocular solution</i>	1 or 1b*	
<b>*OPHTHALMIC LOCAL ANESTHETICS*** - DRUGS FOR THE EYE</b>		
<i>proparacaine hcl ophthalmic solution</i>	1 or 1b*	
<i>tetracaine hcl (Tetcaine Ophthalmic Solution)</i>	1 or 1b*	
<b>*OPHTHALMIC NONSTEROIDAL ANTI-INFLAMMATORY AGENTS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>bromfenac sodium (once-daily) ophthalmic solution</i>	2	
<i>diclofenac sodium ophthalmic solution</i>	1 or 1b*	
<i>flurbiprofen sodium ophthalmic solution</i>	1 or 1b*	
<b>ILEVRO OPHTHALMIC SUSPENSION (<i>nepafenac</i>)</b>	2	
<i>ketorolac tromethamine ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC SELECTIVE ALPHA ADRENERGIC AGONISTS*** - DRUGS FOR GLAUCOMA</b>		
<b>ALPHAGAN P OPHTHALMIC SOLUTION (<i>brimonidine tartrate</i>)</b>	2	
<i>apraclonidine hcl ophthalmic solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>brimonidine tartrate ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC STEROID COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment</i>	1 or 1b*	
<i>neomycin-polymyxin-dexameth ophthalmic ointment</i>	1 or 1a*	
<i>neomycin-polymyxin-dexameth ophthalmic suspension</i>	1 or 1a*	
<i>neomycin-polymyxin-hc ophthalmic suspension</i>	1 or 1b*	
<i>bacitracin-polymyx-neo-hc (Neo-Polycin Hc Ophthalmic Ointment)</i>	1 or 1b*	
<i>sulfacetamide-prednisolone ophthalmic solution</i>	1 or 1a*	
<b>TOBRADEX OPHTHALMIC OINTMENT (tobramycin-dexamethasone)</b>	2	
<i>tobramycin-dexamethasone ophthalmic suspension</i>	1 or 1b*	
<b>ZYLET OPHTHALMIC SUSPENSION (loteprednol-tobramycin)</b>	2	
<b>*OPHTHALMIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>dexamethasone sodium phosphate ophthalmic solution</i>	1 or 1b*	
<b>DUREZOL OPHTHALMIC EMULSION (difluprednate)</b>	2	QL (10 mL per 30 days)
<i>fluorometholone ophthalmic suspension</i>	1 or 1b*	
<b>LOTEMAX OPHTHALMIC GEL (loteprednol etabonate)</b>	2	
<b>LOTEMAX OPHTHALMIC OINTMENT (loteprednol etabonate)</b>	3	
<b>LOTEMAX OPHTHALMIC SUSPENSION (loteprednol etabonate)</b>	3	
<i>loteprednol etabonate ophthalmic suspension</i>	1 or 1b*	
<i>prednisolone acetate ophthalmic suspension</i>	1 or 1b*	
<b>*OPHTHALMIC SULFONAMIDES*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>sulfacetamide sodium ophthalmic ointment</i>	1 or 1b*	
<i>sulfacetamide sodium ophthalmic solution</i>	1 or 1b*	
<b>*OPHTHALMIC SURGICAL AIDS*** - DRUGS FOR THE EYE</b>		
<i>hypromellose (Ocucoat Viscoadherent Intraocular Solution)</i>	1 or 1b*	
<b>*OPHTHALMICS - CYSTINOSIS AGENTS** - DRUGS FOR THE EYE</b>		
<b>CYSTARAN OPHTHALMIC SOLUTION (cysteamine hcl)</b>	4	PA; LD
<b>*PROSTAGLANDINS - OPHTHALMIC*** - DRUGS FOR GLAUCOMA</b>		
<i>bimatoprost ophthalmic solution</i>	2	
<i>latanoprost ophthalmic solution</i>	1 or 1b*	
<b>LUMIGAN OPHTHALMIC SOLUTION (bimatoprost)</b>	2	
<b>TRAVATAN Z OPHTHALMIC SOLUTION (travoprost)</b>	2	
<i>travoprost (bak free) ophthalmic solution</i>	1 or 1b*	
<b>*OTIC AGENTS* - DRUGS FOR THE EAR</b>		
<b>*OTIC AGENTS - MISCELLANEOUS*** - WAX REMOVAL</b>		
<i>acetic acid otic solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*OTIC ANALGESIC COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>pramoxine-hc-chloroxylenol (Cortic-Nd Otic Solution)</i>	1 or 1b*	
<i>exotic-hc otic solution</i>	1 or 1b*	
<b>*OTIC ANTI-INFECTIVES*** - ANTIBIOTICS</b>		
<i>ciprofloxacin hcl otic solution</i>	1 or 1b*	
<i>ofloxacin otic solution</i>	1 or 1b*	
<b>*OTIC STEROID-ANTI-INFECTIVE COMBINATIONS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<b>CIPRODEX OTIC SUSPENSION</b> ( <i>ciprofloxacin-dexamethasone</i> )	2	
<i>neomycin-polymyxin-hc otic solution</i>	1 or 1b*	
<i>neomycin-polymyxin-hc otic suspension</i>	1 or 1b*	
<b>OTOVEL OTIC SOLUTION</b> ( <i>ciprofloxacin-fluocinolone</i> )	2	
<b>*OTIC STEROIDS*** - ANTI-INFECTIVE/ANTI-INFLAMMATORIES</b>		
<i>fluocinolone acetonide (Flac Otic Oil)</i>	1 or 1b*	
<i>fluocinolone acetonide otic oil</i>	1 or 1b*	
<i>hydrocortisone-acetic acid otic solution</i>	1 or 1b*	
<b>*OXYTOCICS* - HORMONES</b>		
<b>*ABORTIFACIENTS/CERVICAL RIPENING - PROSTAGLANDINS*** - DRUGS FOR WOMEN</b>		
<i>carboprost tromethamine intramuscular solution</i>	1 or 1b*	
<b>*OXYTOCICS*** - DRUGS FOR WOMEN</b>		
<i>methylergonovine maleate (Methergine Oral Tablet)</i>	1 or 1b*	
<i>methylergonovine maleate injection solution</i>	1 or 1b*	
<i>methylergonovine maleate oral tablet</i>	1 or 1b*	
<i>oxytocin injection solution</i>	1 or 1b*	
<b>*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR INFECTIONS</b>		
<b>*PA ENDONUCLEASE INHIBITORS*** - DRUGS FOR INFECTIONS</b>		
<b>XOFLUZA ORAL TABLET THERAPY PACK</b> ( <i>baloxavir marboxil</i> )	3	QL (1 dose pack per 90 days)
<b>*PASSIVE IMMUNIZING AGENTS* - BIOLOGICAL AGENTS</b>		
<b>*ANTITOXINS-ANTIVENINS*** - BIOLOGICAL AGENTS</b>		
<b>ANASCORP INTRAVENOUS SOLUTION RECONSTITUTED</b> ( <i>centruroides (scorpion) im fab</i> )	2	
<i>antivenin latrodectus mactans injection kit</i>	2	
<i>antivenin micrurus fulvius intravenous solution reconstituted</i>	2	
<b>CROFAB INTRAVENOUS SOLUTION RECONSTITUTED</b> ( <i>crotalidae polyval immune fab</i> )	2	
<b>*IMMUNE SERUMS*** - BIOLOGICAL AGENTS</b>		
<b>GAMUNEX-C INJECTION SOLUTION</b> ( <i>immune globulin (human)</i> )	4	PA; SP
<b>OCTAGAM INTRAVENOUS SOLUTION</b> ( <i>immune globulin (human)</i> )	4	PA; SP

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*PCSK9 INHIBITORS*** - DRUGS FOR THE HEART</b>		
<b>*PCSK9 INHIBITORS*** - DRUGS FOR THE HEART</b>		
<b>REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE</b> ( <i>evolocumab</i> )	3	PA; QL (1 injector per 30 days)
<b>REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>evolocumab</i> )	3	PA; QL (2 syringe per 28 days)
<b>REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> ( <i>evolocumab</i> )	3	PA; QL (2 syringe per 28 days)
<b>*PENICILLINS* - DRUGS FOR INFECTIONS</b>		
<b>*AMINOPENICILLINS*** - ANTIBIOTICS</b>		
<i>amoxicillin oral capsule</i>	1 or 1a*	
<i>amoxicillin oral suspension reconstituted</i>	1 or 1a*	
<i>amoxicillin oral tablet</i>	1 or 1a*	
<i>amoxicillin oral tablet chewable</i>	1 or 1a*	
<i>ampicillin oral capsule</i>	1 or 1a*	
<i>ampicillin sodium injection solution reconstituted</i>	2	
<i>ampicillin sodium intravenous solution reconstituted</i>	2	
<b>*NATURAL PENICILLINS*** - ANTIBIOTICS</b>		
<i>penicillin g potassium injection solution reconstituted</i>	2	
<i>penicillin g sodium injection solution reconstituted</i>	2	
<i>penicillin v potassium oral solution reconstituted</i>	1 or 1b*	
<i>penicillin v potassium oral tablet</i>	1 or 1b*	
<b>PFIZERPEN INJECTION SOLUTION RECONSTITUTED</b> ( <i>penicillin g potassium</i> )	2	
<b>*PENICILLIN COMBINATIONS*** - ANTIBIOTICS</b>		
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral suspension reconstituted</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet</i>	1 or 1b*	
<i>amoxicillin-pot clavulanate oral tablet chewable</i>	1 or 1b*	
<i>ampicillin-sulbactam sodium injection solution reconstituted</i>	2	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted</i>	2	
<b>AUGMENTIN ORAL SUSPENSION RECONSTITUTED</b> ( <i>amoxicillin-pot clavulanate</i> )	2	
<i>piperacillin sod-tazobactam so intravenous solution reconstituted</i>	2	
<b>*PENICILLINASE-RESISTANT PENICILLINS*** - ANTIBIOTICS</b>		
<i>dicloxacillin sodium oral capsule</i>	1 or 1b*	
<i>nafcillin sodium injection solution reconstituted</i>	2	
<i>nafcillin sodium intravenous solution reconstituted</i>	2	
<i>oxacillin sodium injection solution reconstituted</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*PHARMACEUTICAL ADJUVANTS*</b>		
<b>*PARENTERAL VEHICLES***</b>		
<i>bacteriostatic water(benz alc) injection solution</i>	1 or 1b*	
<i>saline bacteriostatic injection solution</i>	2	
<i>sodium chloride bacteriostatic injection solution</i>	2	
<i>sterile diluent/epoprostenol intravenous solution</i>	1 or 1b*	
<i>sterile water for injection injection solution</i>	1 or 1b*	
<i>sterile water for injection intravenous solution</i>	1 or 1b*	
<b>*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE HEART</b>		
<b>*PLASMA KALLIKREIN INHIBITORS - MONOCLONAL ANTIBODIES*** - DRUGS FOR THE HEART</b>		
<b>TAKHZYRO SUBCUTANEOUS SOLUTION</b> ( <i>Ianadelumab-flyo</i> )	4	PA; LD; SP; QL (2 syringes per 30 days)
<b>*POTASSIUM REMOVING AGENTS*** - DRUGS FOR NUTRITION</b>		
<b>*POTASSIUM REMOVING AGENTS*** - DRUGS FOR NUTRITION</b>		
<i>sodium polystyrene sulfonate</i> (Kionex Oral Suspension)	2	
<i>sodium polystyrene sulfonate oral powder</i>	2	
<i>sodium polystyrene sulfonate oral suspension</i>	2	
<i>sodium polystyrene sulfonate rectal suspension 30 gm/120ml</i>	2	
<i>sodium polystyrene sulfonate rectal suspension 50 gm/200ml</i>	1 or 1b*	
<i>sodium polystyrene sulfonate</i> (Sps Oral Suspension)	2	
<b>*PROGESTINS* - HORMONES</b>		
<b>*PROGESTINS*** - DRUGS FOR WOMEN</b>		
<i>hydroxyprogesterone caproate intramuscular oil</i>	4	PA; SP; QL (25 mL per 21 weekss)
<i>medroxyprogesterone acetate oral tablet</i>	1 or 1a*	QL (1 tablet per 1 day)
<i>megestrol acetate oral suspension</i>	1 or 1b*	
<i>norethindrone acetate oral tablet</i>	1 or 1b*	
<i>progesterone intramuscular oil</i>	1 or 1b*	
<i>progesterone micronized oral capsule 100 mg</i>	1 or 1b*	QL (2 capsules per 1 day)
<i>progesterone micronized oral capsule 200 mg</i>	1 or 1b*	QL (1 capsule per 1 day)
<b>*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.* - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*ALCOHOL DETERRENTS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>acamprosate calcium oral tablet delayed release</i>	2	QL (6 tablet per 1 day)
<i>disulfiram oral tablet</i>	1 or 1b*	
<b>*BENZODIAZEPINES &amp; TRICYCLIC AGENTS*** - DRUGS FOR SEIZURES /PERSONALITY DISORDER/NERVE PAIN</b>		
<i>chlordiazepoxide-amitriptyline oral tablet</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*CHOLINOMIMETICS - ACHE INHIBITORS*** - DRUGS FOR ALZHEIMER'S DISEASE</b>		
<i>donepezil hcl oral tablet</i>	1 or 1b*	
<i>donepezil hcl oral tablet dispersible</i>	1 or 1b*	
<i>galantamine hydrobromide er oral capsule extended release 24 hour</i>	2	
<i>galantamine hydrobromide oral solution</i>	2	
<i>galantamine hydrobromide oral tablet</i>	2	
<i>rivastigmine tartrate oral capsule</i>	2	
<i>rivastigmine transdermal patch 24 hour</i>	2	
<b>*MOVEMENT DISORDER DRUG THERAPY*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>tetrabenazine oral tablet</i>	4	PA; SP
<b>*MS AGENTS - PYRIMIDINE SYNTHESIS INHIBITORS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<b>AUBAGIO ORAL TABLET</b> ( <i>teriflunomide</i> )	4	PA; LD; SP; QL (1 tablet per 1 day)
<b>*MULTIPLE SCLEROSIS AGENTS - INTERFERONS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<b>AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT</b> ( <i>interferon beta-1a</i> )	4	PA; SP
<b>AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT</b> ( <i>interferon beta-1a</i> )	4	PA; SP
<b>BETASERON SUBCUTANEOUS KIT</b> ( <i>interferon beta-1b</i> )	4	PA; SP
<b>EXTAVIA SUBCUTANEOUS KIT</b> ( <i>interferon beta-1b</i> )	4	PA; SP
<b>PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>peginterferon beta-1a</i> )	4	PA; LD; SP
<b>PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>peginterferon beta-1a</i> )	4	PA; LD; SP
<b>PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR</b> ( <i>peginterferon beta-1a</i> )	4	PA; LD; SP
<b>PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>peginterferon beta-1a</i> )	4	PA; LD; SP
<b>REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> ( <i>interferon beta-1a</i> )	4	PA; SP
<b>REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR</b> ( <i>interferon beta-1a</i> )	4	PA; SP
<b>REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>interferon beta-1a</i> )	4	PA; SP
<b>REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>interferon beta-1a</i> )	4	PA; SP
<b>*MULTIPLE SCLEROSIS AGENTS - NRF2 PATHWAY ACTIVATORS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<b>TECFIDERA ORAL</b> ( <i>dimethyl fumarate</i> )	4	PA; LD; SP; QL (1 kit per 365 days)

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG</b> ( <i>dimethyl fumarate</i> )	4	PA; LD; SP; QL (14 capsules per 365 days)
<b>TECFIDERA ORAL CAPSULE DELAYED RELEASE 240 MG</b> ( <i>dimethyl fumarate</i> )	4	PA; LD; SP; QL (2 capsules per 1 day)
<b>*MULTIPLE SCLEROSIS AGENTS - POTASSIUM CHANNEL BLOCKERS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<i>dalfampridine er oral tablet extended release 12 hour</i>	4	PA; SP; QL (2 tablets per 1 day)
<b>*MULTIPLE SCLEROSIS AGENTS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
<b>COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE</b> ( <i>glatiramer acetate</i> )	4	PA; SP
<i>glatiramer acetate subcutaneous solution prefilled syringe</i>	4	PA; SP
<i>glatiramer acetate</i> (Glatopa Subcutaneous Solution Prefilled Syringe)	4	PA; SP
<b>*N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONISTS*** - DRUGS FOR ALZHEIMER'S DISEASE</b>		
<i>memantine hcl er oral capsule extended release 24 hour</i>	2	
<i>memantine hcl oral solution</i>	2	
<i>memantine hcl oral tablet</i>	2	
<b>NAMENDA XR TITRATION PACK ORAL CAPSULE EXTENDED RELEASE 24 HOUR</b> ( <i>memantine hcl</i> )	2	
<b>*PHENOTHIAZINES &amp; TRICYCLIC AGENTS*** - DRUGS FOR DEPRESSION</b>		
<i>perphenazine-amitriptyline oral tablet</i>	1 or 1b*	
<b>*PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS - SSRIS*** - DRUGS FOR DEPRESSION</b>		
<i>fluoxetine hcl (pmdd) oral tablet 10 mg</i>	1 or 1b*	
<i>fluoxetine hcl (pmdd) oral tablet 20 mg</i>	1 or 1b*	QL (4 tablets per 1 day)
<b>*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>ergoloid mesylates oral tablet</i>	2	
<i>pimozide oral tablet</i>	1 or 1b*	
<b>*SMOKING DETERRENTS*** - DRUGS FOR DEPRESSION</b>		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour</i>	1 or 1b*; \$0	PA; QL (2 tablets per 1 day)
<b>CHANTIX CONTINUING MONTH PAK ORAL TABLET</b> ( <i>varenicline tartrate</i> )	2; \$0	PA; QL (60 tablet per 30 days)
<b>CHANTIX ORAL TABLET 0.5 MG</b> ( <i>varenicline tartrate</i> )	2; \$0	PA; QL (2 tablets per 1 day)
<b>CHANTIX ORAL TABLET 1 MG</b> ( <i>varenicline tartrate</i> )	2; \$0	PA; QL (2 tablet per 1 day)
<b>CHANTIX STARTING MONTH PAK ORAL TABLET</b> ( <i>varenicline tartrate</i> )	2; \$0	PA; QL (1 tablet per 365 days)
<b>NICOTROL INHALATION INHALER</b> ( <i>nicotine</i> )	2; \$0	PA
<b>NICOTROL NS NASAL SOLUTION</b> ( <i>nicotine</i> )	2; \$0	PA

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*SPHINGOSINE 1-PHOSPHATE (S1P) RECEPTOR MODULATORS*** - DRUGS FOR MULTIPLE SCLEROSIS</b>		
GILENYA ORAL CAPSULE ( <i>fingolimod hcl</i> )	4	PA; SP; QL (1 capsule per 1 day)
MAYZENT ORAL TABLET 0.25 MG ( <i>siponimod fumarate</i> )	4	PA; LD; SP; QL (4 tablets per 1 day)
MAYZENT ORAL TABLET 2 MG ( <i>siponimod fumarate</i> )	4	PA; LD; SP; QL (1 tablet per 1 day)
<b>*THIENBENZODIAZEPINES &amp; SSRIS*** - DRUGS FOR SEVERE MENTAL DISORDERS</b>		
<i>olanzapine-fluoxetine hcl oral capsule</i>	1 or 1b*	
<b>*VASOMOTOR SYMPTOM AGENTS - SSRIS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>paroxetine mesylate oral capsule</i>	1 or 1b*	
<b>*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
<b>*PULMONARY FIBROSIS AGENTS - KINASE INHIBITORS*** - DRUGS FOR CANCER</b>		
OFEV ORAL CAPSULE ( <i>nintedanib esylate</i> )	4	PA; LD; SP; QL (2 capsules per 1 day)
<b>*RESPIRATORY AGENTS - MISC.* - DRUGS FOR THE LUNGS</b>		
<b>*HYDROLYTIC ENZYMES*** - DRUGS FOR THE LUNGS</b>		
PULMOZYME INHALATION SOLUTION ( <i>dornase alfa</i> )	4	SP
<b>*SEROTONIN MODULATORS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<b>*SEROTONIN MODULATORS*** - DRUGS FOR THE NERVOUS SYSTEM</b>		
<i>nefazodone hcl oral tablet</i>	1 or 1b*	
<i>trazodone hcl oral tablet</i>	1 or 1a*	
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - HORMONES</b>		
<b>*SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITOR-BIGUANIDE COMB*** - HORMONES</b>		
SYNJARDY ORAL TABLET ( <i>empagliflozin-metformin hcl</i> )	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG ( <i>empagliflozin-metformin hcl</i> )	2	ST; QL (2 tablets per 1 day)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG ( <i>empagliflozin-metformin hcl</i> )	2	ST; QL (1 tablet per 1 day)
<b>*STEROIDS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<b>*STEROIDS - MOUTH/THROAT/DENTAL*** - DRUGS FOR THE MOUTH AND THROAT</b>		
<i>triamcinolone acetonide</i> (Oralene Mouth/Throat Paste)	1 or 1b*	
<i>triamcinolone acetonide mouth/throat paste</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*TETRACYCLINES* - DRUGS FOR INFECTIONS</b>		
<b>*TETRACYCLINES*** - ANTIBIOTICS</b>		
<i>avidoxy oral tablet</i>	1 or 1b*	
<i>minocycline hcl</i> (Coremino Oral Tablet Extended Release 24 Hour)	1 or 1b*	ST
<i>demeclocycline hcl oral tablet</i>	2	
<i>doxycycline hyclate</i> (Doxy 100 Intravenous Solution Reconstituted)	2	
<i>doxycycline hyclate intravenous solution reconstituted</i>	2	
<i>doxycycline hyclate oral capsule</i>	1 or 1b*	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg, 50 mg</i>	1 or 1b*	
<i>doxycycline hyclate oral tablet 150 mg, 75 mg</i>	1 or 1b*	ST
<i>doxycycline hyclate oral tablet delayed release</i>	1 or 1b*	ST
<i>doxycycline monohydrate oral capsule</i>	1 or 1b*	
<i>doxycycline monohydrate oral suspension reconstituted</i>	1 or 1b*	
<i>doxycycline monohydrate oral tablet</i>	1 or 1b*	
<i>minocycline hcl er oral tablet extended release 24 hour</i>	1 or 1b*	ST
<i>minocycline hcl oral capsule</i>	1 or 1b*	
<i>minocycline hcl oral tablet</i>	1 or 1b*	
<i>doxycycline monohydrate</i> (Mondoxyne NI Oral Capsule)	1 or 1b*	
<i>doxycycline hyclate</i> (Morgidox Oral Capsule)	1 or 1b*	
<i>doxycycline monohydrate</i> (Okebo Oral Capsule)	1 or 1b*	
<i>tetracycline hcl oral capsule</i>	1 or 1b*	
<b>*THYROID AGENTS* - HORMONES</b>		
<b>*ANTITHYROID AGENTS*** - DRUGS FOR THYROID</b>		
<i>methimazole oral tablet</i>	1 or 1a*	
<i>propylthiouracil oral tablet</i>	1 or 1b*	
<b>*THYROID HORMONES*** - DRUGS FOR THYROID</b>		
<i>levothyroxine sodium</i> (Euthyrox Oral Tablet)	1 or 1b*	
<i>levothyroxine sodium</i> (Levo-T Oral Tablet)	1 or 1b*	
<i>levothyroxine sodium intravenous solution reconstituted</i>	1 or 1a*	
<i>levothyroxine sodium oral tablet</i>	1 or 1a*	
<i>levothyroxine sodium</i> (Levoxyl Oral Tablet)	1 or 1a*	
<i>liothyronine sodium intravenous solution</i>	1 or 1b*	
<i>liothyronine sodium oral tablet</i>	1 or 1b*	
<i>np thyroid oral tablet</i>	1 or 1a*	
<i>thyroid oral tablet</i>	1 or 1a*	
<i>levothyroxine sodium</i> (Unithroid Oral Tablet)	1 or 1a*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*TOXOIDS* - BIOLOGICAL AGENTS</b>		
<b>*TOXOID COMBINATIONS*** - VACCINES</b>		
ADACEL INTRAMUSCULAR SUSPENSION ( <i>tetanus-diphth-acell pertussis</i> )	2; \$0	
BOOSTRIX INTRAMUSCULAR SUSPENSION ( <i>tetanus-diphth-acell pertussis</i> )	2; \$0	
DAPTACEL INTRAMUSCULAR SUSPENSION ( <i>diphth-acell pertussis-tetanus</i> )	2; \$0	
<i>diphtheria-tetanus toxoids dt intramuscular suspension</i>	2; \$0	
INFANRIX INTRAMUSCULAR SUSPENSION ( <i>diphth-acell pertussis-tetanus</i> )	2; \$0	
KINRIX INTRAMUSCULAR SUSPENSION ( <i>dtap-ipv vaccine</i> )	2; \$0	
PEDIARIX INTRAMUSCULAR SUSPENSION ( <i>dtap-hepatitis b recomb-ipv</i> )	2; \$0	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED ( <i>dtap-ipv-hib vaccine</i> )	2; \$0	
QUADRACEL INTRAMUSCULAR SUSPENSION ( <i>dtap-ipv vaccine</i> )	2; \$0	
TDVAX INTRAMUSCULAR SUSPENSION ( <i>tetanus-diphtheria toxoids td</i> )	2; \$0	
TENIVAC INTRAMUSCULAR INJECTABLE ( <i>tetanus-diphtheria toxoids td</i> )	2; \$0	
<b>*ULCER DRUGS* - DRUGS FOR THE STOMACH</b>		
<b>*ANTICHOLINERGIC COMBINATIONS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>chlordiazepoxide-clidinium oral capsule</i>	1 or 1b*	
<i>phenobarbital-belladonna alk oral elixir</i>	1 or 1b*	
<b>*ANTISPASMODICS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>dicyclomine hcl intramuscular solution</i>	2	
<i>dicyclomine hcl oral capsule</i>	1 or 1a*	
<i>dicyclomine hcl oral solution</i>	1 or 1a*	
<i>dicyclomine hcl oral tablet</i>	1 or 1a*	
<b>*BELLADONNA ALKALOIDS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>atropine sulfate injection solution</i>	2	
<i>atropine sulfate injection solution prefilled syringe</i>	2	
<i>hyoscyamine sulfate er oral tablet extended release 12 hour</i>	1 or 1b*	
<i>hyoscyamine sulfate sl sublingual tablet sublingual</i>	1 or 1b*	
<b>*H-2 ANTAGONISTS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>cimetidine hcl oral solution</i>	1 or 1b*	
<i>cimetidine oral tablet</i>	1 or 1b*	
<i>famotidine intravenous solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>famotidine oral suspension reconstituted</i>	1 or 1b*	
<i>famotidine oral tablet</i>	1 or 1b*	
<i>famotidine premixed intravenous solution</i>	1 or 1b*	
<i>nizatidine oral capsule</i>	1 or 1b*	
<i>nizatidine oral solution</i>	1 or 1b*	
<i>ranitidine hcl injection solution</i>	1 or 1b*	
<i>ranitidine hcl oral capsule</i>	1 or 1b*	
<i>ranitidine hcl oral syrup</i>	1 or 1b*	
<i>ranitidine hcl oral tablet</i>	1 or 1b*	
<b>*MISC. ANTI-ULCER*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<b>CARAFATE ORAL SUSPENSION</b> ( <i>sucralfate</i> )	2	
<i>sucralfate oral suspension</i>	2	
<i>sucralfate oral tablet</i>	1 or 1b*	
<b>*PROTON PUMP INHIBITORS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>omeprazole oral capsule delayed release</i>	1 or 1b*	QL (1 capsule per 1 day)
<b>*QUATERNARY ANTICHOLINERGICS*** - DRUGS FOR STOMACH CRAMPS</b>		
<i>glycopyrrolate injection solution</i>	1 or 1b*	
<i>glycopyrrolate oral tablet</i>	1 or 1b*	
<i>methscopolamine bromide oral tablet</i>	1 or 1b*	
<i>propantheline bromide oral tablet</i>	1 or 1b*	
<b>*ULCER DRUGS - PROSTAGLANDINS*** - DRUGS FOR ULCERS AND STOMACH ACID</b>		
<i>misoprostol oral tablet</i>	1 or 1a*	
<b>*URINARY ANTI-INFECTIVES* - DRUGS FOR THE URINARY SYSTEM</b>		
<b>*URINARY ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS</b>		
<i>methenamine hippurate oral tablet</i>	2	
<i>methenamine mandelate oral tablet</i>	2	
<i>nitrofurantoin macrocrystal oral capsule</i>	1 or 1b*	
<i>nitrofurantoin monohyd macro oral capsule</i>	1 or 1b*	
<i>nitrofurantoin oral suspension</i>	1 or 1b*	
<b>*URINARY ANTISEPTIC-ANTISPASMODIC &amp;/OR ANALGESICS*** - DRUGS FOR INFECTIONS</b>		
<i>meth-hyo-m bl-na phos-ph sal</i> (Uretron D/S Oral Tablet)	1 or 1b*	
<i>methen-hyosc-meth blue-na phos</i> (Uryl Oral Tablet)	1 or 1b*	
<i>uticap oral capsule</i>	1 or 1b*	
<i>meth-hyo-m bl-na phos-ph sal</i> (Utrona-C Oral Tablet)	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*URINARY ANTISPASMODICS* - DRUGS FOR THE URINARY SYSTEM</b>		
<b>*BETA-3 ADRENERGIC AGONISTS*** - DRUGS FOR THE BLADDER</b>		
<b>MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR</b> (mirabegron)	3	
<b>*URINARY ANTISPASMODIC - ANTIMUSCARINIC (ANTICHOLINERGIC)*** - DRUGS FOR THE BLADDER</b>		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour</i>	2	
<i>oxybutynin chloride er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>oxybutynin chloride oral syrup</i>	1 or 1b*	
<i>oxybutynin chloride oral tablet</i>	1 or 1b*	
<i>solifenacin succinate oral tablet</i>	2	
<i>tolterodine tartrate er oral capsule extended release 24 hour</i>	1 or 1b*	
<i>tolterodine tartrate oral tablet</i>	1 or 1b*	
<b>TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HOUR</b> (fesoterodine fumarate)	3	
<i>trospium chloride er oral capsule extended release 24 hour</i>	2	
<i>trospium chloride oral tablet</i>	2	
<b>VESICARE ORAL TABLET</b> (solifenacin succinate)	3	ST
<b>*URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOL)*** (NEW) - DRUGS FOR THE BLADDER</b>		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour</i>	2	
<i>oxybutynin chloride er oral tablet extended release 24 hour</i>	1 or 1b*	
<i>oxybutynin chloride oral syrup</i>	1 or 1b*	
<i>oxybutynin chloride oral tablet</i>	1 or 1b*	
<i>solifenacin succinate oral tablet</i>	2	
<i>tolterodine tartrate er oral capsule extended release 24 hour</i>	1 or 1b*	
<i>tolterodine tartrate oral tablet</i>	1 or 1b*	
<b>TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HOUR</b> (fesoterodine fumarate)	3	
<i>trospium chloride er oral capsule extended release 24 hour</i>	2	
<i>trospium chloride oral tablet</i>	2	
<b>VESICARE ORAL TABLET</b> (solifenacin succinate)	3	ST
<b>*URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS*** - DRUGS FOR THE BLADDER</b>		
<b>MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR</b> (mirabegron)	3	
<b>*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS*** - DRUGS FOR THE BLADDER</b>		
<i>bethanechol chloride oral tablet</i>	2	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS*** (NEW) - DRUGS FOR THE BLADDER</b>		
<i>bethanechol chloride oral tablet</i>	2	
<b>*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS*** - DRUGS FOR THE BLADDER</b>		
<i>flavoxate hcl oral tablet</i>	1 or 1b*	
<b>*URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS*** (NEW) - DRUGS FOR THE BLADDER</b>		
<i>flavoxate hcl oral tablet</i>	1 or 1b*	
<b>*VACCINES* - BIOLOGICAL AGENTS</b>		
<b>*BACTERIAL VACCINES*** - VACCINES</b>		
<b>ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED</b> <i>(haemophilus b polysac conj vac)</i>	2; \$0	
<i>bcg vaccine injection injectable</i>	2; \$0	
<b>BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> <i>(meningococcal b recomb omv adj)</i>	2; \$0	
<b>BIOTHRAX INTRAMUSCULAR SUSPENSION</b> <i>(anthrax vaccine adsorbed)</i>	2	
<b>HIBERIX INJECTION SOLUTION RECONSTITUTED</b> <i>(haemophilus b polysac conj vac)</i>	2; \$0	
<b>MENACTRA INTRAMUSCULAR INJECTABLE</b> <i>(meningococcal a c y&amp;w-135 conj)</i>	2; \$0	
<b>MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED</b> <i>(meningococcal a c y&amp;w-135 olig)</i>	2; \$0	
<b>PEDVAX HIB INTRAMUSCULAR SUSPENSION</b> <i>(haemophilus b polysac conj vac)</i>	2; \$0	
<b>PNEUMOVAX 23 INJECTION INJECTABLE</b> <i>(pneumococcal vac polyvalent)</i>	2; \$0	
<b>PREVNAR 13 INTRAMUSCULAR SUSPENSION</b> <i>(pneumococcal 13-val conj vacc)</i>	2; \$0	
<b>TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> <i>(meningococcal b vac (recomb))</i>	2; \$0	
<b>TYPHIM VI INTRAMUSCULAR SOLUTION</b> <i>(typhoid vi polysaccharide vacc)</i>	2	
<b>VAXCHORA ORAL SUSPENSION RECONSTITUTED</b> <i>(cholera vac live attenuated)</i>	2	
<b>VIVOTIF ORAL CAPSULE DELAYED RELEASE</b> <i>(typhoid vaccine)</i>	2	
<b>*VIRAL VACCINE COMBINATIONS*** - VACCINES</b>		
<b>M-M-R II INJECTION SOLUTION RECONSTITUTED</b> <i>(measles, mumps &amp; rubella vac)</i>	2; \$0	
<b>PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED</b> <i>(measles-mumps-rubella-varicell)</i>	2; \$0	
<b>TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> <i>(hepatitis a-hep b recomb vac)</i>	2; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>*VIRAL VACCINES*** - VACCINES</b>		
<b>AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>AFLURIA QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>ENGERIX-B INJECTION SUSPENSION</b> ( <i>hepatitis b vac recombinant</i> )	2; \$0	
<b>FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac a&amp;b surf ant adj</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUARIX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUBLOK QUADRIVALENT INTRAMUSCULAR SOLUTION PREFILLED SYRINGE</b> ( <i>influenza vac recomb ha quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION</b> ( <i>influenza vac subunit quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUCELVAX QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac subunit quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLULAVAL QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUMIST QUADRIVALENT NASAL SUSPENSION</b> ( <i>influenza virus vac live quad</i> )	2; \$0	
<b>FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac split high-dose</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>FLUZONE QUADRIVALENT INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>influenza vac split quad</i> )	2; \$0	QL (2 injections per 180 days)
<b>GARDASIL 9 INTRAMUSCULAR SUSPENSION</b> ( <i>hvp 9-valent recomb vaccine</i> )	2; \$0	
<b>GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE</b> ( <i>hvp 9-valent recomb vaccine</i> )	2; \$0	
<b>HAVRIX INTRAMUSCULAR SUSPENSION</b> ( <i>hepatitis a vaccine</i> )	2; \$0	
<b>HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE</b> ( <i>hepatitis b vac recomb adj</i> )	2; \$0	
<b>IMOVAX RABIES INTRAMUSCULAR INJECTABLE</b> ( <i>rabies virus vaccine, hdc</i> )	2	
<b>IPOL INJECTION INJECTABLE</b> ( <i>poliovirus vaccine inactivated</i> )	2; \$0	
<b>IXIARO INTRAMUSCULAR SUSPENSION</b> ( <i>japanese encephalitis vac inac</i> )	2	
<b>RABAERT INTRAMUSCULAR SUSPENSION RECONSTITUTED</b> ( <i>rabies vaccine, pcec</i> )	2	
<b>RECOMBIVAX HB INJECTION SUSPENSION</b> ( <i>hepatitis b vac recombinant</i> )	2; \$0	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020



Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ROTARIX ORAL SUSPENSION RECONSTITUTED</b> ( <i>rotavirus vaccine live oral</i> )	2; \$0	
<b>ROTATEQ ORAL SOLUTION</b> ( <i>rotavirus vac live pentavalent</i> )	2; \$0	
<b>SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED</b> ( <i>zoster vac recomb adjuvanted</i> )	2; \$0	
<i>stamaril injection suspension reconstituted</i>	2	
<b>VAQTA INTRAMUSCULAR SUSPENSION</b> ( <i>hepatitis a vaccine</i> )	2; \$0	
<b>VARIVAX SUBCUTANEOUS INJECTABLE</b> ( <i>varicella virus vaccine live</i> )	2; \$0	
<b>YF-VAX SUBCUTANEOUS INJECTABLE</b> ( <i>yellow fever vaccine</i> )	2	
<b>ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED</b> ( <i>zoster vaccine live</i> )	2; \$0	
<b>*VAGINAL PRODUCTS* - DRUGS FOR WOMEN</b>		
<b>*IMIDAZOLE-RELATED ANTIFUNGALS*** - DRUGS FOR INFECTIONS</b>		
<i>miconazole 3 vaginal suppository</i>	1 or 1b*	
<i>terconazole vaginal cream</i>	1 or 1b*	
<i>terconazole vaginal suppository</i>	1 or 1b*	
<b>*VAGINAL ANTI-INFECTIVES*** - DRUGS FOR INFECTIONS</b>		
<b>CLEOCIN VAGINAL SUPPOSITORY</b> ( <i>clindamycin phosphate</i> )	2	
<i>clindamycin phosphate vaginal cream</i>	1 or 1b*	
<i>metronidazole vaginal gel</i>	1 or 1b*	
<i>metronidazole</i> (Vandazole Vaginal Gel)	1 or 1b*	
<b>*VAGINAL ESTROGENS*** - DRUGS FOR WOMEN</b>		
<i>estradiol vaginal cream</i>	1 or 1b*	
<i>estradiol vaginal tablet</i>	1 or 1b*	QL (18 tablet per 28 days)
<b>PREMARIN VAGINAL CREAM</b> ( <i>estrogens, conjugated</i> )	2	QL (1 gm per 1 day)
<i>estradiol</i> (Yuvaferm Vaginal Tablet)	1 or 1b*	QL (18 tablet per 28 days)
<b>*VAGINAL PROGESTINS*** - DRUGS FOR WOMEN</b>		
<b>ENDOMETRIN VAGINAL INSERT</b> ( <i>progesterone</i> )	2	PA
<b>*VASOPRESSORS* - DRUGS FOR THE HEART</b>		
<b>*ANAPHYLAXIS THERAPY AGENTS*** - DRUGS FOR SERIOUS ALLERGIC REACTION</b>		
<i>epinephrine injection solution auto-injector</i>	1 or 1b*	QL (2 pens per 1 fill)
<b>SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE</b> ( <i>epinephrine</i> )	2	QL (2 syringes per 1 fill)
<b>*VASOPRESSORS*** - DRUGS FOR SERIOUS ALLERGIC REACTION</b>		
<i>dobutamine hcl intravenous solution</i>	1 or 1b*	
<i>dobutamine in d5w intravenous solution</i>	1 or 1b*	
<i>dopamine hcl intravenous solution</i>	1 or 1b*	

**BRAND**=Brand drug **generic**=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs \$0=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dopamine in d5w intravenous solution</i>	1 or 1b*	
<i>ephedrine sulfate injection solution</i>	1 or 1b*	
<i>epinephrine pf injection solution prefilled syringe</i>	1 or 1b*	
<i>midodrine hcl oral tablet</i>	2	
<i>norepinephrine bitartrate intravenous solution</i>	1 or 1b*	
<i>phenylephrine hcl intravenous solution</i>	1 or 1b*	
<b>*VITAMINS* - DRUGS FOR NUTRITION</b>		
<b>*PABA*** - DRUGS FOR NUTRITION</b>		
<i>aminobenzoate potassium oral packet</i>	1 or 1b*	
<b>*VITAMIN B-1*** - DRUGS FOR NUTRITION</b>		
<i>thiamine hcl injection solution</i>	1 or 1b*	
<b>*VITAMIN B-6*** - DRUGS FOR NUTRITION</b>		
<i>pyridoxine hcl injection solution</i>	1 or 1b*	
<b>*VITAMIN C*** - DRUGS FOR NUTRITION</b>		
<i>ascorbic acid injection solution</i>	1 or 1b*	
<b>*VITAMIN D*** - DRUGS FOR NUTRITION</b>		
<i>ergocalciferol oral capsule</i>	1 or 1a*	
<i>vitamin d (ergocalciferol) oral capsule</i>	1 or 1a*	
<b>*VITAMIN K*** - DRUGS FOR NUTRITION</b>		
<i>phytonadione injection solution</i>	1 or 1b*	
<i>phytonadione oral tablet</i>	2	
<i>vitamin k1 injection solution</i>	1 or 1b*	

**BRAND**=Brand drug *generic*=generic drug \*Your plan may include Tiers 1a/1b. Refer to your pharmacy benefit summary for more information **Tier 1 or 1a\***=Drugs with the lowest cost share **Tier 1 or 1b\***=drugs with a low cost share **Tier 2**=Drugs with a higher cost share than Tier 1 **Tier 3**=Drugs with a higher cost share than Tier 2 **Tier 4**=Drugs with the highest cost share and usually include specialty brand and generic drugs **\$0**=Preventive Drug **DO**=Dose Optimization **LD**=Limited Distribution **OC**=Oral Chemotherapy **PA**=Prior Authorization **QL**=Quantity Limit **SP**=Specialty Pharmacy **ST**=Step Therapy

Effective 02/01/2020

## Index

<i>1st tier unifine pentips</i> .....	87	<i>ak-fluor</i> .....	105	<i>amoxicillin</i> .....	108
<i>1st tier unifine pentips plus</i> .....	87	<i>ak-poly-bac</i> .....	104	<i>amoxicillin-pot clavulanate</i> .....	108
<i>abacavir sulfate</i> .....	48	<i>ala-cort</i> .....	67	<i>amoxicillin-pot clavulanate er</i> .....	108
<i>abacavir sulfate-lamivudine</i> .....	47	<i>albendazole</i> .....	19	<i>amphetamine sulfate</i> .....	11
<i>abacavir-lamivudine-zidovudine</i> .....	47	<i>Albuked 25</i> .....	80	<i>amphetamine-dextroamphet er</i> .....	11
<i>abiraterone acetate</i> .....	40	<i>Albuked 5</i> .....	81	<i>amphetamine-dextroamphetamine</i> .....	11
<i>acamprosate calcium</i> .....	109	<i>albumin human</i> .....	81	<i>amphotericin b</i> .....	33
<i>acarbose</i> .....	28	<i>albumin-zlb</i> .....	81	<i>ampicillin</i> .....	108
<b>ACCU-CHEK AVIVA PLUS</b> .....	72	<i>alburx</i> .....	81	<i>ampicillin sodium</i> .....	108
<b>ACCU-CHEK COMPACT PLUS</b> .....	72	<i>Albutein</i> .....	81	<i>ampicillin-sulbactam sodium</i> .....	108
<b>ACCU-CHEK FASTCLIX LANCET</b> .....	87	<i>albuterol sulfate</i> .....	22	<i>anagrelide hcl</i> .....	81
<b>ACCU-CHEK FASTCLIX</b> .....	87	<i>albuterol sulfate er</i> .....	22	<b>ANASCORP</b> .....	107
<b>LANCETS</b> .....	87	<i>albuterol sulfate hfa</i> .....	22	<i>anastrozole</i> .....	43
<b>ACCU-CHEK GUIDE</b> .....	72	<i>alclometasone dipropionate</i> .....	67	<b>ANNOVERA</b> .....	59
<b>ACCU-CHEK MULTICLIX</b> .....	87	<i>alcohol</i> .....	103	<b>ANORO ELLIPTA</b> .....	21
<b>LANCET DEV</b> .....	87	<i>alendronate sodium</i> .....	74	<i>antivenin latrodectus mactans</i> .....	107
<b>ACCU-CHEK MULTICLIX</b> .....	87	<i>alfuzosin hcl er</i> .....	79	<i>antivenin micrurus fulvius</i> .....	107
<b>LANCETS</b> .....	87	<i>aliskiren fumarate</i> .....	38	<i>apap-caff-dihydrocodeine</i> .....	16
<b>ACCU-CHEK SAFE-T PRO</b> .....	87	<b>ALLEVYN AG ADHESIVE</b> .....	72	<i>apraclonidine hcl</i> .....	105
<b>LANCETS</b> .....	87	<i>allopurinol</i> .....	80	<i>aprepitant</i> .....	32
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>allopurinol sodium</i> .....	80	<i>Apri</i> .....	56
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>almotriptan malate</i> .....	95	<b>APRISO</b> .....	77
<b>DEV</b> .....	87	<i>alosetron hcl</i> .....	77	<b>APTIVUS</b> .....	48
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<b>ALPHAGAN P</b> .....	105	<i>Aranelle</i> .....	60
<b>LANCETS</b> .....	87	<i>alprazolam</i> .....	20	<b>ARANESP (ALBUMIN FREE)</b> ...	81, 82
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>alprazolam er</i> .....	20	<i>argatroban</i> .....	24
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>alprazolam xr</i> .....	20	<i>aripiprazole</i> .....	47
<b>DEV</b> .....	87	<i>alprostadil</i> .....	51	<i>armodafinil</i> .....	12
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<b>ALTABAX</b> .....	65	<b>ARNUTY ELLIPTA</b> .....	23
<b>LANCETS</b> .....	87	<i>altafluor benox</i> .....	105	<i>Ascomp-Codeine</i> .....	16
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>Altafrin</i> .....	104	<i>ascorbic acid</i> .....	120
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>Altavera</i> .....	56	<i>Ashlyna</i> .....	59
<b>DEV</b> .....	87	<i>alyacen 1/35</i> .....	56	<i>aspirin-dipyridamole er</i> .....	81
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<i>alyacen 7/7/7</i> .....	60	<b>ASSURE ID INSULIN SAFETY</b> .....	87
<b>LANCETS</b> .....	87	<i>Alyq</i> .....	54	<b>SYR</b> .....	87
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>Amabelz</i> .....	76	<b>ASSURE ID SAFETY PEN</b> .....	87
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>amantadine hcl</i> .....	45	<b>NEEDLES</b> .....	87
<b>DEV</b> .....	87	<i>ambrisentan</i> .....	54	<i>atazanavir sulfate</i> .....	48
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<i>amcinonide</i> .....	67	<i>atenolol</i> .....	51
<b>LANCETS</b> .....	87	<i>Amethia</i> .....	59	<i>atenolol-chlorthalidone</i> .....	38
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>Amethia Lo</i> .....	59	<i>atomoxetine hcl</i> .....	11
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>Amethyst</i> .....	59	<i>atorvastatin calcium</i> .....	35
<b>DEV</b> .....	87	<i>amikacin sulfate</i> .....	12	<i>atovaquone</i> .....	38
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<i>amiloride hcl</i> .....	73	<i>atovaquone-proguanil hcl</i> .....	39
<b>LANCETS</b> .....	87	<i>amiloride-hydrochlorothiazide</i> .....	73	<i>atracurium besylate</i> .....	103
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>aminoacetic acid</i> .....	79	<i>atropine sulfate</i> .....	114
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>aminobenzoate potassium</i> .....	120	<b>ATROVENT HFA</b> .....	22
<b>DEV</b> .....	87	<i>aminocaproic acid</i> .....	83	<b>AUBAGIO</b> .....	110
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<i>aminophylline</i> .....	23	<i>Aubra</i> .....	56
<b>LANCETS</b> .....	87	<i>Aminoreliefrms</i> .....	103	<i>Aubra Eq</i> .....	56
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>amiodarone hcl</i> .....	21	<b>AUGMENTIN</b> .....	108
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<b>AMITIZA</b> .....	77	<i>aurora pen needles</i> .....	87
<b>DEV</b> .....	87	<i>amitriptyline hcl</i> .....	28	<i>aurora unifine pentips</i> .....	87
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<i>amlodipine besy-benazepril hcl</i> .....	35	<i>Aurovela 1.5/30</i> .....	56
<b>LANCETS</b> .....	87	<i>amlodipine besylate</i> .....	52	<i>Aurovela 1/20</i> .....	56
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>amlodipine besylate-valsartan</i> .....	36	<i>Aurovela 24 Fe</i> .....	56
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>amlodipine-atorvastatin</i> .....	54	<i>Aurovela Fe 1.5/30</i> .....	56
<b>DEV</b> .....	87	<i>amlodipine-olmesartan</i> .....	36	<i>Aurovela Fe 1/20</i> .....	56
<b>ACCU-CHEK SOFTCLIX</b> .....	87	<i>amlodipine-valsartan-hctz</i> .....	37	<i>Aviane</i> .....	56
<b>LANCETS</b> .....	87	<i>ammonium lactate</i> .....	69	<i>avidoxy</i> .....	113
<b>ACCU-CHEK SMARTVIEW</b> .....	72	<i>Amnesteem</i> .....	64	<i>Avita</i> .....	64
<b>ACCU-CHEK SOFTCLIX LANCET</b> .....	87	<i>amoxapine</i> .....	28	<b>AVONEX PEN</b> .....	110
<b>DEV</b> .....	87				

<b>AVONEX PREFILLED</b> .....	110	<b>BETOPTIC-S</b> .....	104	<i>caffeine citrate</i> .....	11
Ayuna.....	56	<i>bexarotene</i> .....	44	<i>calcipotriene</i> .....	66
<b>AZASAN</b> .....	51	<b>BEXSERO</b> .....	117	<i>calcipotriene-betameth diprop</i> .....	71
<i>azathioprine</i> .....	51	<i>bicalutamide</i> .....	40	<i>calcitonin (salmon)</i> .....	74
<i>azelaic acid</i> .....	70	<b>BIDIL</b> .....	54	Calcitrene.....	66
<i>azelastine hcl</i> .....	102, 104	<b>BIKTARVY</b> .....	47	<i>calcitriol</i> .....	66, 75
<i>azithromycin</i> .....	86	<i>bimatoprost</i> .....	106	<i>calcium acetate</i> .....	78
<b>AZOPT</b> .....	105	<i>biocel</i> .....	99	<i>calcium acetate (phos binder)</i> .....	78
<i>aztreonam</i> .....	98	<b>BIOSTEP</b> .....	72	<i>calcium chloride</i> .....	95
Azurette.....	56	<b>BIOSTEP AG</b> .....	72	<i>calcium gluconate</i> .....	96
<i>bacim</i> .....	38	<b>BIOTHRAX</b> .....	117	Camila.....	60
<i>bacitracin</i> .....	38, 104	<i>bisoprolol fumarate</i> .....	51	Camrese.....	59
<i>bacitracin-polymyxin b</i> .....	104	<i>bisoprolol-hydrochlorothiazide</i> .....	38	Camrese Lo.....	59
<i>bacitra-neomycin-polymyxin-hc</i> .....	106	Blanche.....	69	<i>candesartan cilexetil</i> .....	37
<i>baclofen</i> .....	101	Blisovi 24 Fe.....	56	<i>candesartan cilexetil-hctz</i> .....	36
<i>bacteriostatic water(benz alc)</i> .....	109	Blisovi Fe 1.5/30.....	56	<i>capecitabine</i> .....	41
<i>balanced salt</i> .....	105	Blisovi Fe 1/20.....	56	<b>CAPRELSA</b> .....	42
<b>BALCOLTRA</b> .....	56	<b>BOOSTRIX</b> .....	114	<i>captopril</i> .....	36
<i>balsalazide disodium</i> .....	78	<i>bosentan</i> .....	54	<i>captopril-hydrochlorothiazide</i> .....	35
Balziva.....	56	<b>BOSULIF</b> .....	42	<b>CARAC</b> .....	66
<b>BARACLUDE</b> .....	49	<i>bp 10-1</i> .....	64	<b>CARAFATE</b> .....	115
<i>bcg vaccine</i> .....	117	<i>bp cleansing wash</i> .....	64	<i>carbamazepine</i> .....	25
<b>BD AUTOSHIELD</b> .....	88	<i>bp vit 3</i> .....	82	<i>carbamazepine er</i> .....	25
<b>BD AUTOSHIELD DUO</b> .....	88	<i>bp wash</i> .....	64	<i>carbidopa</i> .....	45
<b>BD INSULIN SYR ULTRAFINE II</b> .....	88	<i>b-plex</i> .....	99	<i>carbidopa-levodopa</i> .....	45
<b>BD INSULIN SYRINGE</b> .....	88	<i>b-plex plus</i> .....	100	<i>carbidopa-levodopa er</i> .....	45
<b>BD INSULIN SYRINGE</b>		<b>BREO ELLIPTA</b> .....	21	<i>carbidopa-levodopa-entacapone</i> .....	45
<b>MICROFINE</b> .....	88	<i>briellyn</i> .....	56	<i>carbinoxamine maleate</i> .....	33
<b>BD INSULIN SYRINGE U/F</b> .....	88	<b>BRILINTA</b> .....	72, 80	<i>carboprost tromethamine</i> .....	107
<b>BD INSULIN SYRINGE U/F</b>		<i>brimonidine tartrate</i> .....	106	<b>CARDIOVID PLUS</b> .....	103
<b>1/2UNIT</b> .....	88	Bromfed Dm.....	63	<b>CAREFINE PEN NEEDLES</b> .....	88
<b>BD INSULIN SYRINGE U-500</b> .....	88	<i>bromfenac sodium (once-daily)</i> .....	105	<i>careone insulin syringe</i> .....	88
<b>BD INSULIN SYRINGE</b>		<i>bromocriptine mesylate</i> .....	45	<i>careone unifine pentips</i> .....	88
<b>ULTRAFINE</b> .....	88	<i>brompheniramine tannate</i> .....	33	<i>careone unifine pentips plus</i> .....	88
<b>BD PEN NEEDLE MICRO U/F</b> .....	88	<i>budesonide</i> .....	23, 61	<b>CARETOUCH INSULIN SYRINGE</b> .....	88
<b>BD PEN NEEDLE MINI U/F</b> .....	88	<i>budesonide er</i> .....	61	<b>CARETOUCH PEN NEEDLES</b> .....	88
<b>BD PEN NEEDLE NANO 2ND GEN</b> .....	88	<i>bumetanide</i> .....	73	<i>carisoprodol</i> .....	101
<b>BD PEN NEEDLE NANO U/F</b> .....	88	<i>bupivacaine hcl</i> .....	85	<i>carisoprodol-aspirin</i> .....	102
<b>BD PEN NEEDLE ORIGINAL U/F</b> .....	88	<i>bupivacaine hcl (pf)</i> .....	85	<i>carisoprodol-aspirin-codeine</i> .....	102
<b>BD PEN NEEDLE SHORT U/F</b> .....	88	<i>bupivacaine in dextrose</i> .....	85	<i>carteolol hcl</i> .....	104
<b>BD SAFETYGLIDE INSULIN</b>		<i>bupivacaine spinal</i> .....	85	Cartia Xt.....	52
<b>SYRINGE</b> .....	88	<i>bupivacaine-epinephrine</i> .....	85	<i>carvedilol</i> .....	51
<b>BD SAFETY-LOK INSULIN</b>		<i>bupivacaine-epinephrine (pf)</i> .....	85	<i>carvedilol phosphate er</i> .....	51
<b>SYRINGE</b> .....	88	<i>buprenorphine</i> .....	18	<i>casprofungin acetate</i> .....	33
<b>BD VEO INSULIN SYRINGE U/F</b> .....	88	<i>buprenorphine hcl</i> .....	18	Cavarest.....	98
Bekyree.....	56	<i>buprenorphine hcl-naloxone hcl</i> .....	18	<b>CAYA</b> .....	86
<i>benazepril hcl</i> .....	36	<i>bupropion hcl</i> .....	27	Caziant.....	60
<i>benazepril-hydrochlorothiazide</i> .....	35	<i>bupropion hcl er (smoking det)</i> .....	111	<i>cefaclor</i> .....	55
<b>BENZIQ WASH</b> .....	64	<i>bupropion hcl er (sr)</i> .....	26	<i>cefaclor er</i> .....	55
<i>benzoin compound</i> .....	71	<i>bupropion hcl er (xl)</i> .....	26, 27	<i>cefadroxil</i> .....	55
<i>benzonatate</i> .....	62	<i>buspirone hcl</i> .....	20	<i>cefazolin sodium</i> .....	55
<i>benzoyl peroxide-erythromycin</i> .....	64	<i>butalbital-acetaminophen</i> .....	15	<i>cefdinir</i> .....	55
<i>benzphetamine hcl</i> .....	11	<i>butalbital-apap-caff-cod</i> .....	16	<i>cefditoren pivoxil</i> .....	55
<i>benztropine mesylate</i> .....	44	<i>butalbital-apap-caffeine</i> .....	15	<i>cefepime hcl</i> .....	56
<b>BERINERT</b> .....	80	<i>butalbital-asa-caff-codeine</i> .....	16	<i>cefixime</i> .....	55
Beser.....	67	<i>butalbital-aspirin-caffeine</i> .....	15	<i>cefotaxime sodium</i> .....	55
<i>betamethasone dipropionate</i> .....	67	<i>butorphanol tartrate</i> .....	18	<i>cefotetan disodium</i> .....	55
<i>betamethasone dipropionate aug</i> .....	67	<b>BYDUREON</b> .....	30	<i>cefoxitin sodium</i> .....	55
<i>betamethasone sod phos &amp; acet</i> .....	62	<b>BYDUREON BCISE</b> .....	30	<i>cefpodoxime proxetil</i> .....	55
<i>betamethasone valerate</i> .....	67	<b>BYETTA 10 MCG PEN</b> .....	30	<i>cefprozil</i> .....	55
<b>BETASERON</b> .....	110	<b>BYETTA 5 MCG PEN</b> .....	30	<i>ceftazidime</i> .....	55
<i>betaxolol hcl</i> .....	51, 104	<b>BYSTOLIC</b> .....	51	<i>ceftriaxone sodium</i> .....	55
<i>bethanechol chloride</i> .....	116, 117	<i>cabergoline</i> .....	74	<i>ceftriaxone sodium in dextrose</i> .....	55



<i>cefuroxime axetil</i> .....	55	<i>clobetasol propionate e</i> .....	67	<b>CROTAN</b> .....	71
<i>cefuroxime sodium</i> .....	55	<i>clobetasol propionate emulsion</i> .....	67	Cryselle-28.....	56
<i>celecoxib</i> .....	14	<i>clocortolone pivalate</i> .....	68	<i>cyanocobalamin</i> .....	81
<i>cephalexin</i> .....	55	Clodan.....	68	Cyclafem 1/35.....	56
Cerovel.....	69	<i>clomiphene citrate</i> .....	75	Cyclafem 7/7/7.....	60
<i>cevimeline hcl</i> .....	98	<i>clomipramine hcl</i> .....	28	<i>cyclobenzaprine hcl</i> .....	101
<b>CHANTIX</b> .....	111	<i>clonazepam</i> .....	24	<i>cyclopentolate hcl</i> .....	104
<b>CHANTIX CONTINUING MONTH</b>		<i>clonidine</i> .....	37	<i>cyclophosphamide</i> .....	44
<b>PAK</b> .....	111	<i>clonidine hcl</i> .....	37	<i>cycloserine</i> .....	40
<b>CHANTIX STARTING MONTH</b>		<i>clonidine hcl (analgesia)</i> .....	15	<i>cyclosporine</i> .....	50
<b>PAK</b> .....	111	<i>clonidine hcl er</i> .....	11	<i>cyclosporine modified</i> .....	50
Chateal.....	56	<i>clopidogrel bisulfate</i> .....	81	<i>cyproheptadine hcl</i> .....	34
Chateal Eq.....	56	<i>clorazepate dipotassium</i> .....	20	Cyred.....	57
<i>chloramphenicol sod succinate</i> .....	39	<i>clotrimazole</i> .....	70, 98	Cyred Eq.....	56
<i>chlordiazepoxide hcl</i> .....	20	<i>clotrimazole-betamethasone</i> .....	65	<b>CYSTADANE</b> .....	75
<i>chlordiazepoxide-amitriptyline</i> .....	109	Clovique.....	50	<b>CYSTARAN</b> .....	106
<i>chlordiazepoxide-clidinium</i> .....	114	<i>clozapine</i> .....	46	<i>dalfampridine er</i> .....	111
<i>chlorhexidine gluconate</i> .....	98	<b>COAGUCHEK LANCETS</b> .....	87	<i>danazol</i> .....	19
<i>chlorprocaine hcl (pf)</i> .....	85	<i>coal tar</i> .....	71	<i>dantrolene sodium</i> .....	102
<i>chloroquine phosphate</i> .....	39	<i>colchicine</i> .....	80	<i>dapsone</i> .....	39, 64
<i>chlorothiazide</i> .....	73	<i>colchicine-probenecid</i> .....	79	<b>DAPTACEL</b> .....	114
<i>chlorothiazide sodium</i> .....	73	<b>COLCRYS</b> .....	80	<i>daptomycin</i> .....	39
<i>chlorpromazine hcl</i> .....	46	<i>colesevelam hcl</i> .....	34	<i>darifenacin hydrobromide er</i> .....	116
<i>chlorthalidone</i> .....	73	<i>colestipol hcl</i> .....	34	Dasetta 1/35.....	57
<i>chlorzoxazone</i> .....	101	<i>colistimethate sodium (cba)</i> .....	39	Dasetta 7/7/7.....	60
<i>cholestyramine</i> .....	34	Colocort.....	19	Daysee.....	59
<i>cholestyramine light</i> .....	34	<b>COMBIGAN</b> .....	103	Deblitane.....	60
Chromagen.....	82	<b>COMBIPATCH</b> .....	76	Decadron.....	61
<i>chromic chloride</i> .....	97	<b>COMBIVENT RESPIMAT</b> .....	22	<i>deferasirox</i> .....	31
<i>ciclopirox</i> .....	65	<b>COMETRIQ (100 MG DAILY</b>		Delyla.....	57
<i>ciclopirox olamine</i> .....	65	<b>DOSE)</b> .....	42	<i>demeclocycline hcl</i> .....	113
<i>cilostazol</i> .....	80	<b>COMETRIQ (140 MG DAILY</b>		Dentigel.....	98
<b>CIMDUO</b> .....	47	<b>DOSE)</b> .....	42	<b>DEPO-SUBQ PROVERA 104</b> .....	60
<i>cimetidine</i> .....	114	<b>COMETRIQ (60 MG DAILY</b>		<b>DESCOVY</b> .....	47
<i>cimetidine hcl</i> .....	114	<b>DOSE)</b> .....	42	<i>desflurane</i> .....	78
<i>cinacalcet hcl</i> .....	74	<b>COMFORT ASSIST INSULIN</b>		<i>desipramine hcl</i> .....	28
<b>CIPRODEX</b> .....	107	<b>SYRINGE</b> .....	88	<i>desloratadine</i> .....	34
<i>ciprofloxacin hcl</i> .....	77, 104, 107	<b>COMFORT EZ INSULIN</b>		<i>desmopressin ace spray refrig</i> .....	76
<i>ciprofloxacin in d5w</i> .....	77	<b>SYRINGE</b> .....	88	<i>desmopressin acetate</i> .....	76
<i>cisatracurium besylate</i> .....	103	<b>COMFORT EZ MICRO PEN</b>		<i>desmopressin acetate spray</i> .....	76
<i>cisatracurium besylate (pf)</i> .....	103	<b>NEEDLES</b> .....	88	<i>desogestrel-ethinyl estradiol</i> .....	56, 57
<i>citalopram hydrobromide</i> .....	27	<b>COMFORT EZ PEN NEEDLES</b> .....	88	<i>desonide</i> .....	68
Claravis.....	64	<b>COMFORT EZ SHORT PEN</b>		<i>desoximetasone</i> .....	68
<i>clarithromycin</i> .....	86	<b>NEEDLES</b> .....	88	<i>desvenlafaxine succinate er</i> .....	28
<i>clarithromycin er</i> .....	86	<i>completenate</i> .....	100	<i>dexamethasone</i> .....	61
<i>clemastine fumarate</i> .....	33	Compro.....	46	<b>DEXAMETHASONE INTENSOL</b> .....	61
<b>CLEOCIN</b> .....	119	<i>constulose</i> .....	85	<i>dexamethasone sod phosphate pf</i> .....	61
<b>CLEVER CHOICE COMFORT EZ</b> .....	88	<b>COPAXONE</b> .....	111	<i>dexamethasone sodium phosphate</i> .....	61, 106
<b>CLICKFINE PEN NEEDLES</b> .....	88	<i>copper chloride</i> .....	97	<i>dexchlorpheniramine maleate</i> .....	33
<i>clickfine pen needles</i> .....	88	Coremino.....	113	Dexifol.....	99
<b>CLIMARA PRO</b> .....	76	Cortic-Nd.....	107	<i>dexmedetomidine hcl</i> .....	84
Clindacin Etz.....	63	<i>cortisone acetate</i> .....	61	<i>dexmedetomidine hcl in nacl</i> .....	84
Clindacin-P.....	63	<b>CORVITA</b> .....	99	<i>dexmethylphenidate hcl</i> .....	12
<i>clindamycin hcl</i> .....	39	Corvita 150.....	82	<i>dexmethylphenidate hcl er</i> .....	12
<i>clindamycin palmitate hcl</i> .....	39	Corvite Free.....	100	Dexpak 10 Day.....	61
<i>clindamycin phos-benzoyl perox</i> .....	64	<b>COSENTYX</b> .....	66	Dexpak 13 Day.....	61
<i>clindamycin phosphate</i> .....	39, 63, 119	<b>COSENTYX (300 MG DOSE)</b> .....	66	Dexpak 6 Day.....	61
<i>clindamycin phosphate in d5w</i> .....	39	<b>COSENTYX SENSOREADY (300</b>		<i>dextroamphetamine sulfate</i> .....	11
<i>clindamycin-tretinoin</i> .....	64	<b>MG)</b> .....	66	<i>dextroamphetamine sulfate er</i> .....	11
Clinisol Sf.....	103	<b>COSENTYX SENSOREADY PEN</b> .....	66	<i>dextrose</i> .....	103
<i>clobazam</i> .....	24	<b>CREON</b> .....	72	<i>dextrose in lactated ringers</i> .....	96
<i>clobetasol prop emollient base</i> .....	67	<b>CROFAB</b> .....	107	<i>dextrose-nacl</i> .....	96
<i>clobetasol propionate</i> .....	67, 68	<i>cromolyn sodium</i> .....	22, 77, 104	Dialyvite.....	99

<i>diazepam</i> .....	20, 24	<i>duloxetine hcl</i> .....	28	<b>ERIVEDGE</b> .....	41
Diazepam IntenSol.....	20	<i>duramorph</i> .....	16	<b>ERLEADA</b> .....	41
<i>diclofenac epolamine</i> .....	65	<b>DUREZOL</b> .....	106	<i>erlotinib hcl</i> .....	42
<i>diclofenac potassium</i> .....	14	<i>dutasteride</i> .....	79	Errin.....	60
<i>diclofenac sodium</i> .....	14, 65, 66, 105	<i>dutasteride-tamsulosin hcl</i> .....	79	<i>ery</i> .....	64
<i>diclofenac sodium er</i> .....	14	<b>DVORAH</b> .....	16	Ery-Tab.....	86
<i>diclofenac-misoprostol</i> .....	14	<b>DYMISTA</b> .....	102	<b>ERYTHROCIN STEARATE</b> .....	86
<i>dicloxacillin sodium</i> .....	108	<b>E.E.S. 400</b> .....	86	<i>erythromycin</i> .....	64, 86, 104
<i>dicyclomine hcl</i> .....	114	<i>easy comfort insulin syringe</i> .....	89	<i>erythromycin base</i> .....	86
<i>didanosine</i> .....	48	<i>easy comfort pen needles</i> .....	89	<i>erythromycin ethylsuccinate</i> .....	86
<i>diethylpropion hcl</i> .....	11	<i>easy glide pen needles</i> .....	89	<i>escitalopram oxalate</i> .....	27
<i>diethylpropion hcl er</i> .....	11	<b>EASY TOUCH FLIPLOCK</b> .....		<i>esmolol hcl</i> .....	51
Difil-G Forte.....	23	<b>INSULIN SY</b> .....	89	Estarylla.....	57
<i>diflorasone diacetate</i> .....	68	<b>EASY TOUCH INSULIN SAFETY</b> .....		<i>estazolam</i> .....	84
<i>diflunisal</i> .....	16	<b>SYR</b> .....	89	<i>estradiol</i> .....	76, 119
Digitek.....	53	<b>EASY TOUCH INSULIN SYRINGE</b> .....	89	<i>estradiol valerate</i> .....	76
Digox.....	53	<b>EASY TOUCH PEN NEEDLES</b> .....	89	<i>estradiol-norethindrone acet</i> .....	76
<i>digoxin</i> .....	53	<b>EASY TOUCH SHEATHLOCK</b> .....		<i>eszopiclone</i> .....	84
<i>dihydroergotamine mesylate</i> .....	95	<b>SYRINGE</b> .....	89	<i>ethacrynic acid</i> .....	73
<b>DILANTIN</b> .....	26	<b>EASYGEL</b> .....	98	<i>ethambutol hcl</i> .....	40
<b>DILATRATE-SR</b> .....	19	<i>econazole nitrate</i> .....	70	<i>ethosuximide</i> .....	26
<i>diltiazem hcl</i> .....	52	<b>EDURANT</b> .....	48	<i>ethynodiol diac-eth estradiol</i> .....	57
<i>diltiazem hcl er</i> .....	52	<i>efavirenz</i> .....	48	<i>etodolac</i> .....	14
<i>diltiazem hcl er beads</i> .....	52	Effer-K.....	97	<i>etodolac er</i> .....	14
<i>diltiazem hcl er coated beads</i> .....	52	<i>eletriptan hydrobromide</i> .....	95	<i>etomidate</i> .....	78
<i>dilt-xr</i> .....	52	Elinest.....	57	<i>etonogestrel-ethinyl estradiol</i> .....	59
<i>diphenhydramine hcl</i> .....	34	<b>ELIQUIS</b> .....	23	<i>etoposide</i> .....	44
<i>diphenoxylate-atropine</i> .....	31	<b>ELIQUIS STARTER PACK</b> .....	24	Euthyrox.....	113
<i>diphtheria-tetanus toxoids dt</i> .....	114	<b>ELITE-OB</b> .....	100	<b>EVAMIST</b> .....	76
<i>dipyridamole</i> .....	81	<b>ELLA</b> .....	59	<i>everolimus</i> .....	42
<i>disopyramide phosphate</i> .....	21	Eluryng.....	59	<b>EXEL COMFORT POINT</b> .....	
<i>disulfiram</i> .....	109	<b>EMCYT</b> .....	43	<b>INSULIN SYR</b> .....	89
<i>divalproex sodium</i> .....	26	Emoquette.....	57	<b>EXEL COMFORT POINT PEN</b> .....	
<i>divalproex sodium er</i> .....	26	<b>EMTRIVA</b> .....	48	<b>NEEDLE</b> .....	89
<b>DIVIGEL</b> .....	76	<i>enalapril maleate</i> .....	36	<i>exemestane</i> .....	43
<i>dobutamine hcl</i> .....	119	<i>enalaprilat</i> .....	36	<i>exotic-hc</i> .....	107
<i>dobutamine in d5w</i> .....	119	<i>enalapril-hydrochlorothiazide</i> .....	35	<b>EXTAVIA</b> .....	110
<i>dofetilide</i> .....	21	<b>ENBREL</b> .....	15	<i>ezetimibe</i> .....	35
<i>donepezil hcl</i> .....	110	<b>ENBREL MINI</b> .....	15	<i>ezetimibe-simvastatin</i> .....	35
<i>dopamine hcl</i> .....	119	<b>ENBREL SURECLICK</b> .....	15	<i>fabb</i> .....	82
<i>dopamine in d5w</i> .....	120	Endocet.....	18	Falmina.....	57
<i>dorzolamide hcl</i> .....	105	<b>ENDOMETRIN</b> .....	119	<i>famciclovir</i> .....	49
<i>dorzolamide hcl-timolol mal</i> .....	104	<b>ENGERIX-B</b> .....	118	<i>famotidine</i> .....	114, 115
<i>dorzolamide hcl-timolol mal pf</i> .....	104	<i>enoxaparin sodium</i> .....	24	<i>famotidine premixed</i> .....	115
Dotti.....	76	Enpresse-28.....	60	<i>fa-vitamin b-6-vitamin b-12</i> .....	82
<i>doxazosin mesylate</i> .....	37	Enskyce.....	57	Fayosim.....	59
<i>doxepin hcl</i> .....	28, 66	<i>entacapone</i> .....	45	<i>febuxostat</i> .....	80
<i>doxercalciferol</i> .....	75	<i>entecavir</i> .....	49	<i>felbamate</i> .....	26
Doxy 100.....	113	<b>ENTRESTO</b> .....	103	<i>felodipine er</i> .....	52
<i>doxycycline hyclate</i> .....	113	<b>ENTYVIO</b> .....	84	<b>FEMCAP</b> .....	86
<i>doxycycline monohydrate</i> .....	113	<i>enulose</i> .....	78	Femynor.....	57
<i>doxylamine-pyridoxine</i> .....	32	<i>ephedrine sulfate</i> .....	120	<i>fenofibrate</i> .....	34
<i>dronabinol</i> .....	32	<i>epinastine hcl</i> .....	104	<i>fenofibrate micronized</i> .....	34
<i>droperidol</i> .....	20	<i>epinephrine</i> .....	119	<i>fenofibric acid</i> .....	34
<b>DROPLET INSULIN SYRINGE</b> .....	88	<i>epinephrine pf</i> .....	120	<i>fenoprofen calcium</i> .....	14
<b>DROPLET PEN NEEDLES</b> .....	89	Epitol.....	25	<i>fentanyl</i> .....	16
<i>dropsafe safety pen needles</i> .....	89	<i>eplerenone</i> .....	38	<i>fentanyl citrate</i> .....	16
<i>drospirene-eth estrad-levomefol</i> .....	57	<i>eprosartan mesylate</i> .....	37	<i>fentanyl citrate (pf)</i> .....	16
<i>drospirenone-ethinyl estradiol</i> .....	57	<i>eptifibatide</i> .....	80	<i>ferocon</i> .....	82
<b>DROXIA</b> .....	81	<i>eql insulin syringe</i> .....	89	<i>ferotinsic</i> .....	82
<i>drug mart unifine pentips</i> .....	89	<i>ergocalciferol</i> .....	120	Ferrocite Plus.....	82
<i>drug mart unifine pentips plus</i> .....	89	<i>ergoloid mesylates</i> .....	111	<b>FEXMID</b> .....	101
<b>DULERA</b> .....	22	<i>ergotamine-caffeine</i> .....	95	<b>FIFTY50 PEN NEEDLES</b> .....	89



<b>FIFTY50 SUPERIOR COMFORT SYR</b> .....	89	<i>fosinopril sodium-hctz</i> .....	36	<b>GONAL-F RFF REDJECT</b> .....	75
<i>finasteride</i> .....	71, 79	<i>fosphenytoin sodium</i> .....	26	<i>goodsense clickfine pen needle</i> .....	89
<b>FIRAZYR</b> .....	80	<b>FRAGMIN</b> .....	24	<b>GOODSENSE PEN NEEDLE</b>	
<b>FIRMAGON</b> .....	43	<i>freds pharmacy unifine pentip+</i> .....	89	<b>PENFINE</b> .....	89
Flac.....	107	<i>freds pharmacy unifine pentips</i> .....	89	<i>granisetron hcl</i> .....	32
<i>flavoxate hcl</i> .....	117	<b>FREESTYLE PRECISION INS SYR</b>	89	<i>griseofulvin microsize</i> .....	33
<i>flecainide acetate</i> .....	21	<i>fresenius propoven</i> .....	78	<i>griseofulvin ultramicrosize</i> .....	33
Flexbumin.....	81	<i>frovatriptan succinate</i> .....	95	<i>guaiaatussin ac</i> .....	62
<b>FLOVENT DISKUS</b> .....	23	<b>FULPHILA</b> .....	82	<i>guaifenesin ac</i> .....	62
<b>FLOVENT HFA</b> .....	23	<i>furosemide</i> .....	73	<i>guaifenesin dac</i> .....	62
<b>FLUAD</b> .....	118	<b>FUZEON</b> .....	48	<i>guanfacine hcl</i> .....	37
<b>FLUARIX QUADRIVALENT</b> .....	118	Fyavolv.....	76	<i>guanfacine hcl er</i> .....	11
<b>FLUBLOK QUADRIVALENT</b> .....	118	<i>g tussin ac</i> .....	62	<b>HAEGARDA</b> .....	80
<b>FLUCELVAX QUADRIVALENT</b> .....	118	<i>gabapentin</i> .....	25	Hailey 1.5/30.....	57
<i>fluconazole</i> .....	33	<i>galantamine hydrobromide</i> .....	110	Hailey 24 Fe.....	57
<i>fluconazole in sodium chloride</i> .....	33	<i>galantamine hydrobromide er</i> .....	110	<i>halcinonide</i> .....	68
<i>flucytosine</i> .....	33	<b>GAMUNEX-C</b> .....	107	<i>halobetasol propionate</i> .....	68
<i>fludrocortisone acetate</i> .....	62	<b>GARDASIL 9</b> .....	118	<i>haloperidol</i> .....	46
<b>FLULAVAL QUADRIVALENT</b> .....	118	<i>gatifloxacin</i> .....	104	<i>haloperidol decanoate</i> .....	46
<i>flumazenil</i> .....	31	Gavilyte-C.....	84	<i>haloperidol lactate</i> .....	46
<b>FLUMIST QUADRIVALENT</b> .....	118	Gavilyte-G.....	84	<b>HAVRIX</b> .....	118
<i>fluocinolone acetonide</i> .....	68, 107	Gavilyte-H.....	84	<i>healthwise insulin syr/needle</i> .....	89
<i>fluocinolone acetonide body</i> .....	68	Gavilyte-N With Flavor Pack.....	84	<i>healthwise micron pen needles</i> .....	89
<i>fluocinolone acetonide scalp</i> .....	68	<i>gemfibrozil</i> .....	34	<i>healthwise mini pen needles</i> .....	89
<i>fluocinonide</i> .....	68	<i>generlac</i> .....	78	<i>healthwise pen needles</i> .....	89
<i>fluocinonide emulsified base</i> .....	68	Gengraf.....	50	<i>healthwise short pen needles</i> .....	89
<i>fluorescein-benoxinate</i> .....	105	Genicin Vita-S.....	99	<i>healthwise unifine pentips</i> .....	89
Fluor-I-Strips A.T.....	105	<b>GENTAK</b> .....	104	<i>healthy accents unifine pentip</i> .....	90
<i>fluoritab</i> .....	96	<i>gentamicin in saline</i> .....	12	Heather.....	60
<i>fluorometholone</i> .....	106	<i>gentamicin sulfate</i> .....	12, 65, 104	<i>h-e-b incontrol pen needles</i> .....	90
<i>fluorouracil</i> .....	66	<b>GENVOYA</b> .....	47	<b>H-E-B INCONTROL UNIFINE</b>	
<i>fluoxetine hcl</i> .....	27	<b>GEODON</b> .....	46	<b>PENTIP</b> .....	90
<i>fluoxetine hcl (pmdd)</i> .....	111	Gianvi.....	57	<i>hematinic plus vit/minerals</i> .....	83
<i>fluphenazine decanoate</i> .....	46	<b>GILENYA</b> .....	112	<i>hematinic/folic acid</i> .....	83
<i>fluphenazine hcl</i> .....	46, 47	<b>GILOTRIF</b> .....	42	Hematogen.....	83
<b>FLURA-DROPS</b> .....	96	<i>glatiramer acetate</i> .....	111	Hematogen Forte.....	83
<i>flurandrenolide</i> .....	68	Glatopa.....	111	Hemocyte-F.....	83
<i>flurazepam hcl</i> .....	84	<i>glimepiride</i> .....	30	<i>heparin (porcine) in nacl</i> .....	24
<i>flurbiprofen</i> .....	14	<i>glipizide</i> .....	31	<i>heparin lock flush</i> .....	24
<i>flurbiprofen sodium</i> .....	105	<i>glipizide er</i> .....	30	<i>heparin sod (porcine) in d5w</i> .....	24
<i>flutamide</i> .....	41	<i>glipizide xl</i> .....	31	<i>heparin sodium (porcine)</i> .....	24
<i>fluticasone propionate</i> .....	68	<i>glipizide-metformin hcl</i> .....	30	<i>heparin sodium (porcine) pf</i> .....	24
<i>fluticasone-salmeterol</i> .....	22	<i>global ease inject pen needles</i> .....	89	<i>heparin sodium lock flush</i> .....	24
<i>fluvastatin sodium</i> .....	35	<i>global easy glide insulin syr</i> .....	89	<b>HEPATAMINE</b> .....	103
<i>fluvastatin sodium er</i> .....	35	<i>global easy glide pen needles</i> .....	89	<b>HEPLISAV-B</b> .....	118
<i>fluvoxamine maleate</i> .....	27	<i>global inject ease insulin syr</i> .....	89	<i>hetastarch-nacl</i> .....	80
<i>fluvoxamine maleate er</i> .....	27	<i>global insulin syringes</i> .....	89	<b>HIBERIX</b> .....	117
<b>FLUZONE HIGH-DOSE</b> .....	118	Glostrips.....	105	<b>HUMALOG</b> .....	29
<b>FLUZONE QUADRIVALENT</b> .....	118	<b>GLUCAGEN HYPOKIT</b> .....	28	<b>HUMALOG JUNIOR KWIKPEN</b> .....	29
<i>folbee</i> .....	82	<b>GLUCAGON EMERGENCY</b> .....	29	<b>HUMALOG KWIKPEN</b> .....	29
<i>folbee plus</i> .....	99	<b>GLUCOPRO INSULIN SYRINGE</b> .....	89	<b>HUMALOG MIX 50/50</b> .....	29
<i>folic acid</i> .....	82	<i>glyburide</i> .....	31	<b>HUMALOG MIX 50/50 KWIKPEN</b> .....	29
<b>FOLIVANE-OB</b> .....	100	<i>glyburide micronized</i> .....	31	<b>HUMALOG MIX 75/25</b> .....	29
<i>folplex 2.2</i> .....	82	<i>glyburide-metformin</i> .....	30	<b>HUMALOG MIX 75/25 KWIKPEN</b> .....	29
<i>foltrin</i> .....	82	<i>glycine</i> .....	79	Human Albumin Grifols.....	81
<i>fomepizole</i> .....	31	<i>glycine urologic</i> .....	79	<b>HUMATROPE</b> .....	74
<i>fondaparinux sodium</i> .....	24	<i>glycopyrrolate</i> .....	115	<b>HUMIRA</b> .....	13, 14
<b>FORTEO</b> .....	75	Glydo.....	70	<b>HUMIRA PEDIATRIC CROHNS</b>	
<b>FOSAMAX PLUS D</b> .....	74	<i>gnp clickfine pen needles</i> .....	89	<b>START</b> .....	13
<i>fosamprenavir calcium</i> .....	48	<i>gnp insulin syringe</i> .....	89	<b>HUMIRA PEN</b> .....	13
<i>fosaprepitant dimeglumine</i> .....	32	<i>gnp ultra com insulin syringe</i> .....	89	<b>HUMIRA PEN-CD/UC/HS</b>	
<i>fosinopril sodium</i> .....	36	<b>GONAL-F</b> .....	75	<b>STARTER</b> .....	13
		<b>GONAL-F RFF</b> .....	75		

<b>HUMIRA PEN-PS/UV/ADOL HS</b>	Incassia.....	60	<b>KANGAROO BALLOON</b>	
<b>START</b> .....	<i>indapamide</i> .....	73	<b>12FR/1.5CM</b> .....	93
<b>HUMULIN 70/30</b> .....	<i>indomethacin</i> .....	14	<b>KANGAROO BALLOON</b>	
<b>HUMULIN 70/30 KWIKPEN</b> .....	<i>indomethacin er</i> .....	14	<b>12FR/1.7CM</b> .....	93
<b>HUMULIN N</b> .....	<i>indomethacin sodium</i> .....	14	<b>KANGAROO BALLOON</b>	
<b>HUMULIN N KWIKPEN</b> .....	<b>INFANRIX</b> .....	114	<b>12FR/1CM</b> .....	93
<b>HUMULIN R</b> .....	<b>INLYTA</b> .....	42	<b>KANGAROO BALLOON</b>	
<b>HUMULIN R U-500</b>	<i>insulin lispro</i> .....	30	<b>12FR/2.3CM</b> .....	93
<b>(CONCENTRATED)</b> .....	<i>insulin lispro (1 unit dial)</i> .....	30	<b>KANGAROO BALLOON</b>	
<b>HUMULIN R U-500 KWIKPEN</b> .....	<i>insulin syringe</i> .....	90	<b>12FR/2.5CM</b> .....	93
<b>HYCAMTIN</b> .....	<i>insulin syringe/needle</i> .....	90	<b>KANGAROO BALLOON</b>	
<i>hydralazine hcl</i> .....	<i>insulin syringe-needle u-100</i> .....	90	<b>12FR/2.7CM</b> .....	93
<i>hydrochlorothiazide</i> .....	<i>insupen pen needles</i> .....	90	<b>KANGAROO BALLOON</b>	
<i>hydrocod polst-cpm polst er</i> .....	<b>INSUPEN SENSITIVE</b> .....	90	<b>12FR/2CM</b> .....	93
<i>hydrocodone-acetaminophen</i> .....	<b>INSUPEN ULTRAFIN</b> .....	90	<b>KANGAROO BALLOON</b>	
<i>hydrocodone-homatropine</i> .....	<b>INTELENCE</b> .....	48	<b>12FR/3.5CM</b> .....	93
<i>hydrocodone-ibuprofen</i> .....	<b>INTRON A</b> .....	43	<b>KANGAROO BALLOON</b>	
<i>hydrocortisone</i> .....	Introvale.....	59	<b>12FR/3CM</b> .....	93
<i>hydrocortisone ace-pramoxine</i> .....	<b>IPOL</b> .....	118	<b>KANGAROO BALLOON</b>	
<i>hydrocortisone butyr lipo base</i> .....	<i>ipratropium bromide</i> .....	22, 102	<b>12FR/4.5CM</b> .....	93
<i>hydrocortisone butyrate</i> .....	<i>ipratropium-albuterol</i> .....	22	<b>KANGAROO BALLOON</b>	
<i>hydrocortisone valerate</i> .....	<i>irbesartan</i> .....	37	<b>12FR/4CM</b> .....	93
<i>hydrocortisone-acetic acid</i> .....	<i>irbesartan-hydrochlorothiazide</i> .....	36	<b>KANGAROO BALLOON</b>	
<b>HYDROFERA BLUE 4"X4"</b> .....	<b>IRESSA</b> .....	42	<b>12FR/5CM</b> .....	93
<b>HYDROFERA BLUE 6"X6"</b> .....	<b>ISENTRESS</b> .....	48	<b>KANGAROO BALLOON</b>	
<b>HYDROFERA BLUE FOAM</b>	Isibloom.....	57	<b>14FR/0.8CM</b> .....	93
<b>DRESSING</b> .....	<i>isoflurane</i> .....	78	<b>KANGAROO BALLOON</b>	
<b>HYDROFERA BLUE</b>	<i>isoniazid</i> .....	40	<b>14FR/1.2CM</b> .....	93
<b>FOAM/TUNNELING</b> .....	<b>ISORDIL TITRADOSE</b> .....	20	<b>KANGAROO BALLOON</b>	
<b>HYDROFERA BLUE MRF</b>	<i>isosorbide dinitrate</i> .....	20	<b>14FR/1.5CM</b> .....	93
<b>DRESSING</b> .....	<i>isosorbide mononitrate</i> .....	20	<b>KANGAROO BALLOON</b>	
<b>HYDROFERA BLUE READY</b>	<i>isosorbide mononitrate er</i> .....	20	<b>14FR/1.7CM</b> .....	93
<b>FOAM</b> .....	<i>isotretinoin</i> .....	64	<b>KANGAROO BALLOON</b>	
<i>hydromet</i> .....	<i>isradipine</i> .....	52	<b>14FR/2.3CM</b> .....	93
<i>hydromorphone hcl</i> .....	<i>itraconazole</i> .....	33	<b>KANGAROO BALLOON</b>	
<i>hydromorphone hcl er</i> .....	<i>ivermectin</i> .....	19, 71	<b>14FR/2.5CM</b> .....	93
<i>hydromorphone hcl pf</i> .....	<b>IXIARO</b> .....	118	<b>KANGAROO BALLOON</b>	
<i>hydroxocobalamin acetate</i> .....	<b>JAKAFI</b> .....	43, 44	<b>14FR/2.7CM</b> .....	93
<i>hydroxychloroquine sulfate</i> .....	Jantoven.....	23	<b>KANGAROO BALLOON</b>	
<i>hydroxyprogesterone caproate</i> .....	<b>JANUMET</b> .....	29	<b>14FR/3.5CM</b> .....	93
<i>hydroxyurea</i> .....	<b>JANUMET XR</b> .....	29	<b>KANGAROO BALLOON</b>	
<i>hydroxyzine hcl</i> .....	<b>JANUVIA</b> .....	29	<b>14FR/3CM</b> .....	93
<i>hydroxyzine pamoate</i> .....	<b>JARDIANCE</b> .....	30	<b>KANGAROO BALLOON</b>	
<i>hylavite</i> .....	Jasmiel.....	57	<b>14FR/4.5CM</b> .....	93
<i>hyoscyamine sulfate er</i> .....	Jencycla.....	60	<b>KANGAROO BALLOON</b>	
<i>hyoscyamine sulfate sl</i> .....	<b>JENTADUETO</b> .....	29	<b>14FR/5CM</b> .....	93
<b>HYPERLYTE-CR</b> .....	<b>JENTADUETO XR</b> .....	29	<b>KANGAROO BALLOON</b>	
<i>ibandronate sodium</i> .....	Jinteli.....	76	<b>16FR/0.8CM</b> .....	93
<b>IBRANCE</b> .....	Jolessa.....	59	<b>KANGAROO BALLOON</b>	
Ibu.....	Juleber.....	57	<b>16FR/1.2CM</b> .....	93
<i>ibuprofen</i> .....	Junel 1.5/30.....	57	<b>KANGAROO BALLOON</b>	
<i>ibutilide fumarate</i> .....	Junel 1/20.....	57	<b>16FR/1.5CM</b> .....	93
<i>icatibant acetate</i> .....	Junel Fe 1.5/30.....	57	<b>KANGAROO BALLOON</b>	
<b>ICLUSIG</b> .....	Junel Fe 1/20.....	57	<b>16FR/1.7CM</b> .....	93
<b>ILEVRO</b> .....	Junel Fe 24.....	57	<b>KANGAROO BALLOON</b>	
<i>imatinitib mesylate</i> .....	Kaitlib Fe.....	57	<b>16FR/1CM</b> .....	93
<i>imipenem-cilastatin</i> .....	<b>KALBITOR</b> .....	80	<b>KANGAROO BALLOON</b>	
<i>imipramine hcl</i> .....	<b>KALETRA</b> .....	47	<b>16FR/2.3CM</b> .....	93
<i>imipramine pamoate</i> .....	Kalliga.....	57	<b>KANGAROO BALLOON</b>	
<i>imiquimod</i> .....	<b>KANGAROO BALLOON</b>		<b>16FR/2.7CM</b> .....	93
<i>imiquimod pump</i> .....	<b>12FR/0.8CM</b> .....		<b>KANGAROO BALLOON</b>	
<b>IMOVAX RABIES</b> .....	<b>KANGAROO BALLOON</b>		<b>16FR/2CM</b> .....	93
<b>INATAL GT</b> .....	<b>12FR/1.2CM</b> .....			

<b>KANGAROO BALLOON</b>	<i>kinray insulin syringe</i> .....	90	<i>levabuterol hcl</i> .....	22
<b>16FR/3.5CM</b> .....	<b>KINRIX</b> .....	114	<b>LEVEMIR</b> .....	30
<b>KANGAROO BALLOON</b>	Kionex.....	51, 109	<b>LEVEMIR FLEXTOUCH</b> .....	30
<b>16FR/3CM</b> .....	<b>KISQALI (200 MG DOSE)</b> .....	63	<i>levetiracetam</i> .....	25
<b>KANGAROO BALLOON</b>	<b>KISQALI (400 MG DOSE)</b> .....	63	<i>levetiracetam er</i> .....	25
<b>16FR/4.5CM</b> .....	<b>KISQALI (600 MG DOSE)</b> .....	63	<i>levobunolol hcl</i> .....	104
<b>KANGAROO BALLOON</b>	<b>KISQALI FEMARA (400 MG</b>		<i>levocarnitine</i> .....	74
<b>16FR/4CM</b> .....	<b>DOSE)</b> .....	43	<i>levocarnitine sf</i> .....	74
<b>KANGAROO BALLOON</b>	<b>KISQALI FEMARA (600 MG</b>		<i>levofloxacin in d5w</i> .....	77, 104
<b>16FR/5CM</b> .....	<b>DOSE)</b> .....	43	<i>Levonest</i> .....	60
<b>KANGAROO BALLOON</b>	<b>KISQALI FEMARA(200 MG</b>		<i>levonorgest-eth est &amp; eth est</i> .....	59
<b>18FR/0.8CM</b> .....	<b>DOSE)</b> .....	43	<i>levonorgest-eth estrad 91-day</i> .....	59
<b>KANGAROO BALLOON</b>	Klor-Con.....	97	<i>levonorgestrel-ethinyl estrad</i> .....	57, 59
<b>18FR/1.2CM</b> .....	Klor-Con 10.....	97	<i>levonorg-eth estrad triphasic</i> .....	60
<b>KANGAROO BALLOON</b>	Klor-Con M10.....	97	Levora 0.15/30 (28).....	58
<b>18FR/1.5CM</b> .....	<b>KLOR-CON M15</b> .....	97	<i>levorphanol tartrate</i> .....	17
<b>KANGAROO BALLOON</b>	Klor-Con M20.....	97	Levo-T.....	113
<b>18FR/1.7CM</b> .....	Klor-Con Sprinkle.....	97	<i>levothyroxine sodium</i> .....	113
<b>KANGAROO BALLOON</b>	Klor-Con/Ef.....	97	Levoxyl.....	113
<b>18FR/1CM</b> .....	<i>kmart valu insulin syringe 29g</i> .....	90	<i>lidocaine</i> .....	70
<b>KANGAROO BALLOON</b>	<i>kmart valu insulin syringe 30g</i> .....	90	<i>lidocaine hcl</i> .....	70, 85, 98
<b>18FR/2.3CM</b> .....	K-Prime.....	97	<i>lidocaine hcl (cardiac)</i> .....	21
<b>KANGAROO BALLOON</b>	<i>kroger insulin syringe</i> .....	90	<i>lidocaine hcl (cardiac) pf</i> .....	21
<b>18FR/2.5CM</b> .....	<i>kroger pen needles</i> .....	90	<i>lidocaine hcl (pf)</i> .....	85
<b>KANGAROO BALLOON</b>	Kurvelo.....	57	<i>lidocaine hcl urethral/mucosal</i> .....	70
<b>18FR/2.7CM</b> .....	<b>KUVAN</b> .....	75	<i>lidocaine in d5w</i> .....	21
<b>KANGAROO BALLOON</b>	<i>labetalol hcl</i> .....	51	<i>lidocaine viscous hcl</i> .....	98
<b>18FR/2CM</b> .....	<i>lactated ringers</i> .....	50, 96	<i>lidocaine-epinephrine</i> .....	85
<b>KANGAROO BALLOON</b>	<i>lactic acid</i> .....	69	<i>lidocaine-prilocaine</i> .....	71
<b>18FR/3.5CM</b> .....	<i>lactic acid e</i> .....	69	Lido-Sorb.....	70
<b>KANGAROO BALLOON</b>	<i>lactulose</i> .....	85	<b>LIFESCAN UNISTIK 2</b> .....	87
<b>18FR/3CM</b> .....	<i>lactulose encephalopathy</i> .....	78	<b>LIFESCAN UNISTIK II LANCETS</b> .....	87
<b>KANGAROO BALLOON</b>	<i>lamivudine</i> .....	49	Lillow.....	58
<b>18FR/4.5CM</b> .....	<i>lamivudine-zidovudine</i> .....	47	<i>lindane</i> .....	71
<b>KANGAROO BALLOON</b>	<i>lamotrigine</i> .....	25	<i>linezolid</i> .....	39
<b>18FR/4CM</b> .....	<i>lamotrigine er</i> .....	25	<i>linezolid in sodium chloride</i> .....	39
<b>KANGAROO BALLOON</b>	<i>lamotrigine starter kit-blue</i> .....	25	<b>LINZESS</b> .....	77
<b>18FR/5CM</b> .....	<i>lamotrigine starter kit-green</i> .....	25	<i>liothyronine sodium</i> .....	113
<b>KANGAROO BALLOON</b>	<i>lamotrigine starter kit-orange</i> .....	25	<i>lisinopril</i> .....	36
<b>20FR/0.8CM</b> .....	<b>LANOXIN</b> .....	53	<i>lisinopril-hydrochlorothiazide</i> .....	36
<b>KANGAROO BALLOON</b>	<b>LANOXIN PEDIATRIC</b> .....	53	<i>lissamine green</i> .....	105
<b>20FR/1.2CM</b> .....	<i>lanthanum carbonate</i> .....	78	<b>LITETOUCH INSULIN SYRINGE</b> .....	90
<b>KANGAROO BALLOON</b>	<b>LANTUS</b> .....	30	<b>LITETOUCH PEN NEEDLES</b> .....	90
<b>20FR/1.5CM</b> .....	Larin 1.5/30.....	57	<i>lithium</i> .....	45
<b>KANGAROO BALLOON</b>	Larin 1/20.....	57	<i>lithium carbonate</i> .....	45
<b>20FR/1.7CM</b> .....	Larin 24 Fe.....	57	<i>lithium carbonate er</i> .....	45
<b>KANGAROO BALLOON</b>	Larin Fe 1.5/30.....	57	<b>LMD IN D5W</b> .....	80
<b>20FR/1CM</b> .....	Larin Fe 1/20.....	57	<b>LMD IN NACL</b> .....	80
<b>KANGAROO BALLOON</b>	Larissia.....	57	<b>LO LOESTRIN FE</b> .....	56
<b>20FR/2.3CM</b> .....	<i>latanoprost</i> .....	106	<i>longs insulin syringe</i> .....	90
<b>KANGAROO BALLOON</b>	Layolis Fe.....	57	<i>loperamide hcl</i> .....	31
<b>20FR/2CM</b> .....	<i>leader insulin syringe</i> .....	90	<i>lopinavir-ritonavir</i> .....	47
Kariva.....	<b>LEADER UNIFINE PENTIPS</b> .....	90	Lopreeza.....	76
<i>kcl in dextrose-nacl</i> .....	<b>LEADER UNIFINE PENTIPS PLUS</b> .....	90	<i>lorazepam</i> .....	20
<i>kedbumin</i> .....	Leena.....	60	Lorazepam Intensol.....	20
Kelnor 1/35.....	<i>leflunomide</i> .....	15	Lorcet.....	16
Kelnor 1/50.....	Lessina.....	57	Lorcet Hd.....	16
<i>ketamine hcl</i> .....	<b>LETAIRIS</b> .....	54	Lorcet Plus.....	16
<i>ketoconazole</i> .....	<i>letrozole</i> .....	43	<i>lorid</i> .....	99
33, 70	<i>leucovorin calcium</i> .....	43	Loryna.....	58
Ketodan.....	<b>LEUKERAN</b> .....	44	Lorzzone.....	101
70	<i>leuprolide acetate</i> .....	44	<i>losartan potassium</i> .....	37
<i>ketoprofen</i> .....				
14				
<i>ketoprofen er</i> .....				
14				
<i>ketorolac tromethamine</i> .....				
14, 15, 105				



<i>losartan potassium-hctz</i> .....	36	<i>meprobamate</i> .....	20	Mimvey.....	76
<b>LOTEMAX</b> .....	106	<i>mercaptapurine</i> .....	41	Minitran.....	20
<i>loteprednol etabonate</i> .....	106	<i>meropenem</i> .....	39	<i>minocycline hcl</i> .....	113
<i>lovastatin</i> .....	35	<i>mesalamine</i> .....	78	<i>minocycline hcl er</i> .....	113
Low-Ogestrel.....	58	<i>mesalamine er</i> .....	78	<i>minoxidil</i> .....	38
<i>loxapine succinate</i> .....	46	<i>mesalamine-cleanser</i> .....	78	<i>mirtazapine</i> .....	26
Lo-Zumandimine.....	58	<i>mesna</i> .....	44	<i>misoprostol</i> .....	115
Ludent.....	96	Metadate Er.....	12	Mitigo.....	17
<i>luliconazole</i> .....	70	<i>metaproterenol sulfate</i> .....	22	<i>mm insulin syringe/needle</i> .....	90
<b>LUMIGAN</b> .....	106	<i>metaxalone</i> .....	101	<b>MM PEN NEEDLES</b> .....	90
Lutera.....	58	<i>metformin hcl</i> .....	28	<b>M-M-R II</b> .....	117
Lysiplex Plus.....	100	<i>metformin hcl er</i> .....	28	<i>modafinil</i> .....	12
<b>LYSODREN</b> .....	40	<i>methadone hcl</i> .....	17	<i>moexipril hcl</i> .....	36
Lyza.....	60	Methadone Hcl Intensol.....	17	<i>molindone hcl</i> .....	46
<i>mafenide acetate</i> .....	67	Methadose.....	17	<i>mometasone furoate</i> .....	69, 102
<b>MAGELLAN INSULIN SAFETY</b>		<i>methamphetamine hcl</i> .....	11	Mondoxyne NI.....	113
<b>SYR</b> .....	90	<i>methazolamide</i> .....	73	Monoject Flush Syringe.....	97
<i>magnesium chloride</i> .....	96	<i>methenamine hippurate</i> .....	115	<b>MONOJECT INSULIN SYRINGE</b> .....	90
<i>magnesium sulfate</i> .....	96	<i>methenamine mandelate</i> .....	115	Monoject Sodium Chloride Flush.....	97
<i>magnesium sulfate in d5w</i> .....	96	Methergine.....	107	<b>MONOJECT ULTRA COMFORT</b>	
<i>malathion</i> .....	71	<i>methimazole</i> .....	113	<b>SYRINGE</b> .....	90
<i>manganese chloride</i> .....	96	<i>methocarbamol</i> .....	102	Mono-Linyah.....	58
<i>manganese sulfate</i> .....	96	<i>methotrexate</i> .....	41	<b>MONOVISC</b> .....	102
<i>mannitol</i> .....	73	<i>methotrexate sodium</i> .....	41	<i>montelukast sodium</i> .....	23
<i>maprotiline hcl</i> .....	27	<i>methotrexate sodium (pf)</i> .....	41	Morgidox.....	113
<b>MARATHON MEDICAL PENTIPS</b> .....	90	<i>methoxsalen rapid</i> .....	66	<i>morphine sulfate</i> .....	17
<i>marlissa</i> .....	58	<i>methscopolamine bromide</i> .....	115	<i>morphine sulfate (concentrate)</i> .....	17
<b>MATULANE</b> .....	43	<i>methyldopa</i> .....	37	<i>morphine sulfate (pf)</i> .....	17
Matzim La.....	52, 53	<i>methyldopa-hydrochlorothiazide</i> .....	36	<i>morphine sulfate er</i> .....	17
<b>MAVENCLAD (10 TABS)</b> .....	99	<i>methylene blue</i> .....	31	<i>morphine sulfate er beads</i> .....	17
<b>MAVENCLAD (4 TABS)</b> .....	99	<i>methylergonovine maleate</i> .....	107	<i>moxifloxacin hcl</i> .....	77, 104
<b>MAVENCLAD (5 TABS)</b> .....	99	<i>methylphenidate hcl</i> .....	12	<i>ms insulin syringe</i> .....	90
<b>MAVENCLAD (6 TABS)</b> .....	99	<i>methylphenidate hcl er</i> .....	12	<i>multitrace-4 concentrate</i> .....	97
<b>MAVENCLAD (7 TABS)</b> .....	99	<i>methylphenidate hcl er (cd)</i> .....	12	<i>multitrace-5 concentrate</i> .....	97
<b>MAVENCLAD (8 TABS)</b> .....	99	<i>methylphenidate hcl er (la)</i> .....	12	<i>multi-vit/iron/fluoride</i> .....	100
<b>MAVENCLAD (9 TABS)</b> .....	99	<i>methylprednisolone</i> .....	61	<i>multivitamin/fluoride</i> .....	100
<b>MAVYRET</b> .....	83	<i>methylprednisolone acetate</i> .....	61	<i>multi-vitamin/fluoride</i> .....	100
<b>MAXICOMFORT II PEN NEEDLE</b> .....	90	<i>methylprednisolone sodium succ</i> .....	62	<i>multivitamin/fluoride/iron</i> .....	100
<b>MAXI-COMFORT INSULIN</b>		<i>methyltestosterone</i> .....	19	<i>multi-vitamin/fluoride/iron</i> .....	100
<b>SYRINGE</b> .....	90	<i>metoclopramide hcl</i> .....	77	<i>multivitamins/fluoride</i> .....	100
<b>MAXI-COMFORT SAFETY PEN</b>		<i>metolazone</i> .....	73	<i>mupirocin</i> .....	65
<b>NEEDLE</b> .....	90	<i>metoprolol succinate er</i> .....	51	<i>mupirocin calcium</i> .....	65
<b>MAXICOMFORT SYR 27G X 1/2"</b> .....	90	<i>metoprolol tartrate</i> .....	51	Mvc-Fluoride.....	100
<b>MAYZENT</b> .....	112	<i>metoprolol-hydrochlorothiazide</i> .....	38	<i>mycophenolate mofetil</i> .....	50
<i>meclizine hcl</i> .....	32	<i>metronidazole</i> .....	38, 71, 119	<i>mycophenolate sodium</i> .....	50
<i>meclofenamate sodium</i> .....	15	<i>metronidazole in nacl</i> .....	38	<b>MYLERAN</b> .....	40
<i>medicine shoppe pen needles</i> .....	90	<i>mexiletine hcl</i> .....	21	<i>mynatal plus</i> .....	100
<i>medroxyprogesterone acetate</i> .....	60, 109	Mibelas 24 Fe.....	58	<i>mynatal-z</i> .....	100
<i>mefenamic acid</i> .....	15	<i>miconazole 3</i> .....	119	<i>mynate 90 plus</i> .....	100
<i>mefloquine hcl</i> .....	39	Microgestin 1.5/30.....	58	<i>mynephrocaps</i> .....	99
<i>megestrol acetate</i> .....	44, 109	Microgestin 1/20.....	58	Mynephron.....	99
<i>meijer pen needles</i> .....	90	Microgestin Fe 1.5/30.....	58	Myorisan.....	64
<b>MEKINIST</b> .....	42	Microgestin Fe 1/20.....	58	<b>MYRBETRIQ</b> .....	116
Melodetta 24 Fe.....	58	<i>midazolam hcl</i> .....	84	<i>na ferric gluc cplx in sucrose</i> .....	83
<i>meloxicam</i> .....	15	<i>midazolam hcl (pf)</i> .....	84	<i>nabumetone</i> .....	15
<i>melpaque hp</i> .....	69	<i>midodrine hcl</i> .....	120	<i>n-acetyl-l-cysteine</i> .....	103
<i>melphalan</i> .....	44	<i>mifepristone</i> .....	74	<i>nadolol</i> .....	51
<i>memantine hcl</i> .....	111	<b>MIGERGOT</b> .....	95	<i>nafcillin sodium</i> .....	108
<i>memantine hcl er</i> .....	111	<i>miglitol</i> .....	28	Nafrinse.....	96
<b>MENACTRA</b> .....	117	<i>miglustat</i> .....	81	Nafrinse Drops.....	96
<b>MENEST</b> .....	76	Mili.....	58	<i>naftifine hcl</i> .....	65
<b>MENVEO</b> .....	117	<i>milrinone lactate</i> .....	54	<i>nalbuphine hcl</i> .....	18
<i>meperidine hcl</i> .....	17	<i>milrinone lactate in dextrose</i> .....	53	<i>naloxone hcl</i> .....	32

<i>naltrexone hcl</i> .....	32	<i>norethindrone-eth estradiol</i> .....	76	Nyamyc.....	65
<b>NAMENDA XR TITRATION</b>		<i>norethin-eth estradiol-fe</i> .....	58	<i>nystatin</i> .....	33, 65, 98
<b>PACK</b> .....	111	<i>norgestimate-eth estradiol</i> .....	58	<i>nystatin-triamcinolone</i> .....	65
<i>naproxen</i> .....	15	<i>norgestim-eth estrad triphasic</i> .....	60	Nystop.....	65
<i>naproxen dr</i> .....	15	Norlyda.....	60	Ocella.....	58
<i>naproxen sodium</i> .....	15	Norlyroc.....	60	<b>OCTAGAM</b> .....	107
<i>naproxen sodium er</i> .....	15	<i>normal saline flush</i> .....	97	Ocucoat Viscoadherent.....	106
<i>naratriptan hcl</i> .....	95	<b>NORPACE CR</b> .....	21	<b>OFEV</b> .....	112
<b>NARCAN</b> .....	32	Nortrel 0.5/35 (28).....	58	<i>ofloxacin</i> .....	77, 104, 107
<b>NATAZIA</b> .....	60	Nortrel 1/35 (21).....	58	<b>OGESTREL</b> .....	58
<i>nateglinide</i> .....	30	Nortrel 1/35 (28).....	58	Okebo.....	113
<b>NEBUPENT</b> .....	38	Nortrel 7/7/7.....	61	<i>olanzapine</i> .....	47
Nebusal.....	62	<i>nortriptyline hcl</i> .....	28	<i>olanzapine-fluoxetine hcl</i> .....	112
Necon 0.5/35 (28).....	58	<b>NORVIR</b> .....	48	<i>olmesartan medoxomil</i> .....	37
<i>nefazodone hcl</i> .....	27, 112	<b>NOVAREL</b> .....	75	<i>olmesartan medoxomil-hctz</i> .....	36, 37
<i>neomycin sulfate</i> .....	12	<b>NOVOFINE</b> .....	90	<i>olmesartan-amlodipine-hctz</i> .....	37
<i>neomycin-bacitracin zn-polymyx</i> .....	104	<b>NOVOFINE AUTOCOVER</b> .....	90	<i>olopatadine hcl</i> .....	102, 104
<i>neomycin-polymyxin b gu</i> .....	79	<b>NOVOFINE PLUS</b> .....	91	<i>omeprazole</i> .....	115
<i>neomycin-polymyxin-dexameth</i> .....	106	<b>NOVOTWIST</b> .....	91	<i>ondansetron</i> .....	32
<i>neomycin-polymyxin-gramicidin</i> .....	105	<i>np thyroid</i> .....	113	<i>ondansetron hcl</i> .....	32
<i>neomycin-polymyxin-hc</i> .....	106, 107	Nufol.....	82	<b>ONETOUCH CLUB LANCETS</b>	
Neo-Polycin.....	105	Nutriarx Creampak.....	71	<b>FINE PT</b> .....	87
Neo-Polycin Hc.....	106	Nutrifac Zx.....	100	<b>ONETOUCH DELICA LANCETS</b>	
<i>neostigmine methylsulfate</i> .....	39, 40	<b>NUTRIPORT BALLOON</b>		<b>30G</b> .....	87
Nephronex.....	99	<b>20FR/2.5CM</b> .....	94	<b>ONETOUCH DELICA LANCETS</b>	
Neuac.....	64	<b>NUTRIPORT BALLOON</b>		<b>33G</b> .....	87
<b>NEULASTA</b> .....	82	<b>20FR/2.7CM</b> .....	94	<b>ONETOUCH DELICA LANCING</b>	
<b>NEULASTA ONPRO</b> .....	82	<b>NUTRIPORT BALLOON</b>		<b>DEV</b> .....	87
<i>neutral sodium fluoride</i> .....	98	<b>20FR/3.5CM</b> .....	94	<b>ONETOUCH DELICA PLUS</b>	
<i>nevirapine</i> .....	48	<b>NUTRIPORT BALLOON</b>		<b>LANCET30G</b> .....	87
<i>nevirapine er</i> .....	48	<b>20FR/4.5CM</b> .....	94	<b>ONETOUCH DELICA PLUS</b>	
<b>NEXAVAR</b> .....	42	<b>NUTRIPORT BALLOON</b>		<b>LANCET33G</b> .....	87
<i>niacin (antihyperlipidemic)</i> .....	35	<b>20FR/4CM</b> .....	94	<b>ONETOUCH DELICA PLUS</b>	
<i>niacin er (antihyperlipidemic)</i> .....	35	<b>NUTRIPORT BALLOON</b>		<b>LANCING</b> .....	87
<b>NIACOR</b> .....	35	<b>20FR/5CM</b> .....	94	<b>ONETOUCH FINEPOINT</b>	
<i>nicardipine hcl</i> .....	53	<b>NUTRIPORT BALLOON</b>		<b>LANCETS</b> .....	87
<b>NICAZEL</b> .....	100	<b>24FR/0.8CM</b> .....	94	<b>ONETOUCH SURESOFT</b>	
<b>NICAZEL FORTE</b> .....	100	<b>NUTRIPORT BALLOON</b>		<b>LANCING DEV</b> .....	87
<b>NICOTROL</b> .....	111	<b>24FR/1.2CM</b> .....	94	<b>ONETOUCH ULTRA BLUE</b> .....	72
<b>NICOTROL NS</b> .....	111	<b>NUTRIPORT BALLOON</b>		<b>ONETOUCH ULTRASOFT</b>	
<i>nifedipine</i> .....	53	<b>24FR/1.5CM</b> .....	94	<b>LANCETS</b> .....	87
<i>nifedipine er</i> .....	53	<b>NUTRIPORT BALLOON</b>		<b>ONETOUCH VERIO</b> .....	72
<i>nifedipine er osmotic release</i> .....	53	<b>24FR/1.7CM</b> .....	94	Oralene.....	98, 112
Nikki.....	58	<b>NUTRIPORT BALLOON</b>		<b>ORFADIN</b> .....	75
<i>nilutamide</i> .....	41	<b>24FR/1CM</b> .....	94	<i>orphenadrine citrate</i> .....	102
<i>nimodipine</i> .....	53	<b>NUTRIPORT BALLOON</b>		<i>orphenadrine citrate er</i> .....	102
<i>nisoldipine er</i> .....	53	<b>24FR/2.3CM</b> .....	94	<b>ORPHENGESIC FORTE</b> .....	102
<i>nitisinone</i> .....	75	<b>NUTRIPORT BALLOON</b>		Orsythia.....	58
<b>NITRO-DUR</b> .....	20	<b>24FR/2.5CM</b> .....	94	<b>ORTHOVISC</b> .....	102
<i>nitrofurantoin</i> .....	115	<b>NUTRIPORT BALLOON</b>		<i>oseltamivir phosphate</i> .....	49
<i>nitrofurantoin macrocrystal</i> .....	115	<b>24FR/2.7CM</b> .....	94	<b>OSMITROL</b> .....	73
<i>nitrofurantoin monohyd macro</i> .....	115	<b>NUTRIPORT BALLOON</b>		<b>OTOVEL</b> .....	107
<i>nitroglycerin</i> .....	20	<b>24FR/2CM</b> .....	95	<i>oxacillin sodium</i> .....	108
<i>nitroglycerin in d5w</i> .....	20	<b>NUTRIPORT BALLOON</b>		<i>oxandrolone</i> .....	19
<b>NITRO-TIME</b> .....	20	<b>24FR/3.5CM</b> .....	95	<i>oxaprozin</i> .....	15
<i>nizatidine</i> .....	115	<b>NUTRIPORT BALLOON</b>		<i>oxazepam</i> .....	20
Nolix.....	69	<b>24FR/3CM</b> .....	95	<i>oxcarbazepine</i> .....	25
Nora-Be.....	60	<b>NUTRIPORT BALLOON</b>		<i>oxiconazole nitrate</i> .....	70
<i>norepinephrine bitartrate</i> .....	120	<b>24FR/4.5CM</b> .....	95	<i>oxybutynin chloride</i> .....	116
<i>norethin ace-eth estrad-fe</i> .....	58	<b>NUTROPIN AQ NUSPIN 10</b> .....	74	<i>oxybutynin chloride er</i> .....	116
<i>norethindrone</i> .....	60	<b>NUTROPIN AQ NUSPIN 20</b> .....	74	<i>oxycodone hcl</i> .....	17
<i>norethindrone acetate</i> .....	109	<b>NUTROPIN AQ NUSPIN 5</b> .....	74	<i>oxycodone-acetaminophen</i> .....	18
<i>norethindrone acet-ethinyl est</i> .....	58	<b>NUVARING</b> .....	59	<i>oxycodone-aspirin</i> .....	18

<i>oxycodone-ibuprofen</i> .....	18	Phospha 250 Neutral.....	96	<b>PRECISION SURE-DOSE</b>	
<i>oxymorphone hcl</i> .....	18	<i>phosphorous</i> .....	96	<b>SYRINGE</b> .....	91
<i>oxymorphone hcl er</i> .....	18	Physiolyte.....	50	<i>prednicarbate</i> .....	69
<i>oxytocin</i> .....	107	Physiosol Irrigation.....	50	<i>prednisolone</i> .....	62
<b>OZEMPIC (0.25 OR 0.5 MG/DOSE)</b> .....	30	<i>phytonadione</i> .....	120	<i>prednisolone acetate</i> .....	106
<b>OZEMPIC (1 MG/DOSE)</b> .....	30	<i>pilocarpine hcl</i> .....	98, 104	<i>prednisolone sodium phosphate</i> .....	62
Pacerone.....	21	<i>pimecrolimus</i> .....	70	<i>prednisone</i> .....	62
<i>paliperidone er</i> .....	46	<i>pimozide</i> .....	111	<i>preferred plus insulin syringe</i> .....	91
<i>palonosetron hcl</i> .....	32	Pimtrea.....	56	<i>preferred plus unifine pentips</i> .....	91
<i>pancuronium bromide</i> .....	103	<i>pindolol</i> .....	51	<i>pregabalin</i> .....	25
<i>papaverine hcl</i> .....	54	<i>pioglitazone hcl</i> .....	31	<b>PREMARIN</b> .....	77, 119
<i>paricalcitol</i> .....	75	<i>pioglitazone hcl-glimepiride</i> .....	31	<b>PREMPHASE</b> .....	76
Paroex.....	98	<i>pioglitazone hcl-metformin hcl</i> .....	31	<b>PREMPRO</b> .....	76
<i>paromomycin sulfate</i> .....	12	<i>piperacillin sod-tazobactam so</i> .....	108	<i>prenal</i> .....	101
<i>paroxetine hcl</i> .....	27	Pirmella 1/35.....	58	<b>PRENATABS RX</b> .....	101
<i>paroxetine hcl er</i> .....	27	Pirmella 7/7/7.....	61	<i>prenatal</i> .....	101
<i>paroxetine mesylate</i> .....	112	<i>piroxicam</i> .....	15	<i>prenatal plus iron</i> .....	101
<i>pc unifine pentips</i> .....	91	Plasbumin-25.....	81	<i>prenatal vitamin plus low iron</i> .....	101
<b>PEDIARIX</b> .....	114	Plasbumin-5.....	81	<b>PRENATAL-U</b> .....	101
<b>PEDVAX HIB</b> .....	117	<b>PLEGRIDY</b> .....	110	<i>preplus</i> .....	101
<i>peg 3350-kcl-na bicarb-nacl</i> .....	84	<b>PLEGRIDY STARTER PACK</b> .....	110	<i>pretab</i> .....	101
<i>peg-3350/electrolytes</i> .....	85	Plenamaine.....	103	Prevalite.....	34
Peg-Prep.....	85	<b>PNEUMOVAX 23</b> .....	117	Previfem.....	58
<i>pen needles</i> .....	91	<i>pnv prenatal plus multivitamin</i> .....	100	<b>PREVNAR 13</b> .....	117
<i>pen needles 1/2"</i> .....	91	<i>pnv tabs 29-1</i> .....	100	<b>PREZISTA</b> .....	48
<i>pen needles 3/16"</i> .....	91	<i>podofilox</i> .....	70	<b>PRIFTIN</b> .....	40
<i>pen needles 5/16"</i> .....	91	Polocaine.....	85	<i>prilovix ultralite</i> .....	71
<i>penicillamine</i> .....	50	Polocaine-Mpf.....	85	<i>prilovix ultralite plus</i> .....	71
<i>penicillin g potassium</i> .....	108	Polycin.....	105	<i>primaquine phosphate</i> .....	39
<i>penicillin g sodium</i> .....	108	<i>polymyxin b sulfate</i> .....	39	<i>primidone</i> .....	25
<i>penicillin v potassium</i> .....	108	<i>polymyxin b-trimethoprim</i> .....	105	<b>PRO COMFORT INSULIN</b>	
<b>PENLET II BLOOD SAMPLER</b> .....	87	<i>polysaccharide iron forte</i> .....	83	<b>SYRINGE</b> .....	91
<b>PENLET II REPLACEMENT CAP</b> .....	87	<i>poly-tussin ac</i> .....	63	<i>pro comfort pen needles</i> .....	91
<b>PENTACEL</b> .....	114	<b>POMALYST</b> .....	41	<b>PROAIR HFA</b> .....	22
<i>pentamidine isethionate</i> .....	38	Portia-28.....	58	<b>PROAIR RESPICLICK</b> .....	22
<b>PENTASA</b> .....	78	<i>posaconazole</i> .....	33	<i>probenecid</i> .....	80
<i>pentazocine-naloxone hcl</i> .....	18	<i>pot &amp; sod cit-cit ac</i> .....	79	<i>procainamide hcl</i> .....	21
<b>PENTIPS</b> .....	91	<i>pot bicarb-pot chloride</i> .....	96	<i>prochlorperazine</i> .....	47
<i>pentobarbital sodium</i> .....	83	<i>potassium acetate</i> .....	97	<i>prochlorperazine edisylate</i> .....	47
<i>pentoxifylline er</i> .....	80	<i>potassium bicarbonate</i> .....	97	<i>prochlorperazine maleate</i> .....	47
<b>PERFOROMIST</b> .....	22	<i>potassium chloride</i> .....	97	<b>PROCRIT</b> .....	81, 82
<i>perindopril erbumine</i> .....	36	<i>potassium chloride crys er</i> .....	97	Procto-Med Hc.....	19
Periogard.....	98	<i>potassium chloride er</i> .....	97	Procto-Pak.....	19
<i>permethrin</i> .....	71	<i>potassium chloride in dextrose</i> .....	96	Proctosol Hc.....	19
<i>perphenazine</i> .....	47	<i>potassium chloride in nacl</i> .....	96	Proctozone-Hc.....	19
<i>perphenazine-amitriptyline</i> .....	111	<i>potassium citrate er</i> .....	79	<b>PRODIGY INSULIN SYRINGE</b> .....	91
<b>PFIZERPEN</b> .....	108	<i>potassium citrate-citric acid</i> .....	79	<i>progesterone</i> .....	109
Phenadoz.....	34	<b>PR NATAL 400</b> .....	101	<i>progesterone micronized</i> .....	109
<i>phendimetrazine tartrate</i> .....	12	<b>PR NATAL 400 EC</b> .....	101	<b>PROLIA</b> .....	75
<i>phendimetrazine tartrate er</i> .....	11	<b>PR NATAL 430</b> .....	101	<b>PROMACTA</b> .....	83
<i>phenelzine sulfate</i> .....	27	<b>PR NATAL 430 EC</b> .....	101	<i>promethazine hcl</i> .....	34
<i>phenobarbital</i> .....	83	<b>PRADAXA</b> .....	24	<i>promethazine-codeine</i> .....	63
<i>phenobarbital sodium</i> .....	83	<i>pramipexole dihydrochloride</i> .....	45	<i>promethazine-dm</i> .....	63
<i>phenobarbital-belladonna alk</i> .....	114	<i>pramipexole dihydrochloride er</i> .....	45	<i>promethazine-phenyleph-codeine</i> .....	63
<i>phenoxybenzamine hcl</i> .....	36	<b>PRAMOSONE</b> .....	71	<i>promethazine-phenylephrine</i> .....	62
<i>phentermine hcl</i> .....	12	Pramox.....	70	Promethegan.....	34
<i>phenylamine mesylate</i> .....	36	<i>prasugrel hcl</i> .....	81	<i>propafenone hcl</i> .....	21
<i>phenylephrine hcl</i> .....	104, 120	<i>pravastatin sodium</i> .....	35	<i>propafenone hcl er</i> .....	21
Phenytoin.....	26	<i>praziquantel</i> .....	19	<i>propranolol bromide</i> .....	115
Phenytoin Infatabs.....	26	<i>prazosin hcl</i> .....	38	<i>propracaine hcl</i> .....	105
<i>phenytoin sodium</i> .....	26	<b>PRECISION SUREDOSE PLUS</b>		<i>propracaine-fluorescein</i> .....	105
<i>phenytoin sodium extended</i> .....	26	<b>SYR</b> .....	91	<i>propofol</i> .....	78
Philith.....	58			<i>propranolol hcl</i> .....	52



<i>propranolol hcl er</i> .....	52	<b>REPATHA PUSHTRONEX</b>	<i>sf</i> .....	98
<i>propranolol-hctz</i> .....	38	<b>SYSTEM</b> .....	Sharobel.....	60
<i>propylthiouracil</i> .....	113	<b>REPATHA SURECLICK</b> .....	<b>SHINGRIX</b> .....	119
<b>PROQUAD</b> .....	117	<b>RESTASIS</b> .....	<b>SHOPKO UNIFINE PENTIPS</b> .....	91
<i>protamine sulfate</i> .....	81	<b>RESTORE SILVER DRESSING</b> .....	<b>SHOPKO UNIFINE PENTIPS</b>	
<i>protriptyline hcl</i> .....	28	<b>RETACRIT</b> .....	<b>PLUS</b> .....	91
<i>pseudoeph-bromphen-dm</i> .....	63	<b>REVLIMID</b> .....	<i>sildenafil citrate</i> .....	54
Pulmosal.....	62	Revonto.....	<i>silodosin</i> .....	79
<b>PULMOZYME</b> .....	112	REYATAZ.....	<i>silver sulfadiazine</i> .....	67
<i>purevit dualfe plus</i> .....	83	ribavirin.....	<b>SIMBRINZA</b> .....	103
<i>px extra short pen needles</i> .....	91	<b>RIDAURA</b> .....	Simliya.....	56
<i>px insulin syringe</i> .....	91	<i>rifabutin</i> .....	Simpesse.....	60
<i>px mini pen needles</i> .....	91	<i>rifampin</i> .....	<b>SIMPONI</b> .....	13, 14
<i>px pen needle</i> .....	91	<b>RIFATER</b> .....	<b>SIMPONI ARIA</b> .....	13, 14
<i>px shortlength pen needles</i> .....	91	<i>riluzole</i> .....	<i>simvastatin</i> .....	35
<i>pyrazinamide</i> .....	40	<i>rimantadine hcl</i> .....	<i>sirolimus</i> .....	50
<i>pyridostigmine bromide</i> .....	39, 40	<i>ringers</i> .....	<b>SKYRIZI (150 MG DOSE)</b> .....	66
<i>pyridostigmine bromide er</i> .....	39, 40	<i>ringers irrigation</i> .....	<b>SLYND</b> .....	60
<i>pyridoxine hcl</i> .....	120	<b>RINVOQ</b> .....	<i>sod citrate-citric acid</i> .....	79
<i>qc pen needles</i> .....	91	<i>risedronate sodium</i> .....	<i>sodium acetate</i> .....	95
<i>qc unifine pentips</i> .....	91	<b>RISPERDAL CONSTA</b> .....	<i>sodium bicarbonate</i> .....	95
<b>QUADRACEL</b> .....	114	<i>risperidone</i> .....	<i>sodium bicarbonate-dextrose</i> .....	95
<i>quazepam</i> .....	84	<i>ritonavir</i> .....	<i>sodium chloride</i> .....	63, 79, 97
<i>quetiapine fumarate</i> .....	46	<i>rivastigmine</i> .....	<i>sodium chloride (pf)</i> .....	97
<i>quetiapine fumarate er</i> .....	46	<i>rivastigmine tartrate</i> .....	<i>sodium chloride bacteriostatic</i> .....	109
<i>quinapril hcl</i> .....	36	Rivelsa.....	<i>sodium chloride flush</i> .....	97
<i>quinapril-hydrochlorothiazide</i> .....	36	<i>rizatriptan benzoate</i> .....	<i>sodium fluoride</i> .....	96
<i>quinidine gluconate er</i> .....	21	<i>rocuronium bromide</i> .....	<i>sodium hyaluronate</i> .....	70
<i>quinidine sulfate</i> .....	21	<i>ropinirole hcl</i> .....	<i>sodium phenylbutyrate</i> .....	76
<i>quinine sulfate</i> .....	39	<i>ropinirole hcl er</i> .....	<i>sodium phosphates</i> .....	96
<b>QVAR REDHALER</b> .....	23	<i>ropivacaine hcl</i> .....	<i>sodium polystyrene sulfonate</i> .....	51, 109
<i>ra insulin syringe</i> .....	91	Rosadan.....	<i>sodium sulfacetamide</i> .....	67
<i>ra pen needles</i> .....	91	<i>rosuvastatin calcium</i> .....	<i>sodium sulfacetamide wash</i> .....	66
<b>RABAVERT</b> .....	118	<b>ROTARIX</b> .....	<i>sodium tetradecyl sulfate</i> .....	51
<i>raloxifene hcl</i> .....	76	<b>ROTATEQ</b> .....	<i>sodium thiosulfate</i> .....	31
<i>ramelteon</i> .....	84	Roweepra.....	<i>sofosbuvir-velpatasvir</i> .....	83
<i>ramipril</i> .....	36	Roweepra Xr.....	<i>solifenacin succinate</i> .....	116
<i>ranitidine hcl</i> .....	115	<b>RUCONEST</b> .....	<b>SOLTAMOX</b> .....	41
<i>ranolazine er</i> .....	19	<b>RYCLORA</b> .....	<b>SOMATULINE DEPOT</b> .....	76
<i>rasagiline mesylate</i> .....	45	<b>RYVENT</b> .....	<b>SOMAVERT</b> .....	74
<b>RASUVO</b> .....	13	<b>SAFESNAP INSULIN SYRINGE</b> .....	Sorine.....	52
<i>reality insulin syringe</i> .....	91	<i>salicylic acid</i> .....	<i>sotalol hcl</i> .....	52
<b>REBIF</b> .....	110	<i>saline bacteriostatic</i> .....	<i>sotalol hcl (af)</i> .....	52
<b>REBIF REBIDOSE</b> .....	110	<i>saline flush</i> .....	<i>sotalol hydrochloride</i> .....	52
<b>REBIF REBIDOSE TITRATION</b>		Saline Flush Zr.....	Sotradecol.....	51
<b>PACK</b> .....	110	<i>sb insulin syringe</i> .....	<i>spinosad</i> .....	71
<b>REBIF TITRATION PACK</b> .....	110	<i>scopolamine</i> .....	<b>SPIRIVA HANDHALER</b> .....	22
Reclipsen.....	58	<i>selegiline hcl</i> .....	<b>SPIRIVA RESPIMAT</b> .....	22
<b>RECOMBIVAX HB</b> .....	118	<i>selenium</i> .....	<i>spironolactone</i> .....	73
<b>REFISSA</b> .....	65	<i>selenium sulfide</i> .....	<i>spironolactone-hctz</i> .....	73
<b>RELENZA DISKHALER</b> .....	49	<b>SELZENTRY</b> .....	Sprintec 28.....	58
<b>RELION INSULIN SYRINGE</b> .....	91	<i>se-natal 19</i> .....	<b>SPRYCEL</b> .....	42
<b>RELI-ON INSULIN SYRINGE</b> .....	91	Sensorcaine.....	Sps.....	51, 109
<b>RELION MINI PEN NEEDLES</b> .....	91	Sensorcaine/Epinephrine.....	Sronyx.....	58
<b>RELION PEN NEEDLES</b> .....	91	Sensorcaine-Mpf.....	Ssd.....	67
<b>RELION SHORT PEN NEEDLES</b> .....	91	Sensorcaine-Mpf/Epinephrine.....	<i>sss 10-5</i> .....	64
Remergent Hq.....	69	<b>SEREVENT DISKUS</b> .....	<i>stamaril</i> .....	119
<b>REMICADE</b> .....	78	<i>sertraline hcl</i> .....	<i>stavudine</i> .....	49
<i>remifentanil hcl</i> .....	18	<i>se-tan plus</i> .....	<b>STELARA</b> .....	66, 84
Renal.....	99	Setlakin.....	<i>sterile diluent/epoprostenol</i> .....	109
<i>reno caps</i> .....	99	<i>sevelamer carbonate</i> .....	<i>sterile water for injection</i> .....	109
<i>repaglinide</i> .....	30	<i>sevelamer hcl</i> .....	<i>sterile water for irrigation</i> .....	50
<b>REPATHA</b> .....	108	<i>sevoflurane</i> .....	<b>STIOLTO RESPIMAT</b> .....	22

<b>STIVARGA</b> .....	42	<i>tazarotene</i> .....	66	<i>topiramate</i> .....	25
<i>streptomycin sulfate</i> .....	12	Tazicef.....	55	<i>topiramate er</i> .....	25
<b>STRIBILD</b> .....	47	<b>TAZICEF</b> .....	55	<i>toremifene citrate</i> .....	41
Subvenite.....	25	<b>TAZORAC</b> .....	66	<i>torseamide</i> .....	73
Subvenite Starter Kit-Blue.....	25	Taztia Xt.....	53	<b>TOUJEO MAX SOLOSTAR</b> .....	30
Subvenite Starter Kit-Green.....	25	<b>TDVAX</b> .....	114	<b>TOUJEO SOLOSTAR</b> .....	30
Subvenite Starter Kit-Orange.....	25	<b>TECFIDERA</b> .....	110, 111	Tovet.....	69
<i>succinylcholine chloride</i> .....	103	<i>techlite insulin syringe</i> .....	92	<b>TOVIAZ</b> .....	116
<i>sucralfate</i> .....	115	<b>TECHLITE PEN NEEDLES</b> .....	92	<b>TRACLEER</b> .....	54
<i>sufentanil citrate</i> .....	18	<i>telmisartan</i> .....	37	<b>TRADJENTA</b> .....	29
<i>sulfacetamide sodium</i> .....	67, 106	<i>telmisartan-amlodipine</i> .....	36	<i>tramadol hcl</i> .....	18
<i>sulfacetamide sodium (acne)</i> .....	64	<i>telmisartan-hctz</i> .....	37	<i>tramadol hcl er</i> .....	18
<i>sulfacetamide sodium-sulfur</i> .....	64	<i>temazepam</i> .....	84	<i>tramadol hcl er (biphasic)</i> .....	18
<i>sulfacetamide sod-sulfur wash</i> .....	64	<b>TEMIXYS</b> .....	47	<i>tramadol-acetaminophen</i> .....	18
<i>sulfacetamide-prednisolone</i> .....	106	<i>temozolomide</i> .....	43	<i>trandolapril</i> .....	36
<i>sulfamethoxazole-trimethoprim</i> .....	38	<b>TENCON</b> .....	15	<i>trandolapril-verapamil hcl er</i> .....	35
<i>sulfasalazine</i> .....	78	<b>TENIVAC</b> .....	114	<i>tranexamic acid</i> .....	83
Sulfatrim Pediatric.....	38	<i>tenofovir disoproxil fumarate</i> .....	49	<i>tranylcypromine sulfate</i> .....	27
<i>sulindac</i> .....	15	<i>terazosin hcl</i> .....	38	<b>TRAVATAN Z</b> .....	106
<i>sumatriptan</i> .....	95	<i>terbinafine hcl</i> .....	33	<i>travoprost (bak free)</i> .....	106
<i>sumatriptan succinate</i> .....	95	<i>terbutaline sulfate</i> .....	22	<i>trazodone hcl</i> .....	27, 112
<i>sumatriptan succinate refill</i> .....	95	<i>terconazole</i> .....	119	<b>TRELSTAR MIXJECT</b> .....	44
<i>sumatriptan-naproxen sodium</i> .....	95	Terrell.....	79	<b>TREMFYA</b> .....	66
<b>SUPREP BOWEL PREP KIT</b> .....	85	<i>testosterone</i> .....	19	<i>trepstinil</i> .....	54
<i>sure comfort insulin syringe</i> .....	91	<i>testosterone cypionate</i> .....	19	<i>tretinoin</i> .....	44, 64
<i>sure comfort pen needles</i> .....	91	<i>testosterone enanthate</i> .....	19	<i>tretinoin (emollient)</i> .....	65
<i>sure result dss premium pack</i> .....	65	Tetcaine.....	105	<i>tretinoin microsphere</i> .....	64
<b>SURE-FINE PEN NEEDLES</b> .....	92	<i>tetrabenazine</i> .....	110	<i>tretinoin microsphere pump</i> .....	65
<b>SURE-JECT INSULIN SYRINGE</b> .....	92	<i>tetracycline hcl</i> .....	113	<b>TREXALL</b> .....	41
<b>SUTENT</b> .....	42	<b>THALOMID</b> .....	50	<b>TREZIX</b> .....	16
Swabflush Saline Flush.....	97	<b>THEO-24</b> .....	23	Tri Femynor.....	61
Syeda.....	58	<i>theophylline</i> .....	23	<i>triamcinolone acetonide</i> .....	62, 69, 98, 112
<b>SYMBICORT</b> .....	22	<i>theophylline er</i> .....	23	<i>triamterene</i> .....	73
<b>SYMFI</b> .....	47	<i>thiamine hcl</i> .....	120	<i>triamterene-hctz</i> .....	73
<b>SYMFI LO</b> .....	47	<i>thioridazine hcl</i> .....	47	<i>triazolam</i> .....	84
<b>SYMJEPI</b> .....	119	<i>thiothixene</i> .....	47	<i>tricitrates</i> .....	79
<b>SYMLINPEN 120</b> .....	28	<i>thrivite 19</i> .....	101	Tricon.....	83
<b>SYMLINPEN 60</b> .....	28	<i>thyroid</i> .....	113	Triderm.....	69
<b>SYNAREL</b> .....	75	Tiadyt Er.....	53	<i>trientine hcl</i> .....	50
<b>SYNJARDY</b> .....	112	<i>tiagabine hcl</i> .....	26	Tri-Estarylla.....	61
<b>SYNJARDY XR</b> .....	112	Tilia Fe.....	61	<i>trifluoperazine hcl</i> .....	47
<b>SYNVISC</b> .....	102	<i>timolol maleate</i> .....	52, 104	<i>trifluridine</i> .....	105
<b>SYNVISC ONE</b> .....	102	<i>tinidazole</i> .....	38	<i>trigels-f forte</i> .....	83
<b>TABLOID</b> .....	41	Tis-U-Sol.....	50	<i>trihexyphenidyl hcl</i> .....	45
<i>tacrolimus</i> .....	50, 70	<b>TIVICAY</b> .....	48	Tri-Legest Fe.....	61
<i>tadalafil</i> .....	54	<i>tizanidine hcl</i> .....	102	Tri-Linyah.....	61
<i>tadalafil (pah)</i> .....	54	<i>tl gard rx</i> .....	82	Tri-Lo-Estarylla.....	61
<b>TAFINLAR</b> .....	41	<i>tl hydroquinone</i> .....	69	Tri-Lo-Marzia.....	61
<b>TAKHZYRO</b> .....	109	<i>tl-hem 150</i> .....	83	Tri-Lo-Mili.....	61
<b>TALIVA</b> .....	82	<b>TOBRADEX</b> .....	106	Tri-Lo-Sprintec.....	61
<i>tamoxifen citrate</i> .....	41	<i>tobramycin</i> .....	12, 104	Trilyte.....	85
<i>tamsulosin hcl</i> .....	79	<i>tobramycin sulfate</i> .....	12	<i>trimethobenzamide hcl</i> .....	32
<b>TAPERDEX 12-DAY</b> .....	62	<i>tobramycin-dexamethasone</i> .....	106	<i>trimethoprim</i> .....	38
Taperdex 6-Day.....	62	<i>today's health mini pen needles</i> .....	92	Tri-Mili.....	61
<b>TAPERDEX 7-DAY</b> .....	62	<i>today's health pen needles</i> .....	92	<i>trimipramine maleate</i> .....	28
<b>TARCEVA</b> .....	42	<i>today's health short pen needle</i> .....	92	<i>trinatal rx 1</i> .....	101
<b>TARGRETIN</b> .....	71	<i>tolbutamide</i> .....	31	<b>TRINATE</b> .....	101
Tarina 24 Fe.....	58	<i>tolcapone</i> .....	45	<i>triphrocaps</i> .....	99
Tarina Fe 1/20.....	59	<i>tolmetin sodium</i> .....	15	Tri-Previfem.....	61
Tarina Fe 1/20 Eq.....	58	<i>tolterodine tartrate</i> .....	116	Tri-Sprintec.....	61
Taron-Crystals.....	79	<i>tolterodine tartrate er</i> .....	116	<b>TRIUMEQ</b> .....	47
<b>TASIGNA</b> .....	42	<i>topcare clickfine pen needles</i> .....	92	<b>TRIVEEN-DUO DHA</b> .....	101
<b>TAYTULLA</b> .....	59	<i>topcare ultra comfort ins syr</i> .....	92	<i>tri-vitamin/fluoride</i> .....	100

<i>tri-vite/fluoride</i> .....	100	<i>valproic acid</i> .....	26	<b>WIDE-SEAL DIAPHRAGM 65</b> .....	86
Trivora (28).....	61	<i>valsartan</i> .....	37	<b>WIDE-SEAL DIAPHRAGM 70</b> .....	86
Tri-Vylibra.....	61	<i>valsartan-hydrochlorothiazide</i> .....	37	<b>WIDE-SEAL DIAPHRAGM 75</b> .....	86
Tri-Vylibra Lo.....	61	<i>value health insulin syringe</i> .....	92	<b>WIDE-SEAL DIAPHRAGM 80</b> .....	86
<i>tronvite</i> .....	99	<i>valumark pen needles</i> .....	92	<b>WIDE-SEAL DIAPHRAGM 85</b> .....	87
<i>tropicamide</i> .....	104	<i>vancomycin hcl</i> .....	79	<b>WIDE-SEAL DIAPHRAGM 90</b> .....	87
<i>tropium chloride</i> .....	116	<i>Vandazole</i> .....	119	<b>WIDE-SEAL DIAPHRAGM 95</b> .....	87
<i>tropium chloride er</i> .....	116	<b>VANISHPOINT INSULIN</b>		Wixela Inhub.....	22
<i>true comfort insulin syringe</i> .....	92	<b>SYRINGE</b> .....	92	Wymzya Fe.....	59
<i>true comfort pen needles</i> .....	92	<b>VAQTA</b> .....	119	<b>XALKORI</b> .....	43
<b>TRUEPLUS 5-BEVEL PEN</b>		<i>varidenafil hcl</i> .....	54	<b>XARELTO</b> .....	24
<b>NEEDLES</b> .....	92	<b>VARIVAX</b> .....	119	<b>XARELTO STARTER PACK</b> .....	24
<b>TRUEPLUS INSULIN SYRINGE</b> .....	92	<b>VAXCHORA</b> .....	117	<b>XELJANZ</b> .....	12
<b>TRUEPLUS PEN NEEDLES</b> .....	92	<i>v-c forte</i> .....	100	<b>XELJANZ XR</b> .....	12
<b>TRULICITY</b> .....	30	<i>vecuronium bromide</i> .....	103	<b>XIIDRA</b> .....	85
<b>TRUMENBA</b> .....	117	Velivet.....	61	<b>XOFLUZA</b> .....	107
<b>TRUVADA</b> .....	47	<i>venlafaxine hcl</i> .....	28	<b>XTANDI</b> .....	41
<i>trymine cg</i> .....	62	<i>venlafaxine hcl er</i> .....	28	<b>XULANE</b> .....	59
Tulana.....	60	<b>VENTAVIS</b> .....	54	Xylocaine Dental.....	85
<b>TUSSICAPS</b> .....	63	<i>verapamil hcl</i> .....	53	<b>YF-VAX</b> .....	119
<b>TWINRIX</b> .....	117	<i>verapamil hcl er</i> .....	53	Yuvaferm.....	119
Tydemy.....	59	<b>VESICARE</b> .....	116	<i>zafirlukast</i> .....	23
<b>TYKERB</b> .....	42	Vic-Forte.....	100	<i>zaleplon</i> .....	84
<b>TYPHIM VI</b> .....	117	Vicodin Hp.....	16	Zarah.....	59
<b>ULTICARE INSULIN SAFETY</b>		<b>VICTOZA</b> .....	30	<b>ZARXIO</b> .....	82
<b>SYR</b> .....	92	<b>VIDA MIA UNIFINE PENTIPS</b> .....	92	Zebutal.....	16
<b>ULTICARE INSULIN SYRINGE</b> .....	92	Vienva.....	59	<b>ZELBORAF</b> .....	41
<b>ULTICARE MICRO PEN</b>		<i>vigabatrin</i> .....	26	Zenatane.....	65
<b>NEEDLES</b> .....	92	Vigadrone.....	26	<b>ZENPEP</b> .....	72
<b>ULTICARE MINI PEN NEEDLES</b> .....	92	<b>VINATE II</b> .....	101	<b>ZENZEDI</b> .....	11
<b>ULTICARE PEN NEEDLES</b> .....	92	<b>VINATE M</b> .....	101	<i>zidovudine</i> .....	49
<b>ULTICARE SHORT PEN</b>		<b>VINATE ONE</b> .....	101	<i>zileuton er</i> .....	21
<b>NEEDLES</b> .....	92	<b>VIOKACE</b> .....	72	<i>zinc sulfate</i> .....	98
<i>ultiguard safepack pen needle</i> .....	92	<i>viorele</i> .....	56	<i>ziprasidone hcl</i> .....	46
<b>ULTILET PEN NEEDLE</b> .....	92	<b>VIREAD</b> .....	49	<b>ZOLINZA</b> .....	41
<i>ultra comfort insulin syringe</i> .....	92	<i>virt-caps</i> .....	99	<i>zolmitriptan</i> .....	95
<b>ULTRA THIN PEN NEEDLES</b> .....	92	Virt-Gard.....	82	<i>zolpidem tartrate</i> .....	84
<i>ultracare insulin syringe</i> .....	92	<i>virt-phos 250 neutral</i> .....	96	<i>zonisamide</i> .....	25
<i>ultracare pen needles</i> .....	92	<i>virtussin a/c</i> .....	62	<b>ZORTRESS</b> .....	51
<i>ultra-comfort insulin syringe</i> .....	92	<i>virtussin dac</i> .....	62	<b>ZOSTAVAX</b> .....	119
<b>ULTRA-THIN II INS SYR SHORT</b> .....	92	Vita S Forte.....	100	Zovia 1/35E (28).....	59
<b>ULTRA-THIN II INSULIN</b>		Vitamax Pediatric.....	100	Zumandimine.....	59
<b>SYRINGE</b> .....	92	<i>vitamin d (ergocalciferol)</i> .....	120	<b>ZYLET</b> .....	106
<b>ULTRA-THIN II MINI PEN</b>		<i>vitamin k1</i> .....	120	<b>ZYTIGA</b> .....	40
<b>NEEDLE</b> .....	92	<i>vitamins acd-fluoride</i> .....	100		
<b>ULTRA-THIN II PEN NEEDLE</b>		<b>VIVOTIF</b> .....	117		
<b>SHORT</b> .....	92	<i>vol-plus</i> .....	101		
<b>ULTRA-THIN II PEN NEEDLES</b> .....	92	<i>vol-tab rx</i> .....	101		
<b>UNIFINE PENTIPS</b> .....	92	<i>voriconazole</i> .....	33		
<b>UNIFINE PENTIPS PLUS</b> .....	92	<b>VOSEVI</b> .....	83		
Unithroid.....	113	<b>VOTRIENT</b> .....	43		
<i>urea</i> .....	69	<i>vp insulin syringe</i> .....	93		
<i>urea hydrating</i> .....	69	<i>vp-vite rx</i> .....	99		
<i>urea nail</i> .....	69	Vyfemla.....	59		
<i>urea-c40</i> .....	69	Vylibra.....	59		
Uretron D/S.....	115	<b>VYVANSE</b> .....	11		
<i>ursodiol</i> .....	77	<i>warfarin sodium</i> .....	23		
Uryl.....	115	<i>water for irrigation, sterile</i> .....	50		
<i>uticap</i> .....	115	<i>wegmans unifine pentips plus</i> .....	93		
Utrona-C.....	115	<b>WELCHOL</b> .....	34		
<i>valacyclovir hcl</i> .....	49	Wera.....	59		
<i>valganciclovir hcl</i> .....	49	<i>westab one</i> .....	82		
<i>valproate sodium</i> .....	26	<b>WIDE-SEAL DIAPHRAGM 60</b> .....	86		

Most plans include our home delivery program at no extra cost to you. Find out more by going online to [anthem.com/ca](https://www.anthem.com/ca) or call 866-297-1013.

**For information about your pharmacy benefit, log in at [anthem.com/ca](https://www.anthem.com/ca).**

You'll find the most up-to-date drug list and details about your benefits.  
If you still have questions, we're here. Just call the Member Services number on your ID card.

Speech and hearing impaired (TDD/TTY) users  
Call 1-800-221-6915, Monday through Friday, 8:30 a.m. to 5 p.m.ET.



Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Express Scripts, Inc. is a separate company that manages the pharmacy benefit services for members of our health plans.  
Rev. 11/18