



GlobalHealth

Medicare Advantage C-SNP Plans

DRUG FORMULARY

FORMULARIO DE MEDICAMENTOS

January 1-December 31, 2024

Del 1 de enero al 31 de diciembre de 2024

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

Approved Formulary File Submission ID 00024137, Version Number 17

This document contains a list of covered drugs for Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP). The Drug Formulary was updated on 10/22/2024. For more recent information or other questions, please contact GlobalHealth Customer Care. GlobalHealth Generations has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) in 2024. This approval is based on a review of GlobalHealth Generation's Model of Care.

1-866-494-3927 (TTY: 711), 24 hours a day, 7 days a week
www.GlobalHealth.com

POR FAVOR LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS
MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Identificación del formulario aprobado 00024137, número de versión 17

Este documento contiene una lista de medicamentos cubiertos para Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP). El Formulario de Medicamentos se actualizó el 10/22/2024. Para obtener información más reciente u otras preguntas, comuníquese con Atención al cliente de GlobalHealth. El Comité Nacional de Garantía de Calidad (National Committee for Quality Assurance, NCQA) aprobó a GlobalHealth Generations a fin de que administre un Plan para Necesidades Especiales (Special Needs Plan, SNP) en el 2024. Esta aprobación se basa en una revisión del Modelo de Atención de GlobalHealth Generations.

1-866-494-3927 (TTY: 711) las 24 horas del día, los 7 días de la semana
www.GlobalHealth.com

H3706_021_FMLRYCSNP2024_C

Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP) 2024 Formulary (List of Covered Drugs)

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

HPMS Approved Formulary File Submission ID 00024137, Version Number 17

This formulary was updated on 10/22/2024. For more recent information or other questions, please contact us, CVS Caremark Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit www.GlobalHealth.com.

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

When this drug list (formulary) refers to “we,” “us”, or “our,” it means GlobalHealth, Inc. When it refers to “plan” or “our plan,” it means Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP).

This document includes a list of the drugs (formulary) for our plan which is current as of 11/01/2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

What is the Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP) Formulary?

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

For a complete listing of all prescription drugs covered by us, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the Formulary (drug list) change?

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

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

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP)’s Formulary?”

Drugs removed from the market. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section

below entitled “How do I request an exception to the Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP)’s Formulary?”

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

The enclosed formulary is current as of 11/01/2024. To get updated information about the drugs covered by Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP) please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 16. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular”. If you know what your drug is used for, look for the category name in the list that begins on 16. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 99. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don’t get approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, our plan provides 30 per prescription for Rosuvastatin. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 16. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP)’s formulary?” on page 4 for information about how to request an exception.

What if my drug is not on the Formulary?

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

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

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

How do I request an exception to the Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP)’s Formulary?

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

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

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

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

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

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

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

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

If you are a current member in our plan, we will also cover a temporary transition supply if you have a change in your medications because of a level-of-care change. This may include unplanned changes in treatment settings, such as being discharged from an acute care (hospital) setting or being admitted to, or discharged from, a long-term care facility. For each drug that is not in our formulary, or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (up to a 31-day supply if you are a resident of a long-term care facility) when you go to a network pharmacy.

For more information

For more detailed information about your Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP) prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

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

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

Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP) Formulary

The formulary below provides coverage information about the drugs covered our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 99.

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

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

Drug Tier

Tier 1 = Preferred Generic

Tier 2 = Generic

Tier 3 = Preferred Brand

Tier 4 = Non-Preferred Drug

Tier 5 = Specialty Tier

You can find information on what the symbols and abbreviations on this table mean here:

- **PA – Prior Authorization.** Our plan requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **QL – Drug has Quantity limit.** For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 30 tablets per 30 days per prescription for rosuvastatin.
- **ST – Step Therapy.** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
- **NM – Not available at our Mail-order pharmacies.**
- **LA – Limited Access.** This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Care at 1-866-494-3927, 24 hours a day, seven days a week. TTY users should call 711.
- **B/D –** This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- **GC – Gap Coverage.** Your plan offers additional coverage in the Coverage Gap phase for these medications. Refer to your *Evidence of Coverage* for cost sharing information.

- **ED - Excluded Drug.** This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug. These drugs may not be covered after you reach the Coverage Gap.

Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP) Formulario 2024 (Lista de Medicamentos Cubiertos)

**LEA ESTA INFORMACIÓN: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS
MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN**

Identificación de Presentación del Archivo de la Lista de Medicamentos Aprobada por el HPMS 00024137,
versión 17

Esta lista se actualizó el 10/22/2024. Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio de Atención al Cliente CVS Caremark al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite www.GlobalHealth.com.

Nota para los miembros existentes: Esta lista de medicamentos cambió desde el año pasado. Revise este documento para asegurarse de que aún contenga los medicamentos que toma.

Cuando en esta lista de medicamentos (lista) se hace referencia a "nosotros" o "nuestro", se hace referencia a GlobalHealth, Inc. Cuando se hace referencia a "plan" o "nuestro plan", se hace referencia a Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP).

Este documento incluye una lista de los medicamentos (lista) de nuestro plan que entra en vigor a partir del 11/01/2024. Para obtener una lista actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

Por lo general, debe usar las farmacias de la red para usar su beneficio de medicamentos recetados. Los beneficios, la lista, la red de farmacias o los copagos y coseguros pueden cambiar el 1 de enero de 2024 y de manera periódica durante el año.

¿Qué es la Lista de Medicamentos de Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP)?

Es una lista de medicamentos cubiertos seleccionados por nuestro plan en consulta con un equipo de proveedores de atención médica, que representa las terapias recetadas consideradas como una parte necesaria de un programa de tratamiento de calidad. Nuestro plan, por lo general, cubrirá los medicamentos que figuran en nuestra lista, siempre y cuando el medicamento sea médicamente necesario, la receta sea surtida en una farmacia de la red del plan y se cumplan otras normas del plan. Para obtener más información sobre cómo surtir sus recetas, consulte su Evidencia de Cobertura.

Para obtener una lista completa de todos los medicamentos recetados cubiertos por nuestro plan, visite nuestro sitio web o llámenos. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

¿Puede cambiar la Lista (lista de medicamentos)?

La mayoría de los cambios en la cobertura de medicamentos se producen el 1 de enero, pero podemos agregar o eliminar medicamentos de la Lista de Medicamentos durante el año, moverlos a diferentes niveles de costo compartido o agregar nuevas restricciones. Debemos cumplir con las normas de Medicare para realizar estos cambios.

Cambios que pueden afectarle este año: En los siguientes casos, usted se verá afectado por los cambios en la cobertura durante el año:

- **Nuevos medicamentos genéricos.** Podemos eliminar inmediatamente un medicamento de marca registrada de nuestra Lista de Medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de costo compartido o uno más bajo, y con las mismas o con menos restricciones. Además, al agregar el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca registrada en nuestra Lista de Medicamentos, pero inmediatamente moverlo a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente usted está tomando ese medicamento de marca registrada, podríamos no avisarle con anticipación que realizaremos ese cambio, pero luego le proporcionaremos información sobre el cambio o los cambios específicos que hicimos.
 - Si realizamos ese cambio, usted o el recetador pueden solicitarnos hacer una excepción y continuar con la cobertura de su medicamento de marca registrada. El aviso que le enviaremos también incluirá información sobre cómo solicitar una excepción, y puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción a la Lista de Medicamentos de Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP)?”
- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento incluido en nuestra lista de medicamentos no es seguro, o si el fabricante del medicamento lo retira del mercado, lo retiraremos de nuestra lista de inmediato y se lo notificaremos a los miembros que toman el medicamento.
- **Otros cambios.** Es posible que realicemos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos agregar un medicamento genérico que no es nuevo en el mercado para reemplazar un medicamento de marca registrada que se encuentra actualmente en la lista de medicamentos, o podemos agregar nuevas restricciones al medicamento de marca registrada, moverlo a un nivel de costo compartido diferente, o ambas cosas. También podemos realizar cambios basados en nuevas pautas clínicas. Si retiramos medicamentos de nuestra lista de medicamentos, agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada para un medicamento, o cambiamos un medicamento a un nivel de costo compartido más alto, debemos notificar a los miembros afectados sobre el cambio al menos 30 días

antes de que el cambio entre en vigor, o cuando el miembro solicita un nuevo surtido del medicamento, momento en el cual recibirá un suministro por 30 días del medicamento.

- Si realizamos estos cambios, usted o el recetador pueden solicitarnos hacer una excepción y continuar con la cobertura de su medicamento de marca registrada. El aviso que le enviaremos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción a la Lista de medicamentos de Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP)?”

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si usted está tomando un medicamento de nuestra Lista de Medicamentos 2024 que estaba cubierto al comienzo del año, no interrumpiremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2024, salvo lo descrito anteriormente. Esto significa que estos medicamentos seguirán disponibles con el mismo costo compartido y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. Este año no se le notificarán directamente sobre los cambios que no lo afecten. Sin embargo, el 1 de enero del año siguiente, dichos cambios pueden afectarlo, y es importante revisar la Lista de Medicamentos del nuevo año de beneficios para ver si hay cambios en los medicamentos.

La lista adjunta entra en vigor a partir del 11/01/2024. Para obtener información actualizada sobre los medicamentos cubiertos por nuestro plan, comuníquese con nosotros. Nuestra información de contacto aparece en la portada y en la contraportada. En caso de que se produzcan cambios a mediados de año en la lista de medicamentos que no sean de mantenimiento, las listas se actualizarán mensualmente y se publicarán en nuestro sitio web.

¿Cómo utilizo la Lista de Medicamentos?

Existen dos maneras de encontrar su medicamento en la lista de medicamentos:

Afección Médica

La lista comienza en la página 16. Los medicamentos de esta lista de medicamentos están agrupados en categorías según el tipo de afección médica para la que se utilizan. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca se enumeran en la categoría “Cardiovascular”. Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 16. Luego busque su medicamento en el nombre de la categoría.

Listado Alfabético

Si no está seguro en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 99. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca registrada como los medicamentos genéricos figuran en el Índice. Busque en el Índice para encontrar su medicamento. Junto con su medicamento, verá el número de página donde puede encontrar información sobre la cobertura. Vaya a la página que aparece en el Índice y busque el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre tanto medicamentos de marca registrada como medicamentos genéricos. Un medicamento genérico es uno aprobado por la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA) que contiene el mismo ingrediente activo que el medicamento de marca registrada. Por lo general, los medicamentos genéricos cuestan menos que los medicamentos de marca registrada.

¿Existe alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales en la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización Previa:** Nuestro plan necesita que usted o su médico obtengan una autorización previa para obtener ciertos medicamentos. Esto significa que necesitará obtener una aprobación de nuestro plan antes de obtener los medicamentos con receta médica. Si no obtiene la aprobación, es posible que no cubramos el medicamento.
- **Límites de Cantidades:** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubrirá nuestro plan. Por ejemplo, nuestro plan proporciona 30 comprimidos por receta para rosuvastatina. Esto puede ser adicional a un suministro estándar para un mes o tres meses.
- **Terapia Escalonada:** En algunos casos, nuestro plan requiere que primero pruebe otros medicamentos para tratar su afección médica antes de cubrir otro medicamento para esa afección. Por ejemplo, si el medicamento A y el medicamento B tratan una condición médica, podemos no cubrir el medicamento B a menos que pruebe con el medicamento A primero. Si el medicamento A no funciona, le cubriremos el medicamento B.

Puede averiguar si su medicamento tiene requisitos o límites adicionales consultando la lista que comienza en la página 16. También puede obtener más información sobre las restricciones aplicadas a medicamentos cubiertos específicos visitando nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia escalonada. También puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

Puede solicitar que se haga una excepción a estas restricciones o límites en nuestros planes, o que le hagan una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección “¿Cómo solicito una excepción a la Lista de medicamentos de Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP)?” en la página 12 para obtener información sobre cómo solicitar una excepción.

¿Qué pasa si mi medicamento no está en la Lista de Medicamentos?

Si su medicamento no está incluido en esta lista (lista de medicamentos cubiertos), primero debe comunicarse con el Servicio de Atención al Cliente y preguntar si su medicamento está cubierto.

Si se entera de que nuestro plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar al Servicio de Atención al Cliente una lista de medicamentos similares que estén cubiertos por nuestro plan. Cuando reciba la lista, muéstrasela a su médico y pídale que le recete un medicamento similar que esté cubierto por nuestro plan.
- Puede solicitar que nuestro plan haga una excepción para que cubra su medicamento. Consulte la siguiente sección para obtener información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción a la Lista de Medicamentos de Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP)?

Puede solicitar que se haga una excepción a nuestras normas de cobertura en nuestro plan. Existen varios tipos de excepciones que puede solicitarnos.

- Puede solicitarnos que cubramos un medicamento incluso si no está en nuestra lista de medicamentos. Si se aprueba, este medicamento estará cubierto a un nivel de costo compartido predeterminado, y usted no podrá solicitarnos que le proporcionemos el medicamento a un nivel de costo compartido más bajo.
- Puede solicitarnos que cubramos un medicamento de la lista de medicamentos en un nivel de costo compartido más bajo, a menos que el medicamento se encuentre en el nivel especializado. Si se aprueba, esto disminuiría el monto que debe pagar por su medicamento.
- Puede solicitarnos que no apliquemos restricciones ni límites de cobertura a su medicamento. Por ejemplo, para ciertos medicamentos, el plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitarnos que no apliquemos el límite y que cubramos una cantidad mayor.

Por lo general, nuestro plan aprobará su solicitud de una excepción únicamente si los medicamentos alternativos incluidos en la lista de medicamentos del plan, el medicamento de menor costo compartido o las restricciones de utilización adicionales no son tan eficaces para tratar su afección o harán que padezca efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión inicial sobre la cobertura de una excepción a la lista, el nivel o la restricción de utilización. **Cuando solicita una excepción a la lista, el nivel o la restricción de utilización, debe presentar una declaración de su recetador o médico que respalde su solicitud.** Por lo general, debemos tomar una decisión dentro de las 72 horas después de recibir la declaración de apoyo de su recetador. Puede solicitar una excepción acelerada (rápida) si usted o su médico creen que su salud podría verse gravemente afectada si espera hasta 72 horas por una decisión. Si se concede su solicitud acelerada, debemos darle una decisión a más tardar 24 horas después de recibir una declaración de apoyo de su médico u otro recetador.

¿Qué debo hacer antes de hablar con mi médico sobre cambiar mis medicamentos o solicitar una excepción?

Como miembro nuevo o existente de nuestro plan, es posible que esté tomando medicamentos que no están en nuestra lista de medicamentos. También puede suceder que esté tomando un medicamento que está en

nuestra lista de medicamentos, pero su capacidad para conseguirlo es limitada. Por ejemplo, es posible que necesite nuestra autorización previa antes de que pueda obtener su receta. Debe hablar con su médico para decidir si debe cambiar a un medicamento apropiado que cubramos, o solicitar una excepción a la lista de medicamentos para que cubramos el medicamento que toma. Mientras habla con su médico para determinar qué medida es adecuada para usted, podemos cubrir su medicamento en ciertos casos durante los primeros 90 días en los que usted es miembro de nuestro plan.

Para cada uno de sus medicamentos que no está en nuestra lista de medicamentos, o si su capacidad para obtener sus medicamentos es limitada, cubriremos un suministro temporal por 30 días. Si su receta médica está escrita por menos días, entregaremos renovaciones para proporcionar hasta un suministro máximo por 30 días de medicamentos. Después de su primer suministro por 30 días, no pagaremos estos medicamentos, incluso si ha sido miembro del plan durante menos de 90 días.

Si usted es residente de un centro de atención médica a largo plazo y necesita un medicamento que no está en nuestra lista de medicamentos, o si su capacidad para obtener sus medicamentos es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia por 31 días de ese medicamento mientras usted busca una excepción a la lista.

Si usted es un miembro actual de nuestro plan, también cubriremos un suministro de transición temporal si sus medicamentos cambian debido a un cambio en el nivel de atención. Esto puede incluir cambios no planificados en los entornos de tratamiento, como ser dado de alta de un centro de cuidados intensivos (hospital) o ser hospitalizado o dado de alta de un centro de atención médica a largo plazo. Por cada medicamento que no esté en nuestra lista de medicamentos o si su capacidad para obtener sus medicamentos es limitada, cubriremos un suministro temporal por 30 días (un suministro por hasta 31 días si usted es residente de un centro de atención médica a largo plazo) cuando vaya a una farmacia de la red.

Para obtener más información

Para obtener información más detallada sobre su cobertura de medicamentos recetados Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP), revise su *Evidencia de Cobertura* y otros materiales del plan.

Si tiene preguntas sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

Si tiene preguntas generales acerca de la cobertura de medicamentos recetados de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY/TDD deben llamar al 1-877-486-2048. O visite <http://www.medicare.gov>.

Lista de Medicamentos de Generations Chronic Care (HMO C-SNP) y Generations Chronic Care Savings (HMO C-SNP)

La lista de medicamentos que comienza en la página siguiente proporciona información de cobertura sobre los medicamentos cubiertos por nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, consulte el Índice que comienza en la página 99.

La primera columna de la tabla enumera el nombre del medicamento. Los medicamentos de marca registrada están en mayúscula (p. ej., SYNTHROID) y los medicamentos genéricos están en minúscula cursiva (p. ej., levotiroxina).

La información en la columna Requisitos/Límites le indica si nuestro plan tiene algún requisito especial para la cobertura de su medicamento.

Nivel de Medicamento

Nivel 1 = Genérico preferido

Nivel 2 = Genérico

Nivel 3 = Marca preferida

Nivel 4 = Medicamentos no preferidos

Nivel 5 = Nivel de especialidad

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas en esta tabla:

- **PA - Autorización Previa.** El plan necesita que usted o su proveedor obtengan una autorización previa para ciertos medicamentos. Esto significa que necesitará obtener nuestra aprobación antes de obtener los medicamentos con receta médica. Si no obtiene la aprobación, es posible que no cubramos el medicamento.
- **QL - El medicamento tiene un límite de cantidad.** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Por ejemplo, nuestro plan proporciona 30 comprimidos por 30 días por receta de rosuvastatina.
- **ST - Terapia Escalonada.** En algunos casos, nuestro plan requiere que primero pruebe otros medicamentos para tratar su afección médica antes de cubrir otro medicamento para esa afección. Por ejemplo, si el medicamento A y el medicamento B tratan una condición médica, podemos no cubrir el medicamento B a menos que pruebe con el medicamento A primero. Si el medicamento A no funciona, le cubriremos el medicamento B.
- **NM - No está disponible en nuestras farmacias de pedidos por correo.**
- **LA - Acceso Limitado.** Esta receta puede estar disponible solo en ciertas farmacias. Para obtener más información, consulte su Directorio de Farmacias o llame al Servicio de Atención al Cliente al 1-866-494-3927, las 24 horas del día, los siete días de la semana. Los usuarios de TTY deben llamar al 711.
- **B/D - Este medicamento puede estar cubierto por Medicare Parte B o Parte D, según las circunstancias.** Es posible que sea necesario presentar información que describa el uso y el entorno del medicamento para tomar la decisión.

- **GC - Etapa sin Cobertura (Gap Coverage).** Brindamos cobertura adicional de este medicamento recetado en la etapa sin cobertura. Consulte su *Evidencia de Cobertura* para obtener más información sobre esta cobertura.
- **ED - Medicamento Excluido (Excluded Drug).** Este medicamento recetado generalmente no está cubierto por un Plan de Medicamentos Recetados de Medicare. El monto que usted paga cuando le dispensan una receta de este medicamento no cuenta entre los costos de medicamentos totales (es decir, el monto que paga no lo ayuda a reunir los requisitos para la cobertura catastrófica). Además, si recibe ayuda adicional para pagar sus recetas, no obtendrá ayuda adicional para pagar este medicamento. Estos medicamentos pueden no estar cubiertos después de alcanzar la Etapa sin Cobertura.

GLOBAL_HEALTH_CY24_5T_STND eff 11/01/2024

Drug Name	Drug Tier	Requirements/Limits
-----------	-----------	---------------------

ANALGESICS**GOUT**

<i>allopurinol</i> TABS 100mg, 300mg	1	GC
<i>colchicine</i> TABS .6mg	2	QL (120 tabs / 30 days)
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	2	
MITIGARE CAPS .6mg	3	QL (60 caps / 30 days)
<i>probenecid</i> TABS 500mg	2	

NSAIDS

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

OPIOID ANALGESICS, LONG-ACTING

<i>fentanyl</i> PT72 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr	2	QL (10 patches / 30 days), PA
<i>hydrocodone bitartrate</i> T24A 20mg, 30mg, 40mg, 60mg	2	QL (30 tabs / 30 days), PA
<i>hydrocodone bitartrate</i> T24A 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	2	QL (450 mL / 30 days), PA
<i>methadone hcl</i> TABS 5mg, 10mg	2	QL (90 tabs / 30 days), PA
<i>methadone hydrochloride i</i> CONC 10mg/ml	2	QL (90 mL / 30 days), PA
<i>morphine sulfate</i> TBCR 15mg, 30mg, 60mg, 100mg, 200mg	2	QL (90 tabs / 30 days), PA

OPIOID ANALGESICS, SHORT-ACTING

<i>acetaminophen w/ codeine soln</i> 120-12 mg/5ml	2	QL (2700 mL / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-15 mg	2	QL (400 tabs / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-30 mg	2	QL (360 tabs / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-60 mg	2	QL (180 tabs / 30 days)
<i>butorphanol tartrate</i> SOLN 1mg/ml, 2mg/ml	4	
<i>endocet tab</i> 2.5-325mg	2	QL (360 tabs / 30 days)
<i>endocet tab</i> 5-325mg	2	QL (360 tabs / 30 days)
<i>endocet tab</i> 7.5-325mg	2	QL (240 tabs / 30 days)
<i>endocet tab</i> 10-325mg	2	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP 200mcg	2	QL (120 lozenges / 30 days), PA
<i>fentanyl citrate</i> LPOP 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	5	QL (120 lozenges / 30 days), PA
<i>hydrocodone-acetaminophen soln</i> 7.5-325 mg/15ml	2	QL (2700 mL / 30 days)
<i>hydrocodone-acetaminophen tab</i> 5-325 mg	2	QL (240 tabs / 30 days)
<i>hydrocodone-acetaminophen tab</i> 7.5-325 mg	2	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen tab</i> 10-325 mg	2	QL (180 tabs / 30 days)
<i>hydrocodone-ibuprofen tab</i> 7.5-200 mg	2	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD 1mg/ml	2	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> TABS 2mg, 4mg, 8mg	2	QL (180 tabs / 30 days)
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml, 50mg/ml	4	B/D
<i>morphine sulfate</i> SOLN 4mg/ml, 8mg/ml, 10mg/ml	4	B/D
<i>morphine sulfate</i> SOLN 10mg/5ml, 20mg/5ml	2	QL (900 mL / 30 days)
<i>morphine sulfate</i> SOLN 100mg/5ml	2	QL (180 mL / 30 days)
<i>morphine sulfate</i> TABS 15mg, 30mg	2	QL (180 tabs / 30 days)

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

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

ANESTHETICS

LOCAL ANESTHETICS

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

ANTI-INFECTIVES

ANTI-INFECTIVES - MISCELLANEOUS

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

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

Drug Name	Drug Tier	Requirements/Limits
CLINDMYC/NAC INJ 900/50ML	4	
<i>colistimethate sodium</i> SOLR 150mg	2	
<i>dapsone</i> TABS 25mg, 100mg	2	
DAPTOMYCIN SOLR 350mg	5	
<i>daptomycin</i> SOLR 350mg, 500mg	5	
EMVERM CHEW 100mg	5	QL (12 tabs / year)
<i>ertapenem sodium</i> SOLR 1gm	2	
<i>gentamicin in saline inj 0.8 mg/ml</i>	2	
<i>gentamicin in saline inj 1 mg/ml</i>	2	
<i>gentamicin in saline inj 1.2 mg/ml</i>	2	
<i>gentamicin in saline inj 1.6 mg/ml</i>	2	
<i>gentamicin in saline inj 2 mg/ml</i>	2	
<i>gentamicin sulfate</i> SOLN 10mg/ml, 40mg/ml	2	
<i>imipenem-cilastatin intravenous for soln 250 mg</i>	2	
<i>imipenem-cilastatin intravenous for soln 500 mg</i>	2	
<i>ivermectin</i> TABS 3mg	2	QL (12 tabs / 90 days), PA
<i>linezolid</i> SOLN 600mg/300ml	2	
<i>linezolid</i> SUSR 100mg/5ml	5	QL (1800 mL / 30 days)
<i>linezolid</i> TABS 600mg	2	QL (60 tabs / 30 days)
LINEZOLID INJ 2MG/ML	2	
<i>meropenem</i> SOLR 1gm, 500mg	2	
<i>methenamine hippurate</i> TABS 1gm	2	
<i>metronidazole</i> SOLN 500mg/100ml	2	
<i>metronidazole</i> TABS 250mg, 500mg	1	GC
<i>neomycin sulfate</i> TABS 500mg	2	
<i>nitazoxanide</i> TABS 500mg	5	QL (6 tabs / 30 days)
<i>nitrofurantoin macrocrystal</i> CAPS 50mg, 100mg	3	
<i>nitrofurantoin monohyd macro</i> CAPS 100mg	3	
<i>pentamidine isethionate inh</i> SOLR 300mg	2	B/D
<i>pentamidine isethionate inj</i> SOLR 300mg	2	
<i>praziquantel</i> TABS 600mg	2	
SIVEXTRO SOLR 200mg; TABS 200mg	5	
<i>streptomycin sulfate</i> SOLR 1gm	5	
<i>sulfadiazine</i> TABS 500mg	5	
<i>sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml</i>	2	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	2	

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

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

ANTIFUNGALS

<i>ABELCET SUSP 5mg/ml</i>	4	B/D
<i>amphotericin b SOLR 50mg</i>	2	B/D
<i>amphotericin b liposome SUSR 50mg</i>	5	B/D
<i>caspofungin acetate SOLR 50mg, 70mg</i>	2	
<i>fluconazole SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 150mg, 200mg</i>	2	
<i>fluconazole in nacl 0.9% inj 200 mg/100ml</i>	2	
<i>fluconazole in nacl 0.9% inj 400 mg/200ml</i>	2	
<i>flucytosine CAPS 250mg, 500mg</i>	5	PA
<i>griseofulvin microsize SUSP 125mg/5ml; TABS 500mg</i>	2	
<i>griseofulvin ultramicrosize TABS 125mg, 250mg</i>	2	
<i>itraconazole CAPS 100mg</i>	2	PA
<i>ketoconazole TABS 200mg</i>	2	PA
<i>miconazole sodium SOLR 50mg, 100mg</i>	5	
<i>nystatin TABS 500000unit</i>	2	
<i>posaconazole SUSP 40mg/ml</i>	5	QL (630 mL / 30 days), PA
<i>posaconazole TBEC 100mg</i>	5	QL (93 tabs / 30 days), PA
<i>terbinafine hcl TABS 250mg</i>	1	GC, QL (90 tabs / year)
<i>voriconazole SOLR 200mg</i>	2	PA
<i>voriconazole SUSR 40mg/ml</i>	5	PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>voriconazole</i> TABS 50mg	2	QL (480 tabs / 30 days), PA
<i>voriconazole</i> TABS 200mg	2	QL (120 tabs / 30 days), PA

ANTIMALARIALS

<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	2	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	2	
<i>chloroquine phosphate</i> TABS 250mg, 500mg	2	
COARTEM TAB 20-120MG	4	
<i>mefloquine hcl</i> TABS 250mg	2	
<i>primaquine phosphate</i> TABS 26.3mg	2	
PRIMAQUINE PHOSPHATE TABS 26.3mg	3	
<i>quinine sulfate</i> CAPS 324mg	2	PA

ANTIRETROVIRAL AGENTS

<i>abacavir sulfate</i> SOLN 20mg/ml; TABS 300mg	2	
APTIVUS CAPS 250mg	5	
<i>atazanavir sulfate</i> CAPS 150mg, 200mg, 300mg	2	
<i>darunavir</i> TABS 600mg	5	QL (60 tabs / 30 days)
<i>darunavir</i> TABS 800mg	5	QL (30 tabs / 30 days)
EDURANT TABS 25mg	5	
<i>efavirenz</i> TABS 600mg	2	
<i>emtricitabine</i> CAPS 200mg	2	
EMTRIVA SOLN 10mg/ml	4	
<i>etravirine</i> TABS 100mg, 200mg	5	
<i>fosamprenavir calcium</i> TABS 700mg	5	
FUZEON SOLR 90mg	5	LA
INTELENCE TABS 25mg	4	
ISENTRESS CHEW 25mg	4	
ISENTRESS CHEW 100mg; PACK 100mg; TABS 400mg	5	
ISENTRESS HD TABS 600mg	5	
<i>lamivudine</i> SOLN 10mg/ml; TABS 150mg, 300mg	2	
<i>maraviroc</i> TABS 150mg, 300mg	5	
<i>nevirapine</i> SUSP 50mg/5ml; TABS 200mg; TB24 400mg	2	
NORVIR PACK 100mg	4	
PIFELTRO TABS 100mg	5	
PREZISTA SUSP 100mg/ml	5	QL (400 mL / 30 days)
PREZISTA TABS 75mg	4	QL (480 tabs / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
PREZISTA TABS 150mg	5	QL (240 tabs / 30 days)
REYATAZ PACK 50mg	5	
<i>ritonavir</i> TABS 100mg	2	
RUKOBIA TB12 600mg	5	
SELZENTRY SOLN 20mg/ml; TABS 75mg	5	
SELZENTRY TABS 25mg	4	
SUNLENCA TBPK 300mg	5	LA
<i>tenofovir disoproxil fumarate</i> TABS 300mg	2	
TIVICAY TABS 10mg	3	
TIVICAY TABS 25mg, 50mg	5	
TIVICAY PD TBSO 5mg	5	
TROGARZO SOLN 200mg/1.33ml	5	LA
TYBOST TABS 150mg	3	
VIRACEPT TABS 250mg, 625mg	5	
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	5	
<i>zidovudine</i> CAPS 100mg; SYRP 50mg/5ml; TABS 300mg	2	

ANTIRETROVIRAL COMBINATION AGENTS

<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	2	
BIKTARVY TAB 30-120-15 MG	5	
BIKTARVY TAB 50-200-25 MG	5	
CIMDUO TAB 300-300	5	
COMPLERA TAB	5	
DELSTRIGO TAB	5	
DESCOVY TAB 120-15MG	5	
DESCOVY TAB 200/25MG	5	
DOVATO TAB 50-300MG	5	
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	5	
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	5	
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	5	
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	2	
EVOTAZ TAB 300-150	5	

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

Drug Name	Drug Tier	Requirements/Limits
GENVOYA TAB	5	
JULUCA TAB 50-25MG	5	
<i>lamivudine-zidovudine tab 150-300 mg</i>	2	
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	2	
<i>lopinavir-ritonavir tab 100-25 mg</i>	2	
<i>lopinavir-ritonavir tab 200-50 mg</i>	2	
ODEFSEY TAB	5	
PREZCOBIX TAB 800-150	5	
STRIBILD TAB	5	
SYMTUZA TAB	5	
TRIUMEQ PD TAB	5	
TRIUMEQ TAB	5	
TRIZIVIR TAB	5	
ANTITUBERCULAR AGENTS		
<i>cycloserine CAPS 250mg</i>	5	
<i>ethambutol hcl TABS 100mg, 400mg</i>	2	
<i>isoniazid SYRP 50mg/5ml</i>	2	
<i>isoniazid TABS 100mg, 300mg</i>	1	GC
PRIFTIN TABS 150mg	4	
<i>pyrazinamide TABS 500mg</i>	2	
<i>rifabutin CAPS 150mg</i>	2	
<i>rifampin CAPS 150mg, 300mg; SOLR 600mg</i>	2	
SIRTURO TABS 20mg, 100mg	5	NM, LA, PA
TRECTOR TABS 250mg	4	
ANTIVIRALS		
<i>acyclovir CAPS 200mg; TABS 400mg, 800mg</i>	1	GC
<i>acyclovir SUSP 200mg/5ml</i>	2	
<i>acyclovir sodium SOLN 50mg/ml</i>	2	B/D
<i>adefovir dipivoxil TABS 10mg</i>	2	
BARACLUDE SOLN .05mg/ml	5	
<i>entecavir TABS .5mg, 1mg</i>	2	
EPCLUSA PAK 150-37.5	5	NM, PA
EPCLUSA PAK 200-50MG	5	NM, PA
EPCLUSA TAB 200-50MG	5	NM, PA
EPCLUSA TAB 400-100	5	NM, PA
<i>famciclovir TABS 125mg, 250mg, 500mg</i>	2	
<i>ganciclovir sodium SOLR 500mg</i>	2	B/D
HARVONI PAK 33.75-150MG	5	NM, PA
HARVONI PAK 45-200MG	5	NM, PA
HARVONI TAB 45-200MG	5	NM, PA

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

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

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

Drug Name	Drug Tier	Requirements/Limits
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	2	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	2	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	2	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	2	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	2	
<i>cephalexin</i> CAPS 250mg, 500mg	1	GC
<i>cephalexin</i> SUSR 125mg/5ml, 250mg/5ml	2	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	2	
TEFLARO SOLR 400mg, 600mg	5	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i> PACK 1gm; SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml	2	
<i>azithromycin</i> TABS 250mg, 500mg, 600mg	1	GC
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg; TB24 500mg	2	
DIFICID SUSR 40mg/ml; TABS 200mg	5	
<i>e.e.s. 400</i> TABS 400mg	2	
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	2	
ERYTHROCIN LACTOBIONATE SOLR 500mg	4	
<i>erythromycin base</i> CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	2	
<i>erythromycin ethylsuccinate</i> TABS 400mg	2	
<i>erythromycin lactobionate</i> SOLR 500mg	2	
FLUOROQUINOLONES		
CIPRO SUSR 500mg/5ml	4	
<i>ciprofloxacin 200 mg/100ml in d5w</i>	2	
<i>ciprofloxacin 400 mg/200ml in d5w</i>	2	
<i>ciprofloxacin hcl</i> TABS 250mg, 500mg, 750mg	1	GC
<i>levofloxacin</i> SOLN 25mg/ml	2	
<i>levofloxacin</i> TABS 250mg, 500mg, 750mg	1	GC
<i>levofloxacin in d5w iv soln 250 mg/50ml</i>	2	
<i>levofloxacin in d5w iv soln 500 mg/100ml</i>	2	
<i>levofloxacin in d5w iv soln 750 mg/150ml</i>	2	
<i>moxifloxacin hcl</i> TABS 400mg	2	
<i>moxifloxacin hcl 400 mg/250ml in sodium chloride 0.8% inj</i>	2	

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

Drug Name	Drug Tier	Requirements/Limits
PENICILLINS		
<i>amoxicillin</i> CAPS 250mg, 500mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1	GC
<i>amoxicillin</i> CHEW 125mg, 250mg	2	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	2	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	2	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	2	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	2	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	2	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	2	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	2	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	2	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	2	
<i>ampicillin</i> CAPS 500mg	1	GC
<i>ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm</i>	2	
<i>ampicillin & sulbactam sodium for inj 3 (2-1) gm</i>	2	
<i>ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm</i>	2	
<i>ampicillin & sulbactam sodium for iv soln 3 (2-1) gm</i>	2	
<i>ampicillin & sulbactam sodium for iv soln 15 (10-5) gm</i>	2	
<i>ampicillin sodium</i> SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg	2	
BICILLIN L-A SUSY 600000unit/ml, 1200000unit/2ml, 2400000unit/4ml	4	
<i>dicloxacillin sodium</i> CAPS 250mg, 500mg	2	
<i>nafcillin sodium</i> SOLR 1gm, 2gm	2	
<i>nafcillin sodium</i> SOLR 10gm	5	
<i>oxacillin sodium</i> SOLR 1gm, 2gm, 10gm	2	
PEN GK/DEXTR INJ 40000/ML	4	
PEN GK/DEXTR INJ 60000/ML	4	
<i>penicillin g potassium</i> SOLR 5000000unit, 20000000unit	2	
<i>penicillin g sodium</i> SOLR 5000000unit	2	

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

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

TETRACYCLINES

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

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

BENDAMUSTINE HYDROCHLORID SOLN 100mg/4ml	5	B/D, NM
BENDEKA SOLN 100mg/4ml	5	B/D, NM, LA
<i>carboplatin</i> SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	2	B/D
<i>cisplatin</i> SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	2	B/D
<i>cyclophosphamide</i> CAPS 25mg, 50mg; SOLR 1gm, 500mg	2	B/D
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml, 500mg/5ml, 1000mg/10ml, 2000mg/20ml	5	B/D
<i>cyclophosphamide</i> SOLR 2gm	5	B/D
CYCLOPHOSPHAMIDE TABS 25mg, 50mg	4	B/D

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

Drug Name	Drug Tier	Requirements/Limits
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	5	B/D
GLEOSTINE CAPS 10mg, 40mg	4	NM
GLEOSTINE CAPS 100mg	5	NM
LEUKERAN TABS 2mg	5	
<i>oxaliplatin</i> SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml; SOLR 50mg	2	B/D
<i>oxaliplatin</i> SOLR 100mg	5	B/D
<i>paraplatin</i> SOLN 1000mg/100ml	2	B/D
ANTIBIOTICS		
<i>doxorubicin hcl</i> SOLN 2mg/ml	2	B/D
<i>doxorubicin hcl liposomal</i> SUSP 2mg/ml	5	B/D
DOXORUBICIN HYDROCHLORIDE SOLN 2mg/ml	2	B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	4	B/D
ANTIMETABOLITES		
<i>azacitidine</i> SUSR 100mg	5	B/D, NM
<i>cytarabine</i> SOLN 20mg/ml	2	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	2	B/D
<i>gemcitabine hcl</i> SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	2	B/D
INQOVI TAB 35-100MG	5	QL (5 tabs / 28 days), NM, LA, PA
LONSURF TAB 15-6.14	5	QL (100 tabs / 28 days), NM, LA, PA
LONSURF TAB 20-8.19	5	QL (80 tabs / 28 days), NM, LA, PA
<i>mercaptopurine</i> TABS 50mg	2	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	2	B/D
ONUREG TABS 200mg, 300mg	5	QL (14 tabs / 28 days), NM, LA, PA
<i>pemetrexed disodium</i> SOLR 100mg, 500mg, 750mg, 1000mg	5	B/D
PURIXAN SUSP 2000mg/100ml	5	NM, LA
TABLOID TABS 40mg	4	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i> TABS 250mg	5	QL (120 tabs / 30 days), NM, PA
<i>abiraterone acetate</i> TABS 500mg	5	QL (60 tabs / 30 days), NM, PA

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

Drug Name	Drug Tier	Requirements/Limits
AKEEGA TAB 50/500MG	5	QL (60 tabs / 30 days), NM, LA, PA
AKEEGA TAB 100/500	5	QL (60 tabs / 30 days), NM, LA, PA
<i>anastrozole</i> TABS 1mg	1	GC
<i>bicalutamide</i> TABS 50mg	2	
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	4	NM, PA
ERLEADA TABS 60mg	5	QL (120 tabs / 30 days), NM, LA, PA
ERLEADA TABS 240mg	5	QL (30 tabs / 30 days), NM, LA, PA
EULEXIN CAPS 125mg	5	
<i>exemestane</i> TABS 25mg	2	
FIRMAGON SOLR 80mg	4	NM, PA
FIRMAGON SOLR 120mg/vial	5	NM, PA
<i>fulvestrant</i> SOSY 250mg/5ml	5	B/D
<i>letrozole</i> TABS 2.5mg	1	GC
<i>leuprolide acetate</i> KIT 1mg/0.2ml	2	NM, PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	5	NM, PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	5	NM, PA
LYSODREN TABS 500mg	5	NM, LA
<i>megestrol acetate</i> TABS 20mg, 40mg	3	
<i>nilutamide</i> TABS 150mg	5	
NUBEQA TABS 300mg	5	QL (120 tabs / 30 days), NM, LA, PA
ORGOVYX TABS 120mg	5	NM, LA, PA
ORSERDU TABS 86mg	5	QL (90 tabs / 30 days), NM, LA, PA
ORSERDU TABS 345mg	5	QL (30 tabs / 30 days), NM, LA, PA
SOLTAMOX SOLN 10mg/5ml	5	
<i>tamoxifen citrate</i> TABS 10mg, 20mg	2	
<i>toremifene citrate</i> TABS 60mg	2	
XTANDI CAPS 40mg	5	QL (120 caps / 30 days), NM, LA, PA
XTANDI TABS 40mg	5	QL (120 tabs / 30 days), NM, LA, PA
XTANDI TABS 80mg	5	QL (60 tabs / 30 days), NM, LA, PA
IMMUNOMODULATORS		
<i>lenalidomide</i> CAPS 2.5mg, 5mg, 10mg, 15mg	5	QL (28 caps / 28 days), NM, LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>lenalidomide</i> CAPS 20mg, 25mg	5	QL (21 caps / 28 days), NM, LA, PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg	5	QL (21 caps / 28 days), NM, LA, PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg	5	QL (28 caps / 28 days), NM, LA, PA
REVLIMID CAPS 20mg, 25mg	5	QL (21 caps / 28 days), NM, LA, PA
THALOMID CAPS 50mg	5	QL (84 caps / 28 days), NM, LA, PA
THALOMID CAPS 100mg	5	QL (112 caps / 28 days), NM, LA, PA
THALOMID CAPS 150mg, 200mg	5	QL (56 caps / 28 days), NM, LA, PA

MISCELLANEOUS

BESREMI SOSY 500mcg/ml	5	QL (2 syringes / 28 days), NM, LA, PA
<i>bexarotene</i> CAPS 75mg	5	QL (300 caps / 30 days), NM, PA
<i>hydroxyurea</i> CAPS 500mg	2	
<i>irinotecan hcl</i> SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	2	B/D
IWILFIN TABS 192mg	5	QL (240 tabs / 30 days), NM, LA, PA
KISQALI 200 PAK FEMARA	5	QL (49 tabs / 28 days), NM, PA
KISQALI 400 PAK FEMARA	5	QL (70 tabs / 28 days), NM, PA
KISQALI 600 PAK FEMARA	5	QL (91 tabs / 28 days), NM, PA
MATULANE CAPS 50mg	5	NM, LA
<i>tretinoin (chemotherapy)</i> CAPS 10mg	5	
WELIREG TABS 40mg	5	QL (90 tabs / 30 days), NM, LA, PA

MITOTIC INHIBITORS

<i>docetaxel</i> CONC 20mg/ml	2	B/D
<i>docetaxel</i> CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
<i>etoposide</i> SOLN 1gm/50ml, 100mg/5ml, 500mg/25ml	2	B/D
<i>paclitaxel</i> CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	2	B/D

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

Drug Name	Drug Tier	Requirements/Limits
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	5	B/D, NM
<i>vincristine sulfate SOLN 1mg/ml</i>	2	B/D
<i>vinorelbine tartrate SOLN 10mg/ml, 50mg/5ml</i>	2	B/D

MOLECULAR TARGET AGENTS

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

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

Drug Name	Drug Tier	Requirements/Limits
CAPRELSA TABS 100mg	5	QL (60 tabs / 30 days), NM, LA, PA
CAPRELSA TABS 300mg	5	QL (30 tabs / 30 days), NM, LA, PA
COMETRIQ (60MG DOSE) KIT 20mg	5	QL (84 caps / 28 days), NM, LA, PA
COMETRIQ KIT 100MG	5	QL (56 caps / 28 days), NM, LA, PA
COMETRIQ KIT 140MG	5	QL (112 caps / 28 days), NM, LA, PA
COPIKTRA CAPS 15mg, 25mg	5	QL (56 caps / 28 days), NM, LA, PA
COTELLIC TABS 20mg	5	QL (63 tabs / 28 days), NM, LA, PA
<i>dasatinib</i> TABS 20mg	5	QL (90 tabs / 30 days), NM, PA
<i>dasatinib</i> TABS 50mg, 70mg, 80mg, 100mg, 140mg	5	QL (30 tabs / 30 days), NM, PA
DAURISMO TABS 25mg	5	QL (60 tabs / 30 days), NM, LA, PA
DAURISMO TABS 100mg	5	QL (30 tabs / 30 days), NM, LA, PA
ERIVEDGE CAPS 150mg	5	QL (30 caps / 30 days), NM, LA, PA
<i>erlotinib hcl</i> TABS 25mg	5	QL (90 tabs / 30 days), NM, PA
<i>erlotinib hcl</i> TABS 100mg, 150mg	5	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TABS 2.5mg, 5mg, 7.5mg, 10mg	5	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 2mg	5	QL (150 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 3mg	5	QL (90 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 5mg	5	QL (60 tabs / 30 days), NM, PA
FOTIVDA CAPS .89mg, 1.34mg	5	QL (21 caps / 28 days), NM, LA, PA
FRUZAQLA CAPS 1mg	5	QL (84 caps / 28 days), NM, LA, PA
FRUZAQLA CAPS 5mg	5	QL (21 caps / 28 days), NM, LA, PA
GAVRETO CAPS 100mg	5	QL (120 caps / 30 days), NM, LA, PA

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

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
MEKINIST SOLR .05mg/ml	5	QL (1260 mL / 30 days), NM, LA, PA
MEKINIST TABS 2mg	5	QL (30 tabs / 30 days), NM, LA, PA
MEKINIST TABS .5mg	5	QL (90 tabs / 30 days), NM, LA, PA
MEKTOVI TABS 15mg	5	QL (180 tabs / 30 days), NM, LA, PA
MONJUVI SOLR 200mg	5	NM, LA, PA
NERLYNX TABS 40mg	5	QL (180 tabs / 30 days), NM, LA, PA
NEXAVAR TABS 200mg	5	QL (120 tabs / 30 days), NM, LA, PA
NINLARO CAPS 2.3mg, 3mg, 4mg	5	QL (3 caps / 28 days), NM, PA
ODOMZO CAPS 200mg	5	QL (30 caps / 30 days), NM, LA, PA
OGIVRI SOLR 150mg, 420mg	5	NM, LA, PA
OGSIVEO TABS 50mg	5	QL (180 tabs / 30 days), NM, LA, PA
OGSIVEO TABS 100mg, 150mg	5	QL (56 tabs / 28 days), NM, LA, PA
OJEMDA SUSR 25mg/ml	5	QL (96 mL / 28 days), NM, LA, PA
OJEMDA TABS 100mg	5	QL (24 tabs / 28 days), NM, LA, PA
OJJAARA TABS 100mg, 150mg, 200mg	5	QL (30 tabs / 30 days), NM, LA, PA
ONTRUZANT SOLR 150mg, 420mg	5	NM, LA, PA
<i>pazopanib hcl</i> TABS 200mg	5	QL (120 tabs / 30 days), NM, PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	5	QL (28 tabs / 28 days), NM, LA, PA
PHESGO SOL	5	NM, LA, PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	5	QL (28 tabs / 28 days), NM, PA
PIQRAY 250MG TAB DOSE	5	QL (56 tabs / 28 days), NM, PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	5	QL (56 tabs / 28 days), NM, PA
QINLOCK TABS 50mg	5	QL (90 tabs / 30 days), NM, LA, PA
RETEVMO CAPS 40mg	5	QL (180 caps / 30 days), NM, LA, PA

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

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

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

Drug Name	Drug Tier	Requirements/Limits
TALZENNA CAPS .25mg	5	QL (90 caps / 30 days), NM, LA, PA
TASIGNA CAPS 50mg	5	QL (120 caps / 30 days), NM, PA
TASIGNA CAPS 150mg, 200mg	5	QL (112 caps / 28 days), NM, PA
TAZVERIK TABS 200mg	5	QL (240 tabs / 30 days), NM, LA, PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	5	NM, LA, PA
TEPMETKO TABS 225mg	5	QL (60 tabs / 30 days), NM, LA, PA
TIBSOVO TABS 250mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>torpenz</i> TABS 2.5mg, 5mg, 7.5mg, 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
TRAZIMERA SOLR 150mg, 420mg	5	NM, PA
TRUQAP TABS 160mg, 200mg	5	QL (64 tabs / 28 days), NM, LA, PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	5	NM, PA
TUKYSA TABS 50mg, 150mg	5	QL (120 tabs / 30 days), NM, LA, PA
TURALIO CAPS 125mg	5	QL (120 caps / 30 days), NM, LA, PA
VANFLYTA TABS 17.7mg, 26.5mg	5	QL (56 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 10mg	4	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 50mg	5	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 100mg	5	QL (180 tabs / 30 days), NM, LA, PA
VENCLEXTA TAB START PK	5	QL (42 tabs / 28 days), NM, LA, PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg	5	QL (56 tabs / 28 days), NM, LA, PA
VITRAKVI CAPS 25mg	5	QL (180 caps / 30 days), NM, LA, PA
VITRAKVI CAPS 100mg	5	QL (60 caps / 30 days), NM, LA, PA
VITRAKVI SOLN 20mg/ml	5	QL (300 mL / 30 days), NM, LA, PA
VIZIMPRO TABS 15mg, 30mg, 45mg	5	QL (30 tabs / 30 days), NM, LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
VONJO CAPS 100mg	5	QL (120 caps / 30 days), NM, LA, PA
XALKORI CAPS 200mg, 250mg; CPSP 50mg	5	QL (120 caps / 30 days), NM, LA, PA
XALKORI CPSP 20mg	5	QL (240 caps / 30 days), NM, LA, PA
XALKORI CPSP 150mg	5	QL (180 caps / 30 days), NM, LA, PA
XOSPATA TABS 40mg	5	QL (90 tabs / 30 days), NM, LA, PA
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg	5	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg	5	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg	5	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg	5	QL (24 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg	5	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg	5	QL (32 tabs / 28 days), NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg	5	QL (8 tabs / 28 days), NM, LA, PA
ZEJULA TABS 100mg, 200mg, 300mg	5	QL (30 tabs / 30 days), NM, LA, PA
ZELBORAF TABS 240mg	5	QL (240 tabs / 30 days), NM, LA, PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	5	NM, LA, PA
ZOLINZA CAPS 100mg	5	QL (120 caps / 30 days), NM, PA
ZYDELIG TABS 100mg, 150mg	5	QL (60 tabs / 30 days), NM, LA, PA
ZYKADIA TABS 150mg	5	QL (84 tabs / 28 days), NM, LA, PA

PROTECTIVE AGENTS

<i>leucovorin calcium</i> SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	2	B/D
<i>leucovorin calcium</i> TABS 5mg, 10mg, 15mg, 25mg	2	
MESNEX TABS 400mg	5	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
ACE INHIBITORS		
<i>benazepril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>captopril</i> TABS 12.5mg, 25mg, 50mg, 100mg	1	GC
<i>enalapril maleate</i> TABS 2.5mg, 5mg, 10mg, 20mg	1	GC
<i>fosinopril sodium</i> TABS 10mg, 20mg, 40mg	1	GC
<i>lisinopril</i> TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	GC
<i>moexipril hcl</i> TABS 7.5mg, 15mg	1	GC
<i>perindopril erbumine</i> TABS 2mg, 4mg, 8mg	1	GC
<i>quinapril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>ramipril</i> CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	GC
<i>trandolapril</i> TABS 1mg, 2mg, 4mg	1	GC
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i> TABS 25mg, 50mg	2	
KERENDIA TABS 10mg, 20mg	3	QL (30 tabs / 30 days)
<i>spironolactone</i> TABS 25mg, 50mg, 100mg	1	GC
ALPHA BLOCKERS		
<i>doxazosin mesylate</i> TABS 1mg, 2mg, 4mg, 8mg	1	GC
<i>prazosin hcl</i> CAPS 1mg, 2mg, 5mg	2	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	1	GC
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	GC, QL (30 tabs / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
ENTRESTO CAP 6-6MG	3	QL (240 caps / 30 days)
ENTRESTO CAP 15-16MG	3	QL (240 caps / 30 days)
ENTRESTO TAB 24-26MG	3	QL (60 tabs / 30 days)
ENTRESTO TAB 49-51MG	3	QL (60 tabs / 30 days)
ENTRESTO TAB 97-103MG	3	QL (60 tabs / 30 days)
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	GC, QL (60 tabs / 30 days)
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	GC
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	GC
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	GC
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	GC, QL (30 tabs / 30 days)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil TABS 4mg, 8mg, 16mg</i>	1	GC, QL (60 tabs / 30 days)

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

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

ANTIARRHYTHMICS

<i>amiodarone hcl</i> SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 400mg	2	
<i>amiodarone hcl</i> TABS 200mg	1	GC
<i>disopyramide phosphate</i> CAPS 100mg, 150mg	4	
<i>dofetilide</i> CAPS 125mcg, 250mcg, 500mcg	2	
<i>flecainide acetate</i> TABS 50mg, 100mg, 150mg	2	
MULTAQ TABS 400mg	4	
NORPACE CR CP12 100mg, 150mg	4	
<i>pacerone</i> TABS 100mg, 400mg	2	
<i>pacerone</i> TABS 200mg	1	GC
<i>propafenone hcl</i> CP12 225mg, 325mg, 425mg; TABS 150mg, 225mg, 300mg	2	
<i>quinidine sulfate</i> TABS 200mg, 300mg	2	
<i>sorine</i> TABS 80mg, 120mg, 160mg, 240mg	1	GC
<i>sotalol hcl</i> TABS 80mg, 120mg, 160mg, 240mg	1	GC
<i>sotalol hcl (afib/afl)</i> TABS 80mg, 120mg, 160mg	2	

ANTILIPEMICS, FIBRATES

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

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

Drug Name	Drug Tier	Requirements/Limits
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
<i>atorvastatin calcium</i> TABS 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
<i>lovastatin</i> TABS 10mg, 20mg, 40mg	1	GC, QL (60 tabs / 30 days)
<i>pravastatin sodium</i> TABS 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
<i>rosuvastatin calcium</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC, QL (30 tabs / 30 days)
<i>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
<i>cholestyramine</i> PACK 4gm; POWD 4gm/dose	2	
<i>cholestyramine light</i> PACK 4gm; POWD 4gm/dose	2	
<i>colesevelam hcl</i> PACK 3.75gm; TABS 625mg	2	
<i>colestipol hcl</i> GRAN 5gm; PACK 5gm; TABS 1gm	2	
<i>ezetimibe</i> TABS 10mg	2	
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	GC, QL (30 tabs / 30 days)
NEXLETOL TABS 180mg	3	QL (30 tabs / 30 days)
NEXLIZET TAB 180/10MG	3	QL (30 tabs / 30 days)
<i>niacin (antihyperlipidemic)</i> TBCR 500mg, 750mg, 1000mg	2	QL (60 tabs / 30 days)
<i>omega-3-acid ethyl esters cap 1 gm</i>	2	PA
<i>prevalite</i> PACK 4gm; POWD 4gm/dose	2	
REPATHA SOSY 140mg/ml	3	NM, PA
REPATHA PUSHTRONEX SYSTEM SOCT 420mg/3.5ml	3	NM, PA
REPATHA SURECLICK SOAJ 140mg/ml	3	NM, PA
VASCEPA CAPS .5gm, 1gm	3	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol & chlorthalidone tab 50-25 mg</i>	1	GC
<i>atenolol & chlorthalidone tab 100-25 mg</i>	1	GC

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

Drug Name	Drug Tier	Requirements/Limits
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	1	GC
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	1	GC
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	1	GC
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	2	
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	2	
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	2	

BETA-BLOCKERS

<i>acebutolol hcl CAPS 200mg, 400mg</i>	2	
<i>atenolol TABS 25mg, 50mg, 100mg</i>	1	GC
<i>bisoprolol fumarate TABS 5mg, 10mg</i>	1	GC
<i>carvedilol TABS 3.125mg, 6.25mg, 12.5mg, 25mg</i>	1	GC
<i>labetalol hcl TABS 100mg, 200mg, 300mg</i>	2	
<i>metoprolol succinate TB24 25mg, 50mg, 100mg, 200mg</i>	1	GC
<i>metoprolol tartrate SOLN 5mg/5ml</i>	2	
<i>metoprolol tartrate TABS 25mg, 50mg, 100mg</i>	1	GC
<i>nadolol TABS 20mg, 40mg, 80mg</i>	2	
<i>nebivolol hcl TABS 2.5mg, 5mg, 10mg</i>	2	QL (30 tabs / 30 days)
<i>nebivolol hcl TABS 20mg</i>	2	QL (60 tabs / 30 days)
<i>pindolol TABS 5mg, 10mg</i>	2	
<i>propranolol hcl CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml; TABS 10mg, 20mg, 40mg, 60mg, 80mg</i>	2	
<i>timolol maleate TABS 5mg, 10mg, 20mg</i>	2	

CALCIUM CHANNEL BLOCKERS

<i>amlodipine besylate TABS 2.5mg, 5mg, 10mg</i>	1	GC
<i>cartia xt CP24 120mg, 180mg, 240mg, 300mg</i>	2	
<i>dilt-xr CP24 120mg, 180mg, 240mg</i>	2	
<i>diltiazem hcl CP12 60mg, 90mg, 120mg; SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml</i>	2	
<i>diltiazem hcl TABS 30mg, 60mg, 90mg, 120mg</i>	1	GC

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

Drug Name	Drug Tier	Requirements/Limits
<i>diltiazem hcl coated beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg	2	
<i>diltiazem hcl extended release beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	2	
<i>nicardipine hcl</i> CAPS 20mg, 30mg	2	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	2	
<i>nimodipine</i> CAPS 30mg	2	
NYMALIZE SOLN 6mg/ml	5	
<i>tiadylt er</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
<i>verapamil hcl</i> CP24 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 360mg; SOLN 2.5mg/ml	2	
<i>verapamil hcl</i> TABS 40mg, 80mg, 120mg; TBCR 120mg, 180mg, 240mg	1	GC
DIURETICS		
<i>acetazolamide</i> CP12 500mg; TABS 125mg, 250mg	2	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	GC
<i>amiloride hcl</i> TABS 5mg	1	GC
<i>bumetanide</i> SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	2	
<i>chlorthalidone</i> TABS 25mg, 50mg	2	
<i>furosemide</i> SOLN 10mg/ml, 40mg/5ml; TABS 20mg, 40mg, 80mg	1	GC
<i>furosemide inj</i> SOLN 10mg/ml	2	
<i>hydrochlorothiazide</i> CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	GC
<i>indapamide</i> TABS 1.25mg, 2.5mg	1	GC
<i>methazolamide</i> TABS 25mg, 50mg	2	
<i>metolazone</i> TABS 2.5mg, 5mg, 10mg	2	
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	2	
<i>toremide</i> TABS 5mg, 10mg, 20mg, 100mg	1	GC
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	GC
<i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	1	GC
<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	1	GC

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

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
<i>aliskiren fumarate</i> TABS 150mg, 300mg	1	GC
<i>clonidine</i> PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	2	
<i>clonidine hcl</i> TABS .1mg, .2mg, .3mg	1	GC
CORLANOR SOLN 5mg/5ml	4	QL (450 mL / 30 days)
CORLANOR TABS 5mg, 7.5mg	4	QL (60 tabs / 30 days)
<i>digoxin</i> SOLN .05mg/ml, .25mg/ml	2	
<i>digoxin</i> TABS 125mcg, 250mcg	2	QL (30 tabs / 30 days)
<i>droxidopa</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA
<i>droxidopa</i> CAPS 200mg, 300mg	5	QL (180 caps / 30 days), NM, PA
<i>epinephrine (anaphylaxis)</i> SOLN 1mg/ml	2	
<i>guanfacine hcl</i> TABS 1mg, 2mg	3	PA; PA if 70 years and older
<i>hydralazine hcl</i> SOLN 20mg/ml; TABS 10mg, 25mg, 50mg, 100mg	2	
<i>ivabradine hcl</i> TABS 5mg, 7.5mg	2	QL (60 tabs / 30 days)
<i>metyrosine</i> CAPS 250mg	5	NM, PA
<i>midodrine hcl</i> TABS 2.5mg, 5mg, 10mg	2	
<i>minoxidil</i> TABS 2.5mg, 10mg	2	
<i>ranolazine</i> TB12 500mg, 1000mg	2	
VERQUVO TABS 2.5mg, 5mg, 10mg	3	QL (30 tabs / 30 days)
NITRATES		
<i>isosorbide dinitrate</i> TABS 5mg, 10mg, 20mg, 30mg	2	
<i>isosorbide mononitrate</i> TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg	1	GC
NITRO-BID OINT 2%	3	
<i>nitroglycerin</i> PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SUBL .3mg, .4mg, .6mg	2	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	5	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i> TABS 5mg, 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan</i> TABS 62.5mg, 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT TABS 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>sildenafil citrate (pulmonary hypertension)</i> TABS 20mg	2	QL (360 tabs / 30 days), NM, PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>treprostinil</i> SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	5	NM, LA, PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	5	NM, LA, PA

CENTRAL NERVOUS SYSTEM

ANTI-ANXIETY

<i>alprazolam</i> TABS .25mg, .5mg, 1mg, 2mg	2	QL (150 tabs / 30 days)
<i>bupirone hcl</i> TABS 5mg, 10mg, 15mg	1	GC
<i>bupirone hcl</i> TABS 7.5mg, 30mg	2	
<i>fluvoxamine maleate</i> TABS 25mg, 50mg, 100mg	2	
<i>lorazepam</i> CONC 2mg/ml	2	QL (150 mL / 30 days)
<i>lorazepam</i> SOLN 2mg/ml, 4mg/ml	2	
<i>lorazepam</i> TABS .5mg, 1mg, 2mg	2	QL (150 tabs / 30 days)
<i>lorazepam intensol</i> CONC 2mg/ml	2	QL (150 mL / 30 days)

ANTIDEMENTIA

<i>donepezil hydrochloride</i> TABS 5mg; TBP 5mg	1	GC, QL (30 tabs / 30 days)
<i>donepezil hydrochloride</i> TABS 10mg; TBP 10mg	1	GC
<i>galantamine hydrobromide</i> CP24 8mg, 16mg, 24mg	2	QL (30 caps / 30 days)
<i>galantamine hydrobromide</i> SOLN 4mg/ml	2	QL (200 mL / 30 days)
<i>galantamine hydrobromide</i> TABS 4mg, 8mg, 12mg	2	QL (60 tabs / 30 days)
<i>memantine hcl</i> CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml; TABS 5mg, 10mg	2	PA; PA applies if 29 years and younger
NAMZARIC CAP 7-10MG	4	
NAMZARIC CAP 14-10MG	4	
NAMZARIC CAP 21-10MG	4	
NAMZARIC CAP 28-10MG	4	
NAMZARIC CAP PACK	4	
<i>rivastigmine</i> PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	2	QL (30 patches / 30 days)
<i>rivastigmine tartrate</i> CAPS 1.5mg, 3mg, 4.5mg, 6mg	2	QL (60 caps / 30 days)

ANTIDEPRESSANTS

<i>amitriptyline hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	3	
<i>amoxapine</i> TABS 25mg, 50mg, 100mg, 150mg	3	
AUVELITY TAB 45-105MG	4	QL (60 tabs / 30 days), PA
<i>bupropion hcl</i> TABS 75mg, 100mg	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>bupropion hcl</i> TB12 100mg, 150mg, 200mg; TB24 150mg	2	QL (60 tabs / 30 days)
<i>bupropion hcl</i> TB24 300mg	2	QL (30 tabs / 30 days)
<i>citalopram hydrobromide</i> SOLN 10mg/5ml	2	
<i>citalopram hydrobromide</i> TABS 10mg, 20mg, 40mg	1	GC
<i>clomipramine hcl</i> CAPS 25mg, 50mg, 75mg	4	PA
<i>desipramine hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	4	
<i>desvenlafaxine succinate</i> TB24 25mg, 50mg, 100mg	2	QL (30 tabs / 30 days), PA
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	3	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg	4	QL (60 caps / 30 days), PA
<i>duloxetine hcl</i> CPEP 20mg, 30mg, 60mg	2	QL (60 caps / 30 days)
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr	5	QL (30 patches / 30 days), PA
<i>escitalopram oxalate</i> SOLN 5mg/5ml	2	
<i>escitalopram oxalate</i> TABS 5mg, 10mg, 20mg	1	GC
FETZIMA CP24 20mg, 40mg	4	QL (60 caps / 30 days), PA
FETZIMA CP24 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA CAP TITRATIO	4	QL (2 packs / year), PA
<i>fluoxetine hcl</i> CAPS 10mg, 20mg, 40mg	1	GC
<i>fluoxetine hcl</i> SOLN 20mg/5ml	2	
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	2	
MARPLAN TABS 10mg	4	QL (180 tabs / 30 days)
<i>mirtazapine</i> TABS 7.5mg; TBDP 15mg, 30mg, 45mg	2	
<i>mirtazapine</i> TABS 15mg, 30mg, 45mg	1	GC
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	2	
<i>nortriptyline hcl</i> CAPS 10mg, 25mg, 50mg, 75mg	2	
<i>nortriptyline hcl</i> SOLN 10mg/5ml	4	
<i>paroxetine hcl</i> SUSP 10mg/5ml	4	QL (900 mL / 30 days), PA
<i>paroxetine hcl</i> TABS 10mg, 20mg, 30mg, 40mg	2	
<i>phenelzine sulfate</i> TABS 15mg	2	
<i>protriptyline hcl</i> TABS 5mg, 10mg	4	

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

Drug Name	Drug Tier	Requirements/Limits
<i>sertraline hcl</i> CONC 20mg/ml	2	
<i>sertraline hcl</i> TABS 25mg, 50mg, 100mg	1	GC
<i>tranylcypromine sulfate</i> TABS 10mg	2	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	GC
<i>trimipramine maleate</i> CAPS 25mg, 50mg	4	QL (120 caps / 30 days)
<i>trimipramine maleate</i> CAPS 100mg	4	QL (60 caps / 30 days)
TRINTELLIX TABS 5mg, 10mg, 20mg	4	QL (30 tabs / 30 days)
<i>venlafaxine hcl</i> CP24 37.5mg, 75mg, 150mg	1	GC
<i>venlafaxine hcl</i> TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	2	
<i>vilazodone hcl</i> TABS 10mg, 20mg, 40mg	2	QL (30 tabs / 30 days)
ZURZUVAE CAPS 20mg, 25mg	5	QL (28 caps / 14 days), LA, PA
ZURZUVAE CAPS 30mg	5	QL (14 caps / 14 days), LA, PA

ANTIPARKINSONIAN AGENTS

<i>amantadine hcl</i> CAPS 100mg	2	QL (120 caps / 30 days)
<i>amantadine hcl</i> SOLN 50mg/5ml; TABS 100mg	2	
<i>benztropine mesylate</i> SOLN 1mg/ml	2	
<i>benztropine mesylate</i> TABS .5mg, 1mg, 2mg	2	PA; PA if 70 years and older
<i>bromocriptine mesylate</i> CAPS 5mg; TABS 2.5mg	2	
<i>carb/levo orally disintegrating tab 10-100mg</i>	2	
<i>carb/levo orally disintegrating tab 25-100mg</i>	2	
<i>carb/levo orally disintegrating tab 25-250mg</i>	2	
<i>carbidopa & levodopa tab 10-100 mg</i>	2	
<i>carbidopa & levodopa tab 25-100 mg</i>	2	
<i>carbidopa & levodopa tab 25-250 mg</i>	2	
<i>carbidopa & levodopa tab er 25-100 mg</i>	2	
<i>carbidopa & levodopa tab er 50-200 mg</i>	2	
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	2	
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	2	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	2	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	2	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	2	
<i>entacapone TABS 200mg</i>	2	
INBRIJA CAPS 42mg	5	QL (300 caps / 30 days), NM, LA, PA
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	4	
<i>pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg</i>	1	GC
<i>rasagiline mesylate TABS .5mg, 1mg</i>	2	QL (30 tabs / 30 days)
<i>ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg</i>	1	GC
<i>selegiline hcl CAPS 5mg; TABS 5mg</i>	2	
<i>trihexyphenidyl hcl SOLN .4mg/ml</i>	3	PA; PA if 70 years and older
<i>trihexyphenidyl hcl TABS 2mg, 5mg</i>	2	PA; PA if 70 years and older

ANTIPSYCHOTICS

ABILIFY MAINTENA PRSY 300mg, 400mg	5	QL (1 syringe / 28 days)
ABILIFY MAINTENA SRER 300mg, 400mg	5	QL (1 injection / 28 days)
<i>aripiprazole SOLN 1mg/ml</i>	2	QL (900 mL / 30 days)
<i>aripiprazole TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg</i>	2	QL (30 tabs / 30 days)
<i>aripiprazole TBDP 10mg, 15mg</i>	2	QL (60 tabs / 30 days)
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	5	QL (1 syringe / 28 days)
ARISTADA PRSY 1064mg/3.9ml	5	QL (1 syringe / 56 days)
ARISTADA INITIO PRSY 675mg/2.4ml	5	
<i>asenapine maleate SUBL 2.5mg, 5mg, 10mg</i>	2	QL (60 tabs / 30 days)
CAPLYTA CAPS 10.5mg, 21mg, 42mg	5	QL (30 caps / 30 days)
<i>chlorpromazine hcl CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg</i>	2	
<i>clozapine TABS 25mg, 50mg</i>	2	
<i>clozapine TABS 100mg</i>	2	QL (270 tabs / 30 days)
<i>clozapine TABS 200mg</i>	2	QL (120 tabs / 30 days)
<i>clozapine TBDP 12.5mg, 25mg</i>	2	PA
<i>clozapine TBDP 100mg</i>	2	QL (270 tabs / 30 days), PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>clozapine</i> TBDP 150mg	2	QL (180 tabs / 30 days), PA
<i>clozapine</i> TBDP 200mg	5	QL (120 tabs / 30 days), PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg	5	QL (60 tabs / 30 days), PA
FANAPT PAK	4	QL (2 packs / year), PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	2	
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	2	
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	2	
<i>haloperidol decanoate</i> SOLN 50mg/ml, 100mg/ml	2	
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	2	
INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml	5	QL (1 injection / 180 days)
INVEGA SUSTENNA SUSY 39mg/0.25ml	4	QL (1 syringe / 28 days)
INVEGA SUSTENNA SUSY 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml	5	QL (1 syringe / 28 days)
INVEGA TRINZA SUSY 273mg/0.88ml, 410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml	5	QL (1 syringe / 90 days)
<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	2	
<i>lurasidone hcl</i> TABS 20mg, 40mg, 60mg, 120mg	2	QL (30 tabs / 30 days)
<i>lurasidone hcl</i> TABS 80mg	2	QL (60 tabs / 30 days)
<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	2	
NUPLAZID CAPS 34mg	5	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>olanzapine</i> SOLR 10mg	2	QL (3 vials / 1 day)
<i>olanzapine</i> TABS 2.5mg, 5mg, 10mg; TBDP 10mg	2	QL (60 tabs / 30 days)
<i>olanzapine</i> TABS 7.5mg, 15mg, 20mg; TBDP 5mg, 15mg, 20mg	2	QL (30 tabs / 30 days)
<i>paliperidone</i> TB24 1.5mg, 3mg, 9mg	2	QL (30 tabs / 30 days)
<i>paliperidone</i> TB24 6mg	2	QL (60 tabs / 30 days)
<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	2	
PERSERIS PRSY 90mg, 120mg	5	QL (1 syringe / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>pimozide</i> TABS 1mg, 2mg	2	
<i>quetiapine fumarate</i> TABS 25mg	2	QL (180 tabs / 30 days)
<i>quetiapine fumarate</i> TABS 50mg, 100mg, 150mg, 200mg	2	QL (90 tabs / 30 days)
<i>quetiapine fumarate</i> TABS 300mg, 400mg	2	QL (60 tabs / 30 days)
<i>quetiapine fumarate</i> TB24 50mg, 300mg, 400mg	2	QL (60 tabs / 30 days), PA
<i>quetiapine fumarate</i> TB24 150mg, 200mg	2	QL (30 tabs / 30 days), PA
REXULTI TABS 3mg, 4mg	5	QL (30 tabs / 30 days)
REXULTI TABS .25mg, .5mg, 1mg, 2mg	5	QL (60 tabs / 30 days)
<i>risperidone</i> SOLN 1mg/ml	2	QL (240 mL / 30 days)
<i>risperidone</i> TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	1	GC
<i>risperidone</i> TBDP 1mg, 2mg, 3mg	2	QL (60 tabs / 30 days)
<i>risperidone</i> TBDP 4mg	2	QL (120 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, .5mg	2	QL (90 tabs / 30 days)
<i>risperidone microspheres</i> SRER 12.5mg, 25mg	2	QL (2 injections / 28 days)
<i>risperidone microspheres</i> SRER 37.5mg, 50mg	5	QL (2 injections / 28 days)
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr	5	QL (30 patches / 30 days)
<i>thioridazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	2	
<i>thiothixene</i> CAPS 1mg, 2mg, 5mg, 10mg	2	
<i>trifluoperazine hcl</i> TABS 1mg, 2mg, 5mg, 10mg	2	
VERSACLOZ SUSP 50mg/ml	5	QL (600 mL / 30 days), PA
VRAYLAR CAPS 1.5mg	5	QL (60 caps / 30 days)
VRAYLAR CAPS 3mg, 4.5mg, 6mg	5	QL (30 caps / 30 days)
VRAYLAR CAP 1.5-3MG	4	QL (2 packs / year)
<i>ziprasidone hcl</i> CAPS 20mg, 40mg, 60mg, 80mg	2	QL (60 caps / 30 days)
<i>ziprasidone mesylate</i> SOLR 20mg	2	QL (6 injections / 3 days)
ZYPREXA RELPREVV SUSR 210mg, 300mg	5	QL (2 vials / 28 days), NM, PA
ZYPREXA RELPREVV SUSR 405mg	5	QL (1 vial / 28 days), NM, PA
ANTISEIZURE AGENTS		
APTIOM TABS 200mg, 400mg	5	QL (30 tabs / 30 days)
APTIOM TABS 600mg, 800mg	5	QL (60 tabs / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
BRIVIACT SOLN 10mg/ml	5	QL (600 mL / 30 days), PA
BRIVIACT SOLN 50mg/5ml	4	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg	5	QL (60 tabs / 30 days), PA
<i>carbamazepine</i> CHEW 100mg; CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TABS 200mg; TB12 100mg, 200mg, 400mg	2	
<i>clobazam</i> SUSP 2.5mg/ml	2	QL (480 mL / 30 days), PA
<i>clobazam</i> TABS 10mg, 20mg	2	QL (60 tabs / 30 days), PA
<i>clonazepam</i> TABS 2mg; TBDP 2mg	2	QL (300 tabs / 30 days)
<i>clonazepam</i> TABS .5mg, 1mg; TBDP .125mg, .25mg, .5mg, 1mg	2	QL (90 tabs / 30 days)
<i>clorazepate dipotassium</i> TABS 3.75mg, 7.5mg, 15mg	2	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIACOMIT CAPS 250mg	5	QL (360 caps / 30 days), NM, LA, PA
DIACOMIT CAPS 500mg	5	QL (180 caps / 30 days), NM, LA, PA
DIACOMIT PACK 250mg	5	QL (360 packets / 30 days), NM, LA, PA
DIACOMIT PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
<i>diazepam</i> SOLN 5mg/5ml	2	QL (1200 mL / 30 days), PA; PA applies if 65 years and older after a 5 day supply in a calendar year
<i>diazepam</i> TABS 2mg, 5mg, 10mg	2	QL (120 tabs / 30 days), PA; PA applies if 65 years and older after a 5 day supply in a calendar year
<i>diazepam (anticonvulsant)</i> GEL 2.5mg, 10mg, 20mg	2	
<i>diazepam inj</i> SOLN 5mg/ml	2	
<i>diazepam intensol</i> CONC 5mg/ml	2	QL (240 mL / 30 days), PA; PA applies if 65 years and older after a 5 day supply in a calendar year

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

Drug Name	Drug Tier	Requirements/Limits
DILANTIN CAPS 30mg, 100mg	4	
DILANTIN INFATABS CHEW 50mg	4	
DILANTIN-125 SUSP 125mg/5ml	4	
<i>divalproex sodium</i> CSDR 125mg; TB24 250mg, 500mg; TBEC 125mg, 250mg, 500mg	2	
EPIDIOLEX SOLN 100mg/ml	5	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i> TABS 200mg	2	
EPRONTIA SOLN 25mg/ml	4	QL (480 mL / 30 days), PA
<i>ethosuximide</i> CAPS 250mg; SOLN 250mg/5ml	2	
<i>felbamate</i> SUSP 600mg/5ml	5	
<i>felbamate</i> TABS 400mg, 600mg	2	
FINTEPLA SOLN 2.2mg/ml	5	QL (360 mL / 30 days), NM, LA, PA
FYCOMPA SUSP .5mg/ml	5	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg	5	QL (30 tabs / 30 days), PA
<i>gabapentin</i> CAPS 100mg, 300mg, 400mg	1	GC, QL (180 caps / 30 days)
<i>gabapentin</i> SOLN 250mg/5ml, 300mg/6ml	2	QL (2160 mL / 30 days)
<i>gabapentin</i> TABS 600mg	2	QL (180 tabs / 30 days)
<i>gabapentin</i> TABS 800mg	2	QL (120 tabs / 30 days)
<i>lacosamide</i> SOLN 200mg/20ml	2	
<i>lacosamide</i> TABS 50mg	2	QL (120 tabs / 30 days)
<i>lacosamide</i> TABS 100mg, 150mg, 200mg	2	QL (60 tabs / 30 days)
<i>lacosamide oral</i> SOLN 10mg/ml	2	QL (1200 mL / 30 days)
<i>lamotrigine</i> CHEW 5mg, 25mg; TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	2	
<i>lamotrigine</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
<i>levetiracetam</i> SOLN 100mg/ml, 500mg/5ml; TABS 250mg, 500mg, 750mg, 1000mg; TB24 500mg, 750mg	2	
<i>levetiracetam in sodium chloride iv soln</i> 500 mg/100ml	2	
<i>levetiracetam in sodium chloride iv soln</i> 1000 mg/100ml	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>levetiracetam in sodium chloride iv soln</i> <i>1500 mg/100ml</i>	2	
LIBERVANT FILM 5mg, 7.5mg, 10mg, 12.5mg, 15mg	4	
<i>methsuximide</i> CAPS 300mg	2	
NAYZILAM SOLN 5mg/0.1ml	4	
<i>oxcarbazepine</i> SUSP 300mg/5ml; TABS 150mg, 300mg, 600mg	2	
<i>phenobarbital</i> ELIX 20mg/5ml	4	QL (1500 mL / 30 days), PA; PA if 70 years and older
<i>phenobarbital</i> TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	3	QL (120 tabs / 30 days), PA; PA if 70 years and older
<i>phenobarbital sodium</i> SOLN 65mg/ml, 130mg/ml	4	PA; PA if 70 years and older
<i>phenytek</i> CAPS 200mg, 300mg	2	
<i>phenytoin</i> CHEW 50mg; SUSP 125mg/5ml	2	
<i>phenytoin sodium</i> SOLN 50mg/ml	2	
<i>phenytoin sodium extended</i> CAPS 100mg, 200mg, 300mg	2	
<i>pregabalin</i> CAPS 25mg, 50mg, 75mg, 100mg, 150mg	2	QL (120 caps / 30 days), PA
<i>pregabalin</i> CAPS 200mg	2	QL (90 caps / 30 days), PA
<i>pregabalin</i> CAPS 225mg, 300mg	2	QL (60 caps / 30 days), PA
<i>pregabalin</i> SOLN 20mg/ml	2	QL (900 mL / 30 days), PA
<i>primidone</i> TABS 50mg, 125mg, 250mg	1	GC
<i>rowepra</i> TABS 500mg	2	
<i>rufinamide</i> SUSP 40mg/ml	5	QL (2400 mL / 30 days), PA
<i>rufinamide</i> TABS 200mg	2	QL (480 tabs / 30 days), PA
<i>rufinamide</i> TABS 400mg	5	QL (240 tabs / 30 days), PA
SPRITAM TB3D 250mg	4	QL (360 tabs / 30 days)
SPRITAM TB3D 500mg	4	QL (180 tabs / 30 days)
SPRITAM TB3D 750mg	4	QL (120 tabs / 30 days)
SPRITAM TB3D 1000mg	4	QL (90 tabs / 30 days)
<i>subvenite</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
SYMPAZAN FILM 5mg, 10mg, 20mg	5	QL (60 films / 30 days), PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>tiagabine hcl</i> TABS 2mg, 4mg, 12mg, 16mg	2	
<i>topiramate</i> CPSP 15mg, 25mg	2	
<i>topiramate</i> TABS 25mg, 50mg, 100mg, 200mg	1	GC
<i>valproate sodium</i> SOLN 100mg/ml, 250mg/5ml	2	
<i>valproic acid</i> CAPS 250mg	2	
VALTOCO 5 MG DOSE LIQD 5mg/0.1ml	4	
VALTOCO 10 MG DOSE LIQD 10mg/0.1ml	4	
VALTOCO 15 MG DOSE LQPK 7.5mg/0.1ml	4	
VALTOCO 20 MG DOSE LQPK 10mg/0.1ml	4	
<i>vigabatrin</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
<i>vigabatrin</i> TABS 500mg	5	QL (180 tabs / 30 days), NM, LA, PA
<i>vigadrone</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
<i>vigadrone</i> TABS 500mg	5	QL (180 tabs / 30 days), NM, LA, PA
VIGAFYDE SOLN 100mg/ml	5	QL (900 mL / 30 days), NM, LA, PA
<i>vigpoder</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
XCOPRI TABS 25mg, 50mg, 100mg	5	QL (30 tabs / 30 days)
XCOPRI TABS 150mg, 200mg	5	QL (60 tabs / 30 days)
XCOPRI PAK 12.5-25	4	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	5	QL (28 tabs / 28 days)
XCOPRI PAK 100-150	5	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (MAINTENANCE)	5	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (TITRATION)	5	QL (28 tabs / 28 days)
ZONISADE SUSP 100mg/5ml	5	QL (900 mL / 30 days), PA
<i>zonisamide</i> CAPS 25mg, 50mg, 100mg	2	
ZTALMY SUSP 50mg/ml	5	QL (1100 mL / 30 days), NM, LA, PA

ATTENTION DEFICIT HYPERACTIVITY DISORDER

<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	2	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	2	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	2	QL (30 caps / 30 days), PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	2	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	2	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	2	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine tab 5 mg</i>	2	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	2	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 10 mg</i>	2	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	2	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 15 mg</i>	2	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 20 mg</i>	2	QL (90 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 30 mg</i>	2	QL (60 tabs / 30 days), PA
<i>atomoxetine hcl CAPS 10mg, 18mg, 25mg</i>	2	QL (120 caps / 30 days)
<i>atomoxetine hcl CAPS 40mg</i>	2	QL (60 caps / 30 days)
<i>atomoxetine hcl CAPS 60mg, 80mg, 100mg</i>	2	QL (30 caps / 30 days)
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i>	2	QL (120 tabs / 30 days), PA
<i>dexmethylphenidate hcl TABS 10mg</i>	2	QL (60 tabs / 30 days), PA
<i>guanfacine hcl (adhd) TB24 1mg, 2mg, 4mg</i>	3	QL (30 tabs / 30 days), PA; PA if 70 years and older
<i>guanfacine hcl (adhd) TB24 3mg</i>	3	QL (60 tabs / 30 days), PA; PA if 70 years and older
<i>methylphenidate hcl SOLN 5mg/5ml</i>	2	QL (1800 mL / 30 days), PA
<i>methylphenidate hcl SOLN 10mg/5ml</i>	2	QL (900 mL / 30 days), PA
<i>methylphenidate hcl TABS 5mg, 10mg</i>	2	QL (180 tabs / 30 days), PA
<i>methylphenidate hcl TABS 20mg; TBCR 10mg, 20mg</i>	2	QL (90 tabs / 30 days), PA
HYPNOTICS		
<i>DAYVIGO TABS 5mg, 10mg</i>	3	QL (30 tabs / 30 days)
<i>doxepin hcl (sleep) TABS 3mg, 6mg</i>	2	QL (30 tabs / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>tasimelteon</i> CAPS 20mg	5	QL (30 caps / 30 days), NM, PA
<i>temazepam</i> CAPS 7.5mg, 30mg	2	QL (30 caps / 30 days), PA; PA if 65 years and older
<i>temazepam</i> CAPS 15mg	2	QL (60 caps / 30 days), PA; PA if 65 years and older
<i>zolpidem tartrate</i> TABS 5mg, 10mg	2	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year

MIGRAINE

AIMOVIG SOAJ 70mg/ml, 140mg/ml	3	QL (1 pen / 30 days), NM, PA
<i>dihydroergotamine mesylate</i> SOLN 1mg/ml	5	
<i>dihydroergotamine mesylate</i> SOLN 4mg/ml	5	QL (8 mL / 30 days), PA
<i>ergotamine w/ caffeine tab 1-100 mg</i>	2	QL (40 tabs / 28 days), PA
<i>naratriptan hcl</i> TABS 1mg, 2.5mg	2	QL (12 tabs / 30 days)
NURTEC TBDP 75mg	3	QL (16 tabs / 30 days), PA
QULIPTA TABS 10mg, 30mg, 60mg	3	QL (30 tabs / 30 days), PA
<i>rizatriptan benzoate</i> TABS 5mg, 10mg; TBDP 5mg, 10mg	2	QL (18 tabs / 30 days)
<i>sumatriptan</i> SOLN 5mg/act	2	QL (24 units / 30 days)
<i>sumatriptan</i> SOLN 20mg/act	2	QL (12 units / 30 days)
<i>sumatriptan succinate</i> SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml	2	QL (18 injections / 30 days)
<i>sumatriptan succinate</i> SOAJ 6mg/0.5ml; SOCT 6mg/0.5ml; SOLN 6mg/0.5ml	2	QL (12 injections / 30 days)
<i>sumatriptan succinate</i> TABS 25mg, 50mg, 100mg	2	QL (12 tabs / 30 days)
UBRELVY TABS 50mg, 100mg	3	QL (16 tabs / 30 days), PA

MISCELLANEOUS

AUSTEDO TABS 6mg	5	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO TABS 9mg, 12mg	5	QL (120 tabs / 30 days), NM, LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR TB24 6mg	5	QL (90 tabs / 30 days), NM, PA
AUSTEDO XR TB24 12mg	5	QL (120 tabs / 30 days), NM, PA
AUSTEDO XR TB24 18mg, 24mg	5	QL (60 tabs / 30 days), NM, PA
AUSTEDO XR TB24 30mg, 36mg, 42mg, 48mg	5	QL (30 tabs / 30 days), NM, PA
AUSTEDO XR TAB TITR KIT	5	QL (2 packs / year), NM, PA
<i>lithium</i> SOLN 8meq/5ml	2	
<i>lithium carbonate</i> CAPS 150mg, 300mg, 600mg; TABS 300mg	1	GC
<i>lithium carbonate</i> TBCR 300mg, 450mg	2	
NUDEXTA CAP 20-10MG	4	QL (60 caps / 30 days), PA
<i>pyridostigmine bromide</i> TABS 60mg	2	
<i>riluzole</i> TABS 50mg	2	
<i>tetrabenazine</i> TABS 12.5mg	5	QL (90 tabs / 30 days), NM, PA
<i>tetrabenazine</i> TABS 25mg	5	QL (120 tabs / 30 days), NM, PA

MULTIPLE SCLEROSIS AGENTS

BAFIERTAM CPDR 95mg	5	QL (120 caps / 30 days), NM, LA, PA
BETASERON KIT .3mg	5	QL (14 syringes / 28 days), NM, PA
<i>dalfampridine</i> TB12 10mg	2	QL (60 tabs / 30 days), NM, PA
<i> fingolimod hcl</i> CAPS .5mg	5	QL (30 caps / 30 days), NM, PA
<i>glatiramer acetate</i> SOSY 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatiramer acetate</i> SOSY 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
<i>glatopa</i> SOSY 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatopa</i> SOSY 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
KESIMPTA SOAJ 20mg/0.4ml	5	QL (16 pens / year), NM, LA, PA

MUSCULOSKELETAL THERAPY AGENTS

<i>baclofen</i> TABS 5mg	2	QL (90 tabs / 30 days)
<i>baclofen</i> TABS 10mg, 20mg	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	3	QL (90 tabs / 30 days), PA; PA applies if 70 years and older after a 30 day supply in a calendar year
<i>dantrolene sodium</i> CAPS 25mg, 50mg, 100mg	2	
<i>tizanidine hcl</i> TABS 2mg, 4mg	2	
NARCOLEPSY/CATAPLEXY		
<i>armodafinil</i> TABS 50mg	2	QL (60 tabs / 30 days), PA
<i>armodafinil</i> TABS 150mg, 200mg, 250mg	2	QL (30 tabs / 30 days), PA
<i>modafinil</i> TABS 100mg	2	QL (30 tabs / 30 days), PA
<i>modafinil</i> TABS 200mg	2	QL (60 tabs / 30 days), PA
SODIUM OXYBATE SOLN 500mg/ml	5	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium</i> TBEC 333mg	2	
<i>buprenorphine hcl</i> SUBL 2mg, 8mg	2	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	2	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	2	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	2	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	2	QL (60 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	2	QL (90 tabs / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	2	QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent)</i> TB12 150mg	2	QL (60 tabs / 30 days)
<i>disulfiram</i> TABS 250mg, 500mg	2	
<i>naloxone hcl</i> LIQD 4mg/0.1ml; SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY .4mg/ml, 2mg/2ml	2	
<i>naltrexone hcl</i> TABS 50mg	2	
NICOTROL INHALER INHA 10mg	4	
NICOTROL NS SOLN 10mg/ml	4	

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

Drug Name	Drug Tier	Requirements/Limits
<i>varenicline tartrate</i> TABS .5mg, 1mg	2	QL (56 tabs / 28 days), PA
<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	2	QL (2 packs / year), PA
VIVITROL SUSR 380mg	5	NM

DIABETIC SUPPLIES

BLOOD GLUCOSE MONITORING KIT

ACCU-CHEK KIT AVIVA PL	PART B
ACCU-CHEK KIT COMPACT	PART B
ACCU-CHEK KIT GUIDE	PART B
ACCU-CHEK KIT GUIDE ME	PART B
ACCU-CHEK KIT NANO	PART B
ONETOUCH KIT ULT MINI	PART B
ONETOUCH KIT ULTRA 2	PART B
ONETOUCH KIT VERIO	PART B
ONETOUCH KIT VERIO FL	PART B
ONETOUCH KIT VERIO IQ	PART B
ONETOUCH KIT VERIO RE	PART B

CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR

DEXCOM G5 MIS RECEIVER	PART B	PA
DEXCOM G5 MIS TRANSMIT	PART B	PA
DEXCOM G6 MIS RECEIVER	PART B	PA
DEXCOM G6 MIS SENSOR	PART B	PA
DEXCOM G6 MIS TRANSMIT	PART B	PA
DEXCOM G7 MIS RECEIVER	PART B	PA
DEXCOM G7 MIS SENSOR	PART B	PA

GLUCOSE BLOOD TEST

ACCU-CHEK TES AVIVA PL	PART B
ACCU-CHEK TES COMPACT	PART B
ACCU-CHEK TES GUIDE	PART B
ACCU-CHEK TES SMART	PART B
ONETOUCH TES ULT BLUE	PART B
ONETOUCH TES ULTRA	PART B
ONETOUCH TES VERIO	PART B

ENDOCRINE AND METABOLIC

ANDROGENS

<i>depo-testosterone</i> SOLN 100mg/ml, 200mg/ml	2	PA
<i>methyltestosterone</i> CAPS 10mg	5	QL (600 caps / 30 days), PA
<i>testosterone</i> GEL 1%, 25mg/2.5gm, 50mg/5gm	2	QL (300 gm / 30 days), PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>testosterone</i> GEL 1.62%	2	QL (150 gm / 30 days), PA
<i>testosterone cypionate</i> SOLN 100mg/ml, 200mg/ml	2	PA
<i>testosterone enanthate</i> SOLN 200mg/ml	2	PA

ANTIDIABETICS

<i>acarbose</i> TABS 25mg, 50mg, 100mg	2	
BYDUREON BCISE AUIJ 2mg/0.85ml	3	QL (4 pens / 28 days), PA
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml	4	QL (1 pen / 30 days), PA
FARXIGA TABS 5mg, 10mg	3	GC, QL (30 tabs / 30 days)
<i>glimepiride</i> TABS 1mg, 2mg	1	GC, QL (90 tabs / 30 days)
<i>glimepiride</i> TABS 4mg	1	GC, QL (60 tabs / 30 days)
<i>glipizide</i> TABS 5mg	1	GC, QL (240 tabs / 30 days)
<i>glipizide</i> TABS 10mg	1	GC, QL (120 tabs / 30 days)
<i>glipizide</i> TB24 2.5mg, 5mg	1	GC, QL (90 tabs / 30 days)
<i>glipizide</i> TB24 10mg	1	GC, QL (60 tabs / 30 days)
<i>glipizide xl</i> TB24 2.5mg, 5mg	1	GC, QL (90 tabs / 30 days)
<i>glipizide xl</i> TB24 10mg	1	GC, QL (60 tabs / 30 days)
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	GC, QL (120 tabs / 30 days)
GLYXAMBI TAB 10-5 MG	3	GC, QL (30 tabs / 30 days)
GLYXAMBI TAB 25-5 MG	3	GC, QL (30 tabs / 30 days)
JANUMET TAB 50-500MG	3	GC, QL (60 tabs / 30 days)
JANUMET TAB 50-1000	3	GC, QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	GC, QL (60 tabs / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
JANUMET XR TAB 50-1000	3	GC, QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	GC, QL (30 tabs / 30 days)
JANUVIA TABS 25mg, 50mg, 100mg	3	GC, QL (30 tabs / 30 days)
JARDIANCE TABS 10mg, 25mg	3	GC, QL (30 tabs / 30 days)
JENTADUETO TAB 2.5-500	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-850	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-1000	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000MG	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000MG	3	GC, QL (30 tabs / 30 days)
<i>metformin hcl</i> TABS 500mg	1	GC, QL (150 tabs / 30 days)
<i>metformin hcl</i> TABS 850mg	1	GC, QL (90 tabs / 30 days)
<i>metformin hcl</i> TABS 1000mg	1	GC, QL (75 tabs / 30 days)
<i>metformin hcl</i> TB24 500mg	1	GC, QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl</i> TB24 750mg	1	GC, QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
MOUNJARO SOAJ 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml	3	QL (4 pens / 28 days), PA
<i>nateglinide</i> TABS 60mg, 120mg	1	GC, QL (90 tabs / 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOPN 2mg/1.5ml	3	QL (1 pen / 28 days), PA
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/3ml	3	QL (1 pen / 28 days), PA
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml	3	QL (1 pen / 28 days), PA
OZEMPIC (2MG/DOSE) SOPN 8mg/3ml	3	QL (1 pen / 28 days), PA
<i>pioglitazone hcl</i> TABS 15mg, 30mg, 45mg	1	GC, QL (30 tabs / 30 days)
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	1	GC, QL (90 tabs / 30 days)

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

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

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

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR TAB 10-1000	3	GC, QL (30 tabs / 30 days)

ANTIDIABETICS, INSULINS

ADMELOG SOLN 100unit/ml	3	
ADMELOG SOLOSTAR SOPN 100unit/ml	3	
BASAGLAR KWIKPEN SOPN 100unit/ml	3	
BD ALCOHOL SWABS	3	
FIASP SOLN 100unit/ml	3	
FIASP FLEXTOUCH SOPN 100unit/ml	3	
FIASP PENFILL SOCT 100unit/ml	3	
FIASP PUMPCART SOCT 100unit/ml	3	B/D
GAUZE PADS 2" X 2"	3	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	5	B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	5	
INSULIN PEN NEEDLES: BD/NOVO	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGES: BD	3	
LANTUS SOLN 100unit/ml	3	
LANTUS SOLOSTAR SOPN 100unit/ml	3	
NOVOLIN INJ 70/30	3	(brand RELION not covered)
NOVOLIN INJ 70/30 FP	3	(brand RELION not covered)
NOVOLIN N SUSP 100unit/ml	3	(brand RELION not covered)
NOVOLIN N FLEXPEN SUPN 100unit/ml	3	(brand RELION not covered)
NOVOLIN R SOLN 100unit/ml	3	(brand RELION not covered)
NOVOLIN R FLEXPEN SOPN 100unit/ml	3	(brand RELION not covered)
NOVOLOG SOLN 100unit/ml	3	(brand RELION not covered)
NOVOLOG FLEXPEN SOPN 100unit/ml	3	(brand RELION not covered)
NOVOLOG MIX INJ 70/30	3	(brand RELION not covered)
NOVOLOG MIX INJ FLEXPEN	3	(brand RELION not covered)
NOVOLOG PENFILL SOCT 100unit/ml	3	(brand RELION not covered)
OMNIPOD 5 DX KIT INT G7G6	4	QL (1 kit / year), PA

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

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD 5 DX MIS POD G7G6	4	QL (15 pods / 30 days), PA
OMNIPOD 5 G7 KIT INTRO	4	QL (1 kit / year), PA
OMNIPOD 5 G7 MIS PODS	4	QL (15 pods / 30 days), PA
OMNIPOD DASH KIT INTRO	4	QL (1 kit / year), PA
OMNIPOD DASH MIS PODS	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 10UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 15UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 20UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 25UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 30UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 35UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD GO KIT 40UNT/DY	4	QL (15 pods / 30 days), PA
OMNIPOD MIS CLASSIC	4	QL (15 pods / 30 days), PA
SOLIQUA INJ 100/33	3	QL (5 pens / 25 days)
TOUJEO MAX SOLOSTAR SOPN 300unit/ml	3	
TOUJEO SOLOSTAR SOPN 300unit/ml	3	
TRESIBA SOLN 100unit/ml	3	
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	3	
V-GO 20 KIT	4	QL (30 devices / 30 days), PA
V-GO 30 KIT	4	QL (30 devices / 30 days), PA
V-GO 40 KIT	4	QL (30 devices / 30 days), PA
XULTOPHY INJ 100/3.6	3	QL (5 pens / 30 days)
CALCIUM REGULATORS		
<i>alendronate sodium</i> TABS 10mg, 35mg, 70mg	1	GC
<i>calcitonin (salmon) spray</i> SOLN 200unit/act	2	B/D
<i>ibandronate sodium</i> TABS 150mg	2	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	5	LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
PAMIDRONATE DISODIUM SOLN 6mg/ml	3	B/D
<i>pamidronate disodium</i> SOLN 30mg/10ml, 90mg/10ml	2	B/D
PROLIA SOSY 60mg/ml	4	QL (1 syringe / 180 days), NM
TERIPARATIDE SOPN 620mcg/2.48ml	5	NM, PA
XGEVA SOLN 120mg/1.7ml	5	NM, PA
<i>zoledronic acid</i> CONC 4mg/5ml; SOLN 5mg/100ml	2	B/D, NM

CHELATING AGENTS

CHEMET CAPS 100mg	5	
<i>deferasirox</i> PACK 90mg, 180mg, 360mg; TABS 180mg, 360mg	5	NM, PA
<i>deferasirox</i> TABS 90mg	2	NM, PA
<i>kionex</i> SUSP 15gm/60ml	2	
LOKELMA PACK 5gm, 10gm	3	
<i>penicillamine</i> TABS 250mg	5	NM
<i>sodium polystyrene sulfonate powder</i>	2	
<i>sps</i> SUSP 15gm/60ml	2	
<i>trientine hcl</i> CAPS 250mg	5	NM, PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	3	

CONTRACEPTIVES

<i>afirmelle</i>	2	
<i>altavera</i>	2	
<i>alyacen 1/35</i>	2	
<i>alyacen 7/7/7</i>	2	
<i>apri</i>	2	
<i>aranelle</i>	2	
<i>aubra eq</i>	2	
<i>aurovela 1/20</i>	2	
<i>aurovela fe 1.5/30</i>	2	
<i>aurovela fe 1/20</i>	2	
<i>aviane</i>	2	
<i>ayuna</i>	2	
<i>azurette</i>	2	
<i>balziva</i>	2	
<i>blisovi fe 1.5/30</i>	2	
<i>briellyn</i>	2	
<i>camila</i> TABS .35mg	2	
<i>chateal eq</i>	2	
<i>cryselle-28</i>	2	
<i>cyred eq</i>	2	
<i>dasetta 1/35</i>	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>dasetta 7/7/7</i>	2	
<i>deblitane TABS .35mg</i>	2	
DEPO-SUBQ PROVERA 104 SUSY 104mg/0.65ml	4	
<i>desogest-eth estrad & eth estrad tab 0.15- 0.02/0.01 mg(21/5)</i>	2	
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	2	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	2	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	2	
<i>elinest</i>	2	
<i>eluryng</i>	2	
<i>emzahh TABS .35mg</i>	2	
<i>enilloring</i>	2	
<i>enpresse-28</i>	2	
<i>enskyce</i>	2	
<i>errin TABS .35mg</i>	2	
<i>estarylla</i>	2	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	2	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	2	
<i>etonogestrel-ethinyl estradiol va ring 0.12- 0.015 mg/24hr</i>	2	
<i>falmina</i>	2	
<i>hailey 1.5/30</i>	2	
<i>haloette</i>	2	
<i>heather TABS .35mg</i>	2	
<i>iclevia</i>	2	
<i>incassia TABS .35mg</i>	2	
<i>introvale</i>	2	
<i>isibloom</i>	2	
<i>jasmiel</i>	2	
<i>jolessa</i>	2	
<i>juleber</i>	2	
<i>junel 1.5/30</i>	2	
<i>junel 1/20</i>	2	
<i>junel fe 1.5/30</i>	2	
<i>junel fe 1/20</i>	2	
<i>kariva</i>	2	
<i>kelnor 1/35</i>	2	
<i>kelnor 1/50</i>	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>kurvelo</i>	2	
<i>larin 1.5/30</i>	2	
<i>larin 1/20</i>	2	
<i>larin fe 1.5/30</i>	2	
<i>larin fe 1/20</i>	2	
<i>leena</i>	2	
<i>lessina</i>	2	
<i>levonest</i>	2	
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	2	
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	2	
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	2	
<i>levonorgestrel-eth estra tab 0.05- 30/0.075-40/0.125-30mg-mcg</i>	2	
<i>levora 0.15/30-28</i>	2	
<i>loestrin 1.5/30-21</i>	2	
<i>loestrin 1/20-21</i>	2	
<i>loestrin fe 1.5/30</i>	2	
<i>loestrin fe 1/20</i>	2	
<i>loryna</i>	2	
<i>low-ogestrel</i>	2	
<i>lutra</i>	2	
<i>lyleq TABS .35mg</i>	2	
<i>lyza TABS .35mg</i>	2	
<i>marlissa</i>	2	
<i>medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml</i>	2	
<i>microgestin 1.5/30</i>	2	
<i>microgestin 1/20</i>	2	
<i>microgestin fe 1.5/30</i>	2	
<i>microgestin fe 1/20</i>	2	
<i>mili</i>	2	
<i>mono-linyah</i>	2	
<i>necon 0.5/35-28</i>	2	
<i>nikki</i>	2	
<i>nora-be TABS .35mg</i>	2	
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	2	
<i>norethindrone (contraceptive) TABS .35mg</i>	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	2	
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	2	
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	2	
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	2	
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	2	
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	2	
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	2	
<i>norlyroc TABS .35mg</i>	2	
<i>nortrel 0.5/35 (28)</i>	2	
<i>nortrel 1/35 (21)</i>	2	
<i>nortrel 1/35 (28)</i>	2	
<i>nortrel 7/7/7</i>	2	
<i>nylia 1/35</i>	2	
<i>nylia 7/7/7</i>	2	
<i>nymyo</i>	2	
<i>ocella</i>	2	
<i>philith</i>	2	
<i>pimtrea</i>	2	
<i>portia-28</i>	2	
<i>reclipsen</i>	2	
<i>setlakin</i>	2	
<i>sharobel TABS .35mg</i>	2	
<i>simliya</i>	2	
<i>sprintec 28</i>	2	
<i>sronyx</i>	2	
<i>syeda</i>	2	
<i>tarina fe 1/20 eq</i>	2	
<i>tilia fe</i>	2	
<i>tri-estarylla</i>	2	
<i>tri-legest fe</i>	2	
<i>tri-linyah</i>	2	
<i>tri-lo-estarylla</i>	2	
<i>tri-lo-marzia</i>	2	
<i>tri-lo-mili</i>	2	
<i>tri-lo-sprintec</i>	2	
<i>tri-mili</i>	2	
<i>tri-nymyo</i>	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>tri-sprintec</i>	2	
<i>tri-vylibra</i>	2	
<i>tri-vylibra lo</i>	2	
<i>trivora-28</i>	2	
<i>turqoz</i>	2	
<i>velivet</i>	2	
<i>vestura</i>	2	
<i>vienva</i>	2	
<i>viorele</i>	2	
<i>vyfemla</i>	2	
<i>vylibra</i>	2	
<i>wera</i>	2	
<i>xulane</i>	2	
<i>zafemy</i>	2	
<i>zovia 1/35</i>	2	
<i>zumandimine</i>	2	
ENDOMETRIOSIS		
<i>danazol CAPS 50mg, 100mg, 200mg</i>	2	
<i>SYNAREL SOLN 2mg/ml</i>	5	PA
ESTROGENS		
<i>dotti PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr</i>	3	
<i>estradiol PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr</i>	3	
<i>estradiol TABS .5mg, 1mg, 2mg</i>	2	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	3	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	3	
<i>estradiol vaginal CREA .1mg/gm; TABS 10mcg</i>	2	
<i>estradiol valerate OIL 10mg/ml, 20mg/ml, 40mg/ml</i>	2	
<i>fyavolv tab 0.5mg-2.5mcg</i>	3	
<i>fyavolv tab 1mg-5mcg</i>	3	
<i>jinteli</i>	3	
<i>lyllana PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr</i>	3	
<i>mimvey</i>	3	
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	3	

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

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone acetate-ethinyl estradiol tab</i> 1 mg-5 mcg	3	
<i>yuvaferm</i> TABS 10mcg	2	
GLUCOCORTICOIDS		
<i>dexamethasone</i> ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	2	B/D
DEXAMETHASONE INTENSOL CONC 1mg/ml	4	B/D
<i>dexamethasone sodium phosphate</i> SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml; SOSY 4mg/ml	2	
<i>fludrocortisone acetate</i> TABS .1mg	2	
<i>hydrocortisone</i> TABS 5mg, 10mg, 20mg	2	
<i>methylprednisolone</i> TABS 4mg, 8mg, 16mg, 32mg	2	B/D
<i>methylprednisolone</i> TBPK 4mg	2	
<i>methylprednisolone acetate</i> SUSP 40mg/ml, 80mg/ml	2	B/D
<i>methylprednisolone sod succ</i> SOLR 40mg, 125mg, 1000mg	2	B/D
<i>prednisolone</i> SOLN 15mg/5ml	2	B/D
<i>prednisolone sodium phosphate</i> SOLN 5mg/5ml, 15mg/5ml, 25mg/5ml	2	B/D
<i>prednisone</i> SOLN 5mg/5ml	2	B/D
<i>prednisone</i> TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	1	GC, B/D
<i>prednisone</i> TBPK 5mg, 10mg	2	
PREDNISONE INTENSOL CONC 5mg/ml	4	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	4	
GLUCOSE ELEVATING AGENTS		
<i>diazoxide</i> SUSP 50mg/ml	5	
GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	3	
GVOKE KIT SOLN 1mg/0.2ml	3	
GVOKE PFS SOSY 1mg/0.2ml	3	
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	5	NM, LA, PA
<i>betaine powder for oral solution</i>	5	NM, LA
<i>cabergoline</i> TABS .5mg	2	
<i>carglumic acid</i> TBSO 200mg	5	NM, LA, PA
CERDELGA CAPS 84mg	5	NM, LA, PA
CEREZYME SOLR 400unit	5	NM, LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>cinacalcet hcl</i> TABS 30mg, 60mg	2	B/D, QL (60 tabs / 30 days), NM
<i>cinacalcet hcl</i> TABS 90mg	5	B/D, QL (120 tabs / 30 days), NM
CYSTAGON CAPS 50mg, 150mg	4	NM, LA, PA
<i>desmopressin acetate</i> SOLN 4mcg/ml	5	
<i>desmopressin acetate</i> TABS .1mg, .2mg	2	
<i>desmopressin acetate spray</i> SOLN .01%	2	
<i>desmopressin acetate spray refrigerated</i> SOLN .01%	2	
FABRAZYME SOLR 5mg, 35mg	5	NM, LA, PA
GENOTROPIN CART 5mg, 12mg	5	NM, PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NM, PA
INCRELEX SOLN 40mg/4ml	5	NM, LA, PA
<i>javygtor</i> PACK 100mg, 500mg; TABS 100mg	5	NM, LA, PA
KORLYM TABS 300mg	5	NM, LA, PA
<i>lanreotide acetate</i> SOLN 120mg/0.5ml	5	NM, PA
<i>levocarnitine (metabolic modifiers)</i> SOLN 1gm/10ml; TABS 330mg	2	B/D
LUMIZYME SOLR 50mg	5	NM, LA, PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	5	NM, PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	5	NM, PA
LUPRON DEPOT-PED (6-MONTH KIT 45mg	5	NM, PA
<i>mifepristone (hyperglycemia)</i> TABS 300mg	5	NM, PA
<i>miglustat</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA
NAGLAZYME SOLN 1mg/ml	5	NM, LA, PA
<i>nitisinone</i> CAPS 2mg, 5mg, 10mg, 20mg	5	NM, PA
<i>octreotide acetate</i> SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml; SOSY 50mcg/ml, 100mcg/ml	2	NM, PA
<i>octreotide acetate</i> SOLN 500mcg/ml, 1000mcg/ml; SOSY 500mcg/ml	5	NM, PA
<i>raloxifene hcl</i> TABS 60mg	2	
<i>sapropterin dihydrochloride</i> PACK 100mg, 500mg; TABS 100mg	5	NM, PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	5	NM, LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
<i>sodium phenylbutyrate</i> POWD 3gm/tsp; TABS 500mg	5	NM, PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	5	NM, LA, PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	5	NM, LA, PA
<i>yargesa</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA

PHOSPHATE BINDER AGENTS

<i>calcium acetate (phosphate binder)</i> CAPS 667mg	2	QL (360 caps / 30 days)
<i>calcium acetate (phosphate binder)</i> TABS 667mg	2	QL (360 tabs / 30 days)
<i>lanthanum carbonate</i> CHEW 500mg, 1000mg	2	QL (90 tabs / 30 days)
<i>lanthanum carbonate</i> CHEW 750mg	2	QL (180 tabs / 30 days)
<i>sevelamer carbonate</i> PACK 2.4gm	2	QL (180 packets / 30 days)
<i>sevelamer carbonate</i> PACK .8gm	2	QL (540 packets / 30 days)
<i>sevelamer carbonate</i> TABS 800mg	2	QL (540 tabs / 30 days)
VELPHORO CHEW 500mg	5	QL (180 tabs / 30 days)

PROGESTINS

<i>medroxyprogesterone acetate</i> TABS 2.5mg, 5mg, 10mg	1	GC
<i>megestrol acetate</i> SUSP 40mg/ml	3	
<i>megestrol acetate (appetite)</i> SUSP 625mg/5ml	4	PA
<i>norethindrone acetate</i> TABS 5mg	2	
<i>progesterone</i> CAPS 100mg, 200mg	2	

THYROID AGENTS

<i>euthyrox</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	
<i>levo-t</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
<i>levothyroxine sodium</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>levoxyl</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	
<i>liothyronine sodium</i> TABS 5mcg, 25mcg, 50mcg	2	
<i>methimazole</i> TABS 5mg, 10mg	1	GC
<i>propylthiouracil</i> TABS 50mg	2	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	4	
<i>unithroid</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	

VITAMIN D ANALOGS

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

GASTROINTESTINAL

ANTIEMETICS

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

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

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

ANTISPASMODICS

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

H2-RECEPTOR ANTAGONISTS

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

INFLAMMATORY BOWEL DISEASE

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

LAXATIVES

<i>constulose</i> SOLN 10gm/15ml	2	
<i>enulose</i> SOLN 10gm/15ml	2	
<i>gavilyte-c</i>	1	GC
<i>gavilyte-g</i>	1	GC
<i>gavilyte-n/flavor pack</i>	1	GC

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

Drug Name	Drug Tier	Requirements/Limits
<i>generlac</i> SOLN 10gm/15ml	2	
<i>lactulose</i> SOLN 10gm/15ml	2	
<i>lactulose (encephalopathy)</i> SOLN 10gm/15ml	2	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	GC
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	1	GC
PLENVU SOL	4	
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	2	

MISCELLANEOUS

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

PANCREATIC ENZYMES

CREON CAP 3000UNIT	3	
CREON CAP 6000UNIT	3	
CREON CAP 12000UNT	3	
CREON CAP 24000UNT	3	
CREON CAP 36000UNT	3	
ZENPEP CAP 3000UNIT	4	
ZENPEP CAP 5000UNIT	4	
ZENPEP CAP 10000UNT	4	
ZENPEP CAP 15000UNT	4	
ZENPEP CAP 20000UNT	4	

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

Drug Name	Drug Tier	Requirements/Limits
ZENPEP CAP 25000UNT	4	
ZENPEP CAP 40000UNT	4	
ZENPEP CAP 60000UNT	4	
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium</i> CPDR 20mg, 40mg	2	QL (30 caps / 30 days), ST
<i>lansoprazole</i> CPDR 15mg, 30mg	2	QL (60 caps / 30 days)
<i>omeprazole</i> CPDR 10mg, 20mg, 40mg	1	GC
<i>pantoprazole sodium</i> SOLR 40mg	2	
<i>pantoprazole sodium</i> TBEC 20mg, 40mg	1	GC
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin hcl</i> TB24 10mg	1	GC, QL (30 tabs / 30 days)
<i>dutasteride</i> CAPS .5mg	2	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl cap</i> 0.5-0.4 mg	2	QL (30 caps / 30 days)
<i>finasteride</i> TABS 5mg	1	GC, QL (30 tabs / 30 days)
<i>tamsulosin hcl</i> CAPS .4mg	1	GC, QL (60 caps / 30 days)
MISCELLANEOUS		
<i>acetic acid</i> SOLN .25%	2	
<i>bethanechol chloride</i> TABS 5mg, 10mg, 25mg, 50mg	2	
<i>potassium citrate (alkalinizer)</i> TBCR 15meq, 540mg, 1080mg	2	
URINARY ANTISPASMODICS		
GEMTESA TABS 75mg	4	QL (30 tabs / 30 days)
MYRBETRIQ SRER 8mg/ml	4	QL (300 mL / 28 days)
MYRBETRIQ TB24 25mg, 50mg	4	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> SOLN 5mg/5ml	2	QL (600 mL / 30 days)
<i>oxybutynin chloride</i> TABS 5mg	2	QL (120 tabs / 30 days)
<i>oxybutynin chloride</i> TB24 5mg	2	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> TB24 10mg, 15mg	2	QL (60 tabs / 30 days)
<i>solifenacin succinate</i> TABS 5mg, 10mg	2	QL (30 tabs / 30 days)
<i>tolterodine tartrate</i> CP24 2mg, 4mg	2	QL (30 caps / 30 days), ST
<i>tolterodine tartrate</i> TABS 1mg, 2mg	2	QL (60 tabs / 30 days)
<i>tropium chloride</i> TABS 20mg	2	QL (60 tabs / 30 days)
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate vaginal</i> CREA 2%	2	
<i>metronidazole vaginal</i> GEL .75%	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	2	

HEMATOLOGIC

ANTICOAGULANTS

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

HEMATOPOIETIC GROWTH FACTORS

PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	NM, PA
PROCRIT SOLN 20000unit/ml, 40000unit/ml	5	NM, PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	5	NM, PA
ZIEXTENZO SOSY 6mg/0.6ml	5	QL (2 syringes / 28 days), NM, PA

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

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
ALVAIZ TABS 9mg, 54mg	5	QL (60 tabs / 30 days), NM, LA, PA
ALVAIZ TABS 18mg, 36mg	5	QL (90 tabs / 30 days), NM, LA, PA
<i>anagrelide hcl</i> CAPS .5mg, 1mg	2	
BERINERT KIT 500unit	5	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i> TABS 50mg, 100mg	1	GC
DOPTELET TABS 20mg	5	NM, LA, PA
DROXIA CAPS 200mg, 300mg, 400mg	3	
ENDARI PACK 5gm	5	NM, LA, PA
HAEGARDA SOLR 2000unit	5	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA SOLR 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
<i>icatibant acetate</i> SOSY 30mg/3ml	5	QL (9 syringes / 30 days), NM, PA
<i>l-glutamine (sickle cell)</i> PACK 5gm	5	NM, PA
<i>pentoxifylline</i> TBCR 400mg	1	GC
PROMACTA PACK 12.5mg	5	QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	5	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	5	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>sajazir</i> SOSY 30mg/3ml	5	QL (9 syringes / 30 days), NM, LA, PA
<i>tranexamic acid</i> SOLN 1000mg/10ml; TABS 650mg	2	
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	2	
BRILINTA TABS 60mg, 90mg	3	
<i>clopidogrel bisulfate</i> TABS 75mg	1	GC
<i>dipyridamole</i> TABS 25mg, 50mg, 75mg	3	PA; PA if 70 years and older
<i>prasugrel hcl</i> TABS 5mg, 10mg	2	
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
ADALIMUMAB-AACF (2 PEN) AJKT 40mg/0.8ml	5	QL (56 pens / 365 days), NM, PA

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

Drug Name	Drug Tier	Requirements/Limits
ADALIMUMAB-AACF (2 SYRING PSKT 40mg/0.8ml)	5	QL (56 syringes / 365 days), NM, PA
DUPIXENT SOAJ 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	5	NM, PA
ENBREL SOLN 25mg/0.5ml	5	QL (16 vials / 28 days), NM, PA
ENBREL SOSY 25mg/0.5ml	5	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	5	QL (8 syringes / 28 days), NM, PA
ENBREL MINI SOCT 50mg/ml	5	QL (8 cartridges / 28 days), NM, PA
ENBREL SURECLICK SOAJ 50mg/ml	5	QL (8 pens / 28 days), NM, PA
HUMIRA PSKT 10mg/0.1ml	5	QL (2 syringes / 28 days), NM, PA
HUMIRA PSKT 20mg/0.2ml	5	QL (4 syringes / 28 days), NM, PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml	5	QL (6 syringes / 28 days), NM, PA
HUMIRA PEN AJKT 40mg/0.4ml, 40mg/0.8ml	5	QL (6 pens / 28 days), NM, PA
HUMIRA PEN AJKT 80mg/0.8ml	5	QL (4 pens / 28 days), NM, PA
HUMIRA PEN KIT PS/UV	5	QL (3 pens / 28 days), NM, PA
HUMIRA PEN-CD/UC/HS START AJKT 80mg/0.8ml	5	QL (3 pens / 28 days), NM, PA
HUMIRA PEN-PEDIATRIC UC S AJKT 80mg/0.8ml	5	QL (4 pens / 28 days), NM, PA
IDACIO (2 PEN) AJKT 40mg/0.8ml	5	QL (56 pens / 365 days), NM, PA
IDACIO (2 SYRINGE) PSKT 40mg/0.8ml	5	QL (56 syringes / 365 days), NM, PA
IDACIO CROHN INJ DISEASE AJKT 40mg/0.8ml	5	QL (2 packs / year), NM, PA
IDACIO PLAQU INJ PSORIASIS AJKT 40mg/0.8ml	5	QL (2 packs / year), NM, PA
INFLIXIMAB SOLR 100mg	5	NM, LA, PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml	5	QL (2 pens / 28 days), NM, PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml	5	QL (2 syringes / 28 days), NM, PA

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

Drug Name	Drug Tier	Requirements/Limits
OTEZLA TABS 20mg, 30mg	5	QL (60 tabs / 30 days), NM, PA
OTEZLA TAB 10/20	5	QL (110 tabs / year), NM, PA
OTEZLA TAB 10/20/30	5	QL (110 tabs / year), NM, PA
REMICADE SOLR 100mg	5	NM, LA, PA
RENFLXIS SOLR 100mg	5	NM, LA, PA
RINVOQ TB24 15mg, 30mg	5	QL (30 tabs / 30 days), NM, PA
RINVOQ TB24 45mg	5	QL (168 tabs / year), NM, PA
RINVOQ LQ SOLN 1mg/ml	5	QL (360 mL / 30 days), NM, PA
SKYRIZI SOCT 180mg/1.2ml, 360mg/2.4ml	5	QL (1 cartridge / 56 days), NM, PA
SKYRIZI SOLN 600mg/10ml	5	QL (12 vials / 365 days), NM, PA
SKYRIZI SOSY 150mg/ml	5	QL (6 syringes / 365 days), NM, PA
SKYRIZI PEN SOAJ 150mg/ml	5	QL (6 pens / 365 days), NM, PA
STELARA SOLN 45mg/0.5ml	5	QL (1 vial / 28 days), NM, LA, PA
STELARA SOLN 130mg/26ml	5	NM, LA, PA
STELARA SOSY 45mg/0.5ml, 90mg/ml	5	QL (1 syringe / 28 days), NM, PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml	5	QL (3 syringes / 28 days), NM, LA, PA
TALTZ SOSY 20mg/0.25ml, 40mg/0.5ml	5	QL (1 syringe / 28 days), NM, LA, PA
TREMFYA SOAJ 100mg/ml	5	QL (1 pen / 28 days), NM, PA
TREMFYA SOSY 100mg/ml	5	QL (1 syringe / 28 days), NM, PA
XELJANZ SOLN 1mg/ml	5	QL (480 mL / 24 days), NM, PA
XELJANZ TABS 5mg, 10mg	5	QL (60 tabs / 30 days), NM, PA
XELJANZ XR TB24 11mg, 22mg	5	QL (30 tabs / 30 days), NM, PA
<i>DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)</i>		
<i>hydroxychloroquine sulfate</i> TABS 200mg	2	
JYLAMVO SOLN 2mg/ml	4	B/D
<i>leflunomide</i> TABS 10mg, 20mg	2	QL (30 tabs / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>methotrexate sodium</i> TABS 2.5mg	2	
XATMEP SOLN 2.5mg/ml	4	B/D
IMMUNOGLOBULINS		
ALYGLO SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml	5	PA
BIVIGAM SOLN 5gm/50ml, 10%	5	NM, LA, PA
FLEBOGAMMA DIF SOLN 5gm/100ml, 10gm/200ml, 20gm/400ml	5	NM, PA
GAMASTAN INJ	4	B/D, NM, LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NM, PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	5	NM, PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	5	NM, PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	NM, LA, PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NM, PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 30gm/300ml	5	NM, PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NM, PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 100mcg/0.5ml	5	NM, LA, PA
ARCALYST SOLR 220mg	5	NM, LA, PA
IMMUNOSUPPRESSANTS		
ASTAGRAF XL CP24 5mg	5	B/D
ASTAGRAF XL CP24 .5mg, 1mg	4	B/D
<i>azathioprine</i> TABS 50mg	2	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	5	QL (8 syringes / 28 days), NM, LA, PA
BENLYSTA SOLR 120mg, 400mg	5	NM, LA, PA
<i>cyclosporine</i> CAPS 25mg, 100mg	2	B/D

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

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

VACCINES

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

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

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

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES/MINERALS, INJECTABLE

D2.5W/NACL INJ 0.45%	4
D5W/LYTES INJ #48	4
D10W/NACL INJ 0.2%	3
<i>dextrose 2.5% w/ sodium chloride 0.45%</i>	2
<i>dextrose 5% in lactated ringers</i>	2
<i>dextrose 5% w/ sodium chloride 0.2%</i>	2

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

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

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

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride</i> SOLN 2meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 20meq/50ml, 40meq/100ml	2	
POTASSIUM CHLORIDE SOLN 10meq/50ml	4	
<i>potassium chloride 20 meq/l (0.15%) in dextrose 5% inj</i>	2	
<i>sodium chloride</i> SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	2	
TPN ELECTROL INJ	4	B/D
<i>ELECTROLYTES/MINERALS/VITAMINS, ORAL</i>		
<i>klor-con</i> PACK 20meq	2	
<i>klor-con 8</i> TBCR 8meq	1	GC
<i>klor-con 10</i> TBCR 10meq	1	GC
<i>klor-con m10</i> TBCR 10meq	1	GC
<i>klor-con m15</i> TBCR 15meq	2	
<i>klor-con m20</i> TBCR 20meq	1	GC
M-NATAL PLUS TAB	3	
<i>potassium chloride</i> CPCR 8meq, 10meq; PACK 20meq; SOLN 10%, 20%	2	
<i>potassium chloride</i> TBCR 8meq, 10meq, 20meq	1	GC
<i>potassium chloride microencapsulated crystals er</i> TBCR 10meq, 20meq	1	GC
<i>potassium chloride microencapsulated crystals er</i> TBCR 15meq	2	
PRENATAL TAB 27-1MG	3	
PRENATAL TAB PLUS	3	
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	2	
<i>IV NUTRITION</i>		
CLINIMIX INJ 4.25/D5W	4	B/D
CLINIMIX INJ 4.25/D10	4	B/D
CLINIMIX INJ 5%/D15W	4	B/D
CLINIMIX INJ 5%/D20W	4	B/D
CLINIMIX INJ 6/5	4	B/D
CLINIMIX INJ 8/10	4	B/D
CLINIMIX INJ 8/14	4	B/D
<i>clinisol sf 15%</i>	2	B/D
CLINOLIPID EMU 20%	4	B/D
<i>dextrose</i> SOLN 5%, 10%	2	
<i>dextrose</i> SOLN 50%, 70%	2	B/D

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

Drug Name	Drug Tier	Requirements/Limits
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	4	B/D
NUTRILIPID EMUL 20gm/100ml	4	B/D
<i>plenamine</i>	2	B/D
PREMASOL SOL 10%	5	B/D
PROSOL INJ 20%	4	B/D
TRAVASOL INJ 10%	4	B/D
TROPHAMINE INJ 10%	4	B/D

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

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

ANTI-INFECTIVES

<i>bacitracin (ophthalmic) OINT 500unit/gm</i>	2	
<i>bacitracin-polymyxin b ophth oint</i>	1	GC
BESIVANCE SUSP .6%	3	
CILOXAN OINT .3%	3	
<i>ciprofloxacin hcl (ophth) SOLN .3%</i>	1	GC
<i>erythromycin (ophth) OINT 5mg/gm</i>	1	GC
<i>gatifloxacin (ophth) SOLN .5%</i>	2	
<i>gentamicin sulfate (ophth) SOLN .3%</i>	1	GC
<i>moxifloxacin hcl (ophth) SOLN .5%</i>	2	
NATACYN SUSP 5%	4	
<i>neo-polycin 5(3.5)mg-400unt-10000unt op oin</i>	2	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	2	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	2	
<i>ofloxacin (ophth) SOLN .3%</i>	2	

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

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

ANTI-INFLAMMATORIES

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

ANTIALLERGICS

<i>azelastine hcl (ophth)</i> SOLN .05%	2	
<i>cromolyn sodium (ophth)</i> SOLN 4%	1	GC
ZERVIAE SOLN .24%	4	

ANTI GLAUCOMA

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

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

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

MISCELLANEOUS

ATROPINE SULFATE SOLN 1%	3	
<i>atropine sulfate (ophthalmic)</i> SOLN 1%	2	
CYSTADROPS SOLN .37%	5	NM, LA, PA
CYSTARAN SOLN .44%	5	NM, LA, PA
MIEBO SOLN 1.338gm/ml	3	
<i>proparacaine hcl</i> SOLN .5%	2	
RESTASIS EMUL .05%	3	
RESTASIS MULTIDOSE EMUL .05%	3	
TYRVAYA SOLN .03mg/act	4	
XIIDRA SOLN 5%	3	

OTIC

OTIC AGENTS

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

Phosphodiesterase Type 5 Inhibitors

Phosphodiesterase Type 5 Inhibitors

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

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

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

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

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

ANTICHOLINERGICS

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

ANTI-HISTAMINES

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

BETA AGONISTS

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

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

Drug Name	Drug Tier	Requirements/Limits
<i>albuterol sulfate</i> NEBU .083%, .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	2	B/D
<i>albuterol sulfate</i> SYRP 2mg/5ml; TABS 2mg, 4mg	2	
<i>levalbuterol hcl</i> NEBU 1.25mg/0.5ml, 1.25mg/3ml	2	B/D
<i>levalbuterol tartrate</i> AERO 45mcg/act	2	QL (2 inhalers / 30 days), ST
SEREVENT DISKUS AEPB 50mcg/dose	3	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS 2.5mg, 5mg	2	
VENTOLIN HFA AERS 108mcg/act	3	QL (2 inhalers / 30 days)
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act	3	QL (6 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> CHEW 4mg, 5mg; PACK 4mg	2	
<i>montelukast sodium</i> TABS 10mg	1	GC
<i>zafirlukast</i> TABS 10mg, 20mg	2	
MISCELLANEOUS		
<i>acetylcysteine</i> SOLN 10%, 20%	2	B/D
ARALAST NP SOLR 500mg, 1000mg	5	NM, LA, PA
BRONCHITOL CAPS 40mg	5	QL (560 caps / 28 days), NM, LA, PA
<i>cromolyn sodium</i> NEBU 20mg/2ml	2	B/D
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.3ml, .3mg/0.3ml	2	(generic of EpiPen)
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.15ml, .3mg/0.3ml	2	(generic of Adrenaclick)
FASENRA SOSY 10mg/0.5ml, 30mg/ml	5	NM, LA, PA
FASENRA PEN SOAJ 30mg/ml	5	NM, LA, PA
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg	5	QL (56 packs / 28 days), NM, LA, PA
KALYDECO TABS 150mg	5	QL (60 tabs / 30 days), NM, LA, PA
OFEV CAPS 100mg, 150mg	5	QL (60 caps / 30 days), NM, LA, PA
ORKAMBI GRA 75-94MG	5	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 100-125	5	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 150-188	5	QL (56 packs / 28 days), NM, LA, PA

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

Drug Name	Drug Tier	Requirements/Limits
ORKAMBI TAB 100-125	5	QL (112 tabs / 28 days), NM, LA, PA
ORKAMBI TAB 200-125	5	QL (112 tabs / 28 days), NM, LA, PA
<i>pirfenidone</i> CAPS 267mg	5	QL (270 caps / 30 days), NM, PA
<i>pirfenidone</i> TABS 267mg	5	QL (270 tabs / 30 days), NM, PA
<i>pirfenidone</i> TABS 534mg, 801mg	5	QL (90 tabs / 30 days), NM, PA
PROLASTIN-C SOLN 1000mg/20ml	5	NM, LA, PA
PULMOZYME SOLN 2.5mg/2.5ml	5	NM, PA
<i>roflumilast</i> TABS 250mcg	2	QL (56 tabs / year)
<i>roflumilast</i> TABS 500mcg	2	QL (30 tabs / 30 days)
SYMDEKO TAB 50-75MG	5	QL (56 tabs / 28 days), NM, LA, PA
SYMDEKO TAB 100-150	5	QL (56 tabs / 28 days), NM, LA, PA
<i>theophylline</i> ELIX 80mg/15ml; SOLN 80mg/15ml; TB12 100mg, 200mg, 300mg, 450mg; TB24 400mg, 600mg	2	
TRIKAFTA PAK 59.5MG	5	QL (56 packs / 28 days), NM, LA, PA
TRIKAFTA PAK 75MG	5	QL (56 packs / 28 days), NM, LA, PA
TRIKAFTA TAB 50-25-37.5MG & 75MG	5	QL (84 tabs / 28 days), NM, LA, PA
TRIKAFTA TAB 100-50-75MG & 150MG	5	QL (84 tabs / 28 days), NM, LA, PA
XOLAIR SOAJ 75mg/0.5ml, 150mg/ml, 300mg/2ml; SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml, 300mg/2ml	5	NM, LA, PA
ZEMAIRA SOLR 1000mg, 4000mg, 5000mg	5	NM, LA, PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i> SOLN .025%	2	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i> SUSP 50mcg/act	2	QL (1 bottle / 30 days)
XHANCE EXHU 93mcg/act	4	QL (32 mL / 30 days), PA
STEROID INHALANTS		
ALVESCO AERS 80mcg/act	4	QL (3 inhalers / 30 days)
ALVESCO AERS 160mcg/act	4	QL (2 inhalers / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	3	QL (30 inhalations / 30 days)
<i>budesonide (inhalation) SUSP .25mg/2ml, .5mg/2ml</i>	2	B/D

STEROID/BETA-AGONIST COMBINATIONS

ADVAIR HFA AER 45/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	3	QL (1 inhaler / 30 days)
AIRSUPRA AER 90-80MCG	3	QL (3 inhalers / 30 days)
BREO ELLIPTA INH 50-25MCG	3	QL (60 blisters / 30 days)
BREO ELLIPTA INH 100-25	3	QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	3	QL (60 blisters / 30 days)
DULERA AER 50-5MCG	4	QL (3 inhalers / 30 days)
DULERA AER 100-5MCG	4	QL (3 inhalers / 30 days)
DULERA AER 200-5MCG	4	QL (3 inhalers / 30 days)
<i>fluticasone-salmeterol aer powder ba 100-50 mcg/act</i>	2	QL (60 inhalations / 30 days); (generic PRASCO not covered)
<i>fluticasone-salmeterol aer powder ba 250-50 mcg/act</i>	2	QL (60 inhalations / 30 days); (generic PRASCO not covered)
<i>fluticasone-salmeterol aer powder ba 500-50 mcg/act</i>	2	QL (60 inhalations / 30 days); (generic PRASCO not covered)
<i>wixela inhub</i>	2	QL (60 inhalations / 30 days)

Respiratory Tract Agents

Antitussives

<i>benzonatate</i> CAPS 100mg, 200mg	2	ED, QL (30 caps / 10 days)
--------------------------------------	---	----------------------------

TOPICAL

DERMATOLOGY, ACNE

<i>acutane</i> CAPS 10mg, 20mg, 30mg, 40mg	2	PA
<i>amnesteem</i> CAPS 10mg, 20mg, 40mg	2	PA
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	2	QL (46.6 gm / 30 days)
<i>claravis</i> CAPS 10mg, 20mg, 30mg, 40mg	2	PA
<i>clindamycin phosphate (topical)</i> GEL 1%	2	QL (75 gm / 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate (topical)</i> LOTN 1%; SOLN 1%	2	QL (60 mL / 30 days)
<i>ery</i> PADS 2%	2	QL (60 pledgets / 30 days)
<i>erythromycin (acne aid)</i> GEL 2%	2	QL (60 gm / 30 days)
<i>erythromycin (acne aid)</i> SOLN 2%	2	QL (60 mL / 30 days)
<i>isotretinoin</i> CAPS 10mg, 20mg, 30mg, 40mg	2	PA
<i>sulfacetamide sodium (acne)</i> LOTN 10%	2	QL (118 mL / 30 days)
<i>tretinoin</i> CREA .025%, .05%, .1%; GEL .01%, .025%	2	QL (45 gm / 30 days), PA
<i>zenatane</i> CAPS 10mg, 20mg, 30mg, 40mg	2	PA

DERMATOLOGY, ANTIBIOTICS

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

DERMATOLOGY, ANTIFUNGALS

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

DERMATOLOGY, ANTIPSORIATICS

<i>acitretin</i> CAPS 10mg, 17.5mg, 25mg	2	PA
<i>calcipotriene</i> CREA .005%; OINT .005%	2	QL (120 gm / 30 days), PA
<i>calcipotriene</i> SOLN .005%	2	QL (120 mL / 30 days), PA
<i>calcitrene</i> OINT .005%	2	QL (120 gm / 30 days), PA
<i>tazarotene</i> CREA .1%	2	QL (60 gm / 30 days), PA

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

Drug Name	Drug Tier	Requirements/Limits
TAZORAC CREA .05%	4	QL (60 gm / 30 days), PA
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole (topical)</i> SHAM 2%	1	GC, QL (120 mL / 30 days)
<i>selenium sulfide</i> LOTN 2.5%	2	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort</i> CREA 1%, 2.5%	1	GC
<i>alclometasone dipropionate</i> CREA .05%; OINT .05%	2	QL (60 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> CREA .05%; OINT .05%	2	QL (120 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> LOTN .05%	2	QL (120 mL / 30 days)
<i>betamethasone dipropionate augmented</i> CREA .05%; GEL .05%; OINT .05%	2	QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> LOTN .05%	2	QL (120 mL / 30 days)
<i>betamethasone valerate</i> CREA .1%; OINT .1%	2	QL (120 gm / 30 days)
<i>betamethasone valerate</i> LOTN .1%	2	QL (120 mL / 30 days)
<i>clobetasol propionate</i> CREA .05%; GEL .05%; OINT .05%	2	QL (60 gm / 30 days)
<i>clobetasol propionate</i> SOLN .05%	2	QL (50 mL / 30 days)
<i>clobetasol propionate e</i> CREA .05%	2	QL (60 gm / 30 days)
ENSTILAR AER	4	QL (120 gm / 30 days), PA
<i>fluocinolone acetonide</i> CREA .01%	2	QL (60 gm / 30 days)
<i>fluocinolone acetonide</i> CREA .025%; OINT .025%	2	QL (120 gm / 30 days)
<i>fluocinolone acetonide</i> OIL .01%	2	QL (118.28 mL / 30 days)
<i>fluocinolone acetonide</i> SOLN .01%	2	QL (90 mL / 30 days)
<i>fluocinonide</i> CREA .05%	2	QL (120 gm / 30 days)
<i>fluocinonide</i> GEL .05%; OINT .05%	2	QL (60 gm / 30 days)
<i>fluocinonide</i> SOLN .05%	2	QL (60 mL / 30 days)
<i>fluocinonide emulsified base</i> CREA .05%	2	QL (120 gm / 30 days)
<i>fluticasone propionate</i> CREA .05%; OINT .005%	2	
<i>halobetasol propionate</i> CREA .05%; OINT .05%	2	QL (50 gm / 30 days)
<i>hydrocortisone (topical)</i> CREA 1%, 2.5%	1	GC
<i>hydrocortisone (topical)</i> LOTN 2.5%; OINT 2.5%	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>mometasone furoate</i> CREA .1%; OINT .1%; SOLN .1%	2	
<i>triamcinolone acetonide (topical)</i> CREA .025%, .1%, .5%	1	GC, QL (454 gm / 30 days)
<i>triamcinolone acetonide (topical)</i> LOTN .025%, .1%	2	
<i>triamcinolone acetonide (topical)</i> OINT .025%, .1%, .5%	1	GC

DERMATOLOGY, LOCAL ANESTHETICS

<i>glydo</i> PRSY 2%	2	QL (60 mL / 30 days), PA
<i>lidocaine</i> OINT 5%	2	QL (50 gm / 30 days), PA
<i>lidocaine</i> PTCH 5%	2	QL (3 patches / 1 day), PA
<i>lidocaine hcl</i> SOLN 4%	2	QL (50 mL / 30 days), PA
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	2	B/D, QL (30 gm / 30 days)
<i>lidocan</i> PTCH 5%	2	QL (3 patches / 1 day), PA
<i>tridacaine ii</i> PTCH 5%	2	QL (3 patches / 1 day), PA

DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE

<i>bexarotene (topical)</i> GEL 1%	5	QL (60 gm / 30 days), NM, PA
<i>diclofenac sodium (topical)</i> GEL 1%	2	QL (1000 gm / 30 days)
<i>diclofenac sodium (topical)</i> SOLN 1.5%	2	QL (300 mL / 28 days)
<i>fluorouracil (topical)</i> CREA 5%	2	QL (40 gm / 30 days)
<i>fluorouracil (topical)</i> SOLN 2%, 5%	2	QL (10 mL / 30 days)
<i>hydrocortisone (rectal)</i> CREA 1%, 2.5%	2	
<i>imiquimod</i> CREA 5%	2	QL (24 packets / 30 days)
<i>lactic acid (ammonium lactate)</i> CREA 12%; LOTN 12%	2	
<i>metronidazole (topical)</i> CREA .75%; GEL .75%	2	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> LOTN .75%	2	QL (59 mL / 30 days)
<i>nitroglycerin (intra-anal)</i> OINT .4%	2	QL (30 gm / 30 days)
PANRETIN GEL .1%	5	QL (60 gm / 30 days), PA
<i>podofilox</i> SOLN .5%	2	QL (7 mL / 28 days)
<i>procto-med hc</i> CREA 2.5%	2	
<i>proctocort</i> CREA 1%	2	

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

Drug Name	Drug Tier	Requirements/Limits
<i>proctosol hc</i> CREA 2.5%	2	
<i>proctozone-hc</i> CREA 2.5%	2	
RECTIV OINT .4%	4	QL (30 gm / 30 days)
<i>tacrolimus (topical)</i> OINT .03%, .1%	2	QL (100 gm / 30 days)
VALCHLOR GEL .016%	5	QL (60 gm / 30 days), NM, LA, PA

DERMATOLOGY, SCABICIDES AND PEDICULIDES

<i>malathion</i> LOTN .5%	2	QL (59 mL / 30 days)
<i>permethrin</i> CREA 5%	2	QL (60 gm / 30 days)

DERMATOLOGY, WOUND CARE AGENTS

REGRANEX GEL .01%	5	QL (30 gm / 30 days), PA
SANTYL OINT 250unit/gm	4	QL (180 gm / 30 days)
<i>sodium chloride (gu irrigant)</i> SOLN .9%	2	
<i>water for irrigation, sterile irrigation soln</i>	2	

MOUTH/THROAT/DENTAL AGENTS

<i>chlorhexidine gluconate (mouth-throat)</i> SOLN .12%	1	GC
<i>clotrimazole</i> TROC 10mg	2	QL (150 lozenges / 30 days)
<i>kourzeq</i> PSTE .1%	2	
<i>lidocaine hcl (mouth-throat)</i> SOLN 2%	2	
<i>nystatin (mouth-throat)</i> SUSP 100000unit/ml	2	
<i>periogard</i> SOLN .12%	1	GC
<i>pilocarpine hcl (oral)</i> TABS 5mg, 7.5mg	2	
<i>triamcinolone acetonide (mouth)</i> PSTE .1%	2	

Vitamins

Vitamin B Complex

<i>cyanocobalamin</i> SOLN 1000mcg/ml	1	ED, GC, QL (1 mL / 30 days)
<i>folic acid</i> TABS 1mg	1	ED, GC, QL (30 tabs / 30 days)

Vitamin D

<i>ergocalciferol</i> CAPS 50000unit	1	ED, GC, QL (4 caps / 28 days)
--------------------------------------	---	-------------------------------

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

Index

A	
<i>abacavir sulfate</i>	21
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	22
ABELCET	20
ABILIFY MAINTENA.....	50
<i>abiraterone acetate</i>	28
ABRYSVO	84
<i>acamprosate calcium</i>	60
<i>acarbose</i>	62
ACCU-CHEK KIT AVIVA PL	61
ACCU-CHEK KIT COMPACT	61
ACCU-CHEK KIT GUIDE	61
ACCU-CHEK KIT GUIDE ME.....	61
ACCU-CHEK KIT NANO.....	61
ACCU-CHEK TES AVIVA PL.....	61
ACCU-CHEK TES COMPACT	61
ACCU-CHEK TES GUIDE	61
ACCU-CHEK TES SMART.....	61
<i>accutane</i>	94
<i>acebutolol hcl</i>	44
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	17
<i>acetaminophen w/ codeine tab 300-15 mg</i>	17
<i>acetaminophen w/ codeine tab 300-30 mg</i>	17
<i>acetaminophen w/ codeine tab 300-60 mg</i>	17
<i>acetazolamide</i>	45
<i>acetic acid</i>	78
<i>acetic acid (otic)</i>	90
<i>acetylcysteine</i>	92
<i>acitretin</i>	95
ACTHIB INJ	84
ACTIMMUNE	83
<i>acyclovir</i>	23
<i>acyclovir sodium</i>	23
ADACEL INJ.....	84
ADALIMUMAB-AACF (2 PEN)	80
ADALIMUMAB-AACF (2 SYRING).....	81
<i>adefovir dipivoxil</i>	23
ADEMPAS	46
ADMELOG.....	65
ADMELOG SOLOSTAR	65
ADVAIR HFA AER 115/21	94
ADVAIR HFA AER 230/21	94
ADVAIR HFA AER 45/21	94
<i>afirmelle</i>	67
AIMOVIG.....	58
AIRSUPRA AER 90-80MCG.....	94
AKEEGA TAB 100/500.....	29
AKEEGA TAB 50/500MG	29
<i>ala-cort</i>	96
<i>albendazole</i>	18
<i>albuterol sulfate</i>	91, 92
<i>alclometasone dipropionate</i>	96
ALDURAZYME	72
ALECENSA.....	31
<i>alendronate sodium</i>	66
<i>alfuzosin hcl</i>	78
<i>aliskiren fumarate</i>	46
<i>allopurinol</i>	16
<i>alose tron hcl</i>	77
<i>alprazolam</i>	47
ALREX	89
<i>altavera</i>	67
ALUNBRIG.....	31
ALUNBRIG PAK	31
ALVAIZ	80
ALVESCO	93
<i>alyacen 1/35</i>	67
<i>alyacen 7/7/7</i>	67
ALYGLO	83
<i>amantadine hcl</i>	49
<i>ambrisentan</i>	46
<i>amikacin sulfate</i>	18
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	45
<i>amiloride hcl</i>	45
<i>amiodarone hcl</i>	42
<i>amitriptyline hcl</i>	47
<i>amlodipine besylate</i>	44
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	39
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	39
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	39
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	39

<i>amlodipine besylate-benazepril hcl cap</i> 5-20 mg	39	<i>amphetamine-dextroamphetamine cap</i> er 24hr 25 mg.....	57
<i>amlodipine besylate-benazepril hcl cap</i> 5-40 mg	39	<i>amphetamine-dextroamphetamine cap</i> er 24hr 30 mg.....	57
<i>amlodipine besylate-olmesartan</i> medoxomil tab 10-20 mg	40	<i>amphetamine-dextroamphetamine cap</i> er 24hr 5 mg	56
<i>amlodipine besylate-olmesartan</i> medoxomil tab 10-40 mg	40	<i>amphetamine-dextroamphetamine tab</i> 10 mg.....	57
<i>amlodipine besylate-olmesartan</i> medoxomil tab 5-20 mg	40	<i>amphetamine-dextroamphetamine tab</i> 12.5 mg	57
<i>amlodipine besylate-olmesartan</i> medoxomil tab 5-40 mg	40	<i>amphetamine-dextroamphetamine tab</i> 15 mg.....	57
<i>amlodipine besylate-valsartan tab 10-</i> 160 mg	40	<i>amphetamine-dextroamphetamine tab</i> 20 mg.....	57
<i>amlodipine besylate-valsartan tab 10-</i> 320 mg	40	<i>amphetamine-dextroamphetamine tab</i> 30 mg.....	57
<i>amlodipine besylate-valsartan tab 5-</i> 160 mg	40	<i>amphetamine-dextroamphetamine tab</i> 5 mg.....	57
<i>amlodipine besylate-valsartan tab 5-</i> 320 mg	40	<i>amphetamine-dextroamphetamine tab</i> 7.5 mg.....	57
<i>amnestem</i>	94	<i>amphotericin b</i>	20
<i>amoxapine</i>	47	<i>amphotericin b liposome</i>	20
<i>amoxicillin</i>	26	<i>ampicillin</i>	26
<i>amoxicillin & k clavulanate chew tab</i> 400-57 mg	26	<i>ampicillin & sulbactam sodium for inj</i> 1.5 (1-0.5) gm.....	26
<i>amoxicillin & k clavulanate for susp</i> 200-28.5 mg/5ml	26	<i>ampicillin & sulbactam sodium for inj 3</i> (2-1) gm	26
<i>amoxicillin & k clavulanate for susp</i> 250-62.5 mg/5ml	26	<i>ampicillin & sulbactam sodium for iv</i> soln 1.5 (1-0.5) gm	26
<i>amoxicillin & k clavulanate for susp</i> 400-57 mg/5ml.....	26	<i>ampicillin & sulbactam sodium for iv</i> soln 15 (10-5) gm	26
<i>amoxicillin & k clavulanate for susp</i> 600-42.9 mg/5ml	26	<i>ampicillin & sulbactam sodium for iv</i> soln 3 (2-1) gm.....	26
<i>amoxicillin & k clavulanate tab 250-125</i> mg	26	<i>ampicillin sodium</i>	26
<i>amoxicillin & k clavulanate tab 500-125</i> mg	26	<i>anagrelide hcl</i>	80
<i>amoxicillin & k clavulanate tab 875-125</i> mg	26	<i>anastrozole</i>	29
<i>amoxicillin & k clavulanate tab er 12hr</i> 1000-62.5 mg.....	26	ANORO ELLIPT AER 62.5-25	90
<i>amphetamine-dextroamphetamine cap</i> er 24hr 10 mg.....	56	<i>aprepitant</i>	75
<i>amphetamine-dextroamphetamine cap</i> er 24hr 15 mg.....	56	<i>aprepitant capsule therapy pack 80 &</i> 125 mg	75
<i>amphetamine-dextroamphetamine cap</i> er 24hr 20 mg.....	57	<i>apri</i>	67
		APTIOM.....	52
		APTIVUS	21
		ARALAST NP	92
		<i>aranelle</i>	67
		ARCALYST	83
		AREXVY	84

<i>aripiprazole</i>	50	<i>bacitracin-polymyxin-neomycin-hc</i>	
ARISTADA	50	<i>ophth oint 1%</i>	88
ARISTADA INITIO.....	50	<i>baclofen</i>	59
<i>armodafinil</i>	60	BAFIERTAM	59
ARNUITY ELLIPTA.....	94	<i>balsalazide disodium</i>	76
<i>asenapine maleate</i>	50	BALVERSA.....	31
<i>aspirin-dipyridamole cap er 12hr 25-</i>		<i>balziva</i>	67
200 mg	80	BARACLUDGE	23
ASTAGRAF XL	83	BASAGLAR KWIKPEN	65
<i>atazanavir sulfat</i> e.....	21	BCG VACCINE.....	84
<i>atenolol</i>	44	BD ALCOHOL SWABS.....	65
<i>atenolol & chlorthalidone tab 100-25</i>		<i>benazepril & hydrochlorothiazide tab</i>	
mg	43	10-12.5 mg	39
<i>atenolol & chlorthalidone tab 50-25 mg</i>		<i>benazepril & hydrochlorothiazide tab</i>	
.....	43	20-12.5 mg	39
<i>atomoxetine hcl</i>	57	<i>benazepril & hydrochlorothiazide tab</i>	
<i>atorvastatin calcium</i>	43	20-25 mg	39
<i>atovaquone</i>	18	<i>benazepril & hydrochlorothiazide tab 5-</i>	
<i>atovaquone-proguanil hcl tab 250-100</i>		6.25mg.....	39
mg	21	<i>benazepril hcl</i>	40
<i>atovaquone-proguanil hcl tab 62.5-25</i>		BENDAMUSTINE HYDROCHLORID.....	27
mg	21	BENDEKA.....	27
ATROPINE SULFATE.....	90	BENLYSTA	83
<i>atropine sulfat</i> e (ophthalmic)	90	<i>benzonatate</i>	94
ATROVENT HFA.....	91	<i>benzoyl peroxide-erythromycin gel 5-</i>	
<i>aubra eq</i>	67	3%	94
AUGTYRO.....	31	<i>benztropine mesylate</i>	49
<i>aurovela 1/20</i>	67	BERINERT	80
<i>aurovela fe 1.5/30</i>	67	BESIVANCE	88
<i>aurovela fe 1/20</i>	67	BESREMI.....	30
AUSTEDO	58	<i>betaine powder for oral solution</i>	72
AUSTEDO XR	59	<i>betamethasone dipropionate (topical)</i>	
AUSTEDO XR TAB TITR KIT	59	96
AUVELITY TAB 45-105MG.....	47	<i>betamethasone dipropionate</i>	
<i>aviane</i>	67	<i>augmented</i>	96
<i>ayuna</i>	67	<i>betamethasone valerate</i>	96
AYVAKIT	31	BETASERON	59
<i>azacitidine</i>	28	<i>betaxolol hcl (ophth)</i>	89
<i>azathioprine</i>	83	<i>bethanechol chloride</i>	78
<i>azelastine hcl</i>	91	BETOPTIC-S	89
<i>azelastine hcl (ophth)</i>	89	BEVESPI AER 9-4.8MCG	90
<i>azithromycin</i>	25	<i>bexarotene</i>	30
<i>aztreonam</i>	18	<i>bexarotene (topical)</i>	97
<i>azurette</i>	67	BEXSERO INJ.....	84
B		<i>bicalutamide</i>	29
<i>bacitracin (ophthalmic)</i>	88	BICILLIN L-A	26
<i>bacitracin-polymyxin b ophth oint</i>	88	BIKTARVY TAB 30-120-15 MG.....	22

BIKTARVY TAB 50-200-25 MG.....	22	<i>buprenorphine hcl-naloxone hcl sl tab</i>	
<i>bisoprolol & hydrochlorothiazide tab</i>		8-2 mg (base equiv)	60
10-6.25 mg	44	<i>bupropion hcl</i>	47, 48
<i>bisoprolol & hydrochlorothiazide tab</i>		<i>bupropion hcl (smoking deterrent) ...</i>	60
2.5-6.25 mg	44	<i>buspirone hcl</i>	47
<i>bisoprolol & hydrochlorothiazide tab 5-</i>		<i>butorphanol tartrate</i>	17
6.25 mg	44	BYDUREON BCISE	62
<i>bisoprolol fumarate</i>	44	BYETTA.....	62
BIVIGAM	83	C	
<i>blisovi fe 1.5/30</i>	67	<i>cabergoline</i>	72
BOOSTRIX INJ	84	CABOMETYX	31
<i>bortezomib</i>	31	<i>calcipotriene</i>	95
BORTEZOMIB.....	31	<i>calcitonin (salmon) spray</i>	66
<i>bosentan</i>	46	<i>calcitrene</i>	95
BOSULIF	31	<i>calcitriol</i>	75
BRAFTOVI	31	<i>calcitriol (oral)</i>	75
BREO ELLIPTA INH 100-25	94	<i>calcium acetate (phosphate binder) ..</i>	74
BREO ELLIPTA INH 200-25	94	CALQUENCE	31
BREO ELLIPTA INH 50-25MCG.....	94	<i>camila</i>	67
BREZTRI AERO AER SPHERE	90	<i>candesartan cilexetil</i>	41, 42
BREZTRI AERO AER SPHERE		CAPLYTA	50
(INSTITUTIONAL PACK).....	91	CAPRELSA	32
<i>briellyn</i>	67	<i>captopril</i>	40
BRILINTA	80	<i>captopril & hydrochlorothiazide tab 25-</i>	
<i>brimonidine tartrate</i>	89	15 mg	39
<i>brinzolamide</i>	89	<i>captopril & hydrochlorothiazide tab 25-</i>	
BRIVIACT	53	25 mg	39
<i>bromfenac sodium (ophth)</i>	89	<i>captopril & hydrochlorothiazide tab 50-</i>	
<i>bromocriptine mesylate</i>	49	15 mg	39
BROMSITE.....	89	<i>captopril & hydrochlorothiazide tab 50-</i>	
BRONCHITOL.....	92	25 mg	39
BRUKINSA	31	<i>carb/levo orally disintegrating tab 10-</i>	
<i>budesonide</i>	76	100mg	49
<i>budesonide (inhalation)</i>	94	<i>carb/levo orally disintegrating tab 25-</i>	
<i>bumetanide</i>	45	100mg	49
<i>buprenorphine hcl</i>	60	<i>carb/levo orally disintegrating tab 25-</i>	
<i>buprenorphine hcl-naloxone hcl sl film</i>		250mg	49
12-3 mg (base equiv)	60	<i>carbamazepine</i>	53
<i>buprenorphine hcl-naloxone hcl sl film</i>		<i>carbidopa & levodopa tab 10-100 mg</i>	49
2-0.5 mg (base equiv)	60	<i>carbidopa & levodopa tab 25-100 mg</i>	49
<i>buprenorphine hcl-naloxone hcl sl film</i>		<i>carbidopa & levodopa tab 25-250 mg</i>	49
4-1 mg (base equiv)	60	<i>carbidopa & levodopa tab er 25-100</i>	
<i>buprenorphine hcl-naloxone hcl sl film</i>		mg	49
8-2 mg (base equiv)	60	<i>carbidopa & levodopa tab er 50-200</i>	
<i>buprenorphine hcl-naloxone hcl sl tab</i>		mg	49
2-0.5 mg (base equiv)	60	<i>carbidopa-levodopa-entacapone tabs</i>	
		12.5-50-200 mg	49

<i>carbidopa-levodopa-entacapone tabs</i> 18.75-75-200 mg	49	<i>cholestyramine light</i>	43
<i>carbidopa-levodopa-entacapone tabs</i> 25-100-200 mg	49	<i>ciclopirox olamine</i>	95
<i>carbidopa-levodopa-entacapone tabs</i> 31.25-125-200 mg	49	<i>cilostazol</i>	80
<i>carbidopa-levodopa-entacapone tabs</i> 37.5-150-200 mg	50	CILOXAN	88
<i>carbidopa-levodopa-entacapone tabs</i> 50-200-200 mg	50	CIMDUO TAB 300-300	22
<i>carboplatin</i>	27	<i>cinacalcet hcl</i>	73
<i>carglumic acid</i>	72	CIPRO	25
<i>carteolol hcl (ophth)</i>	89	<i>ciprofloxacin 200 mg/100ml in d5w</i> ..	25
<i>cartia xt</i>	44	<i>ciprofloxacin 400 mg/200ml in d5w</i> ..	25
<i>carvedilol</i>	44	<i>ciprofloxacin hcl</i>	25
<i>caspofungin acetate</i>	20	<i>ciprofloxacin hcl (ophth)</i>	88
CAYSTON	18	<i>ciprofloxacin-dexamethasone otic susp</i> 0.3-0.1%	90
<i>cefaclor</i>	24	<i>cisplatin</i>	27
CEFACLOR ER	24	<i>citalopram hydrobromide</i>	48
<i>cefadroxil</i>	24	<i>claravis</i>	94
CEFAZOLIN	24	<i>clarithromycin</i>	25
CEFAZOLIN INJ 1GM/50ML	24	<i>clindamycin hcl</i>	18
<i>cefazolin sodium</i>	24	<i>clindamycin palmitate hydrochloride</i> .	18
CEFAZOLIN SOLN 2GM/100ML-4% ...	24	<i>clindamycin phosphate</i>	18
<i>cefdinir</i>	24	<i>clindamycin phosphate (topical)</i> .	94, 95
<i>cefepime hcl</i>	24	<i>clindamycin phosphate in d5w iv soln</i> 300 mg/50ml	18
<i>cefixime</i>	24	<i>clindamycin phosphate in d5w iv soln</i> 600 mg/50ml	18
<i>cefoxitin sodium</i>	24	<i>clindamycin phosphate in d5w iv soln</i> 900 mg/50ml	18
<i>cefpodoxime proxetil</i>	24	<i>clindamycin phosphate vaginal</i>	78
<i>cefprozil</i>	25	CLINDMYC/NAC INJ 300/50ML	18
<i>ceftazidime</i>	25	CLINDMYC/NAC INJ 600/50ML	18
<i>ceftriaxone sodium</i>	25	CLINDMYC/NAC INJ 900/50ML	19
<i>cefuroxime axetil</i>	25	CLINIMIX INJ 4.25/D10	87
<i>cefuroxime sodium</i>	25	CLINIMIX INJ 4.25/D5W	87
<i>celecoxib</i>	16	CLINIMIX INJ 5%/D15W	87
<i>cephalexin</i>	25	CLINIMIX INJ 5%/D20W	87
CERDELGA	72	CLINIMIX INJ 6/5	87
CEREZYME	72	CLINIMIX INJ 8/10	87
<i>cetirizine hcl</i>	91	CLINIMIX INJ 8/14	87
<i>chateal eq</i>	67	<i>clinisol sf 15%</i>	87
CHEMET	67	CLINOLIPID EMU 20%	87
<i>chlorhexidine gluconate (mouth-throat)</i>	98	<i>clobazam</i>	53
<i>chloroquine phosphate</i>	21	<i>clobetasol propionate</i>	96
<i>chlorpromazine hcl</i>	50	<i>clobetasol propionate e</i>	96
<i>chlorthalidone</i>	45	<i>clomipramine hcl</i>	48
<i>cholestyramine</i>	43	<i>clonazepam</i>	53
		<i>clonidine</i>	46
		<i>clonidine hcl</i>	46

<i>clopidogrel bisulfate</i>	80	CYSTARAN	90
<i>clorazepate dipotassium</i>	53	<i>cytarabine</i>	28
<i>clotrimazole</i>	98	D	
<i>clotrimazole (topical)</i>	95	D10W/NAACL INJ 0.2%	85
<i>clotrimazole w/ betamethasone cream</i> 1-0.05%.....	95	D2.5W/NAACL INJ 0.45%.....	85
<i>clozapine</i>	50, 51	D5W/LYTES INJ #48.....	85
COARTEM TAB 20-120MG.....	21	<i>dabigatran etexilate mesylate</i>	79
<i>colchicine</i>	16	<i>dalfampridine</i>	59
<i>colchicine w/ probenecid tab 0.5-500</i> <i>mg</i>	16	<i>danazol</i>	71
<i>colesevelam hcl</i>	43	<i>dantrolene sodium</i>	60
<i>colestipol hcl</i>	43	<i>dapsone</i>	19
<i>colistimethate sodium</i>	19	DAPTACEL INJ	84
COMBIGAN SOL 0.2/0.5%	89	<i>daptomycin</i>	19
COMBIVENT AER 20-100	91	DAPTOMYCIN.....	19
COMETRIQ (60MG DOSE)	32	<i>darunavir</i>	21
COMETRIQ KIT 100MG.....	32	<i>dasatinib</i>	32
COMETRIQ KIT 140MG.....	32	<i>dasetta 1/35</i>	67
COMPLERA TAB.....	22	<i>dasetta 7/7/7</i>	68
<i>compro</i>	75	DAURISMO	32
<i>constulose</i>	76	DAYVIGO	57
COPIKTRA	32	<i>deblitane</i>	68
CORLANOR.....	46	<i>deferasirox</i>	67
COTELLIC.....	32	DELSTRIGO TAB.....	22
CREON CAP 12000UNT.....	77	DENGVAXIA SUS.....	84
CREON CAP 24000UNT.....	77	DEPO-SUBQ PROVERA 104	68
CREON CAP 3000UNIT	77	<i>depo-testosterone</i>	61
CREON CAP 36000UNT.....	77	DESCOVY TAB 120-15MG.....	22
CREON CAP 6000UNIT	77	DESCOVY TAB 200/25MG.....	22
<i>cromolyn sodium</i>	92	<i>desipramine hcl</i>	48
<i>cromolyn sodium (mastocytosis)</i>	77	<i>desmopressin acetate</i>	73
<i>cromolyn sodium (ophth)</i>	89	<i>desmopressin acetate spray</i>	73
<i>cryselle-28</i>	67	<i>desmopressin acetate spray</i> <i>refrigerated</i>	73
<i>cyanocobalamin</i>	98	<i>desogest-eth estrad & eth estrad tab</i> <i>0.15-0.02/0.01 mg(21/5)</i>	68
<i>cyclobenzaprine hcl</i>	60	<i>desogestrel & ethinyl estradiol tab 0.15</i> <i>mg-30 mcg</i>	68
<i>cyclophosphamide</i>	27	<i>desvenlafaxine succinate</i>	48
CYCLOPHOSPHAMIDE	27	<i>dexamethasone</i>	72
CYCLOPHOSPHAMIDE MONOHYDR....	28	DEXAMETHASONE INTENSOL.....	72
<i>cycloserine</i>	23	<i>dexamethasone sodium phosphate</i> ...	72
<i>cyclosporine</i>	83	<i>dexamethasone sodium phosphate</i> <i>(ophth)</i>	89
<i>cyclosporine modified (for</i> <i>microemulsion)</i>	84	DEXCOM G5 MIS RECEIVER.....	61
<i>cyproheptadine hcl</i>	91	DEXCOM G5 MIS TRANSMIT	61
<i>cyred eq</i>	67	DEXCOM G6 MIS RECEIVER.....	61
CYSTADROPS.....	90	DEXCOM G6 MIS SENSOR	61
CYSTAGON	73		

DEXCOM G6 MIS TRANSMIT	61	<i>diphenoxylate w/ atropine tab 2.5-</i>	
DEXCOM G7 MIS RECEIVER	61	0.025 mg	77
DEXCOM G7 MIS SENSOR	61	<i>dipyridamole</i>	80
<i>dexmethylphenidate hcl</i>	57	<i>disopyramide phosphate</i>	42
<i>dextrose</i>	87	<i>disulfiram</i>	60
<i>dextrose 10% w/ sodium chloride</i>		<i>divalproex sodium</i>	54
0.45%.....	86	<i>docetaxel</i>	30
<i>dextrose 2.5% w/ sodium chloride</i>		DOCETAXEL.....	30
0.45%.....	85	<i>dofetilide</i>	42
<i>dextrose 5% in lactated ringers</i>	85	<i>donepezil hydrochloride</i>	47
<i>dextrose 5% w/ sodium chloride 0.2%</i>		DOPTelet	80
.....	85	<i>dorzolamide hcl</i>	89
<i>dextrose 5% w/ sodium chloride</i>		<i>dorzolamide hcl-timolol maleate ophth</i>	
0.225%.....	86	soln 2-0.5%.....	89
<i>dextrose 5% w/ sodium chloride 0.3%</i>		<i>dotti</i>	71
.....	86	DOVATO TAB 50-300MG	22
<i>dextrose 5% w/ sodium chloride 0.45%</i>		<i>doxazosin mesylate</i>	40
.....	86	<i>doxepin hcl</i>	48
<i>dextrose 5% w/ sodium chloride 0.9%</i>		<i>doxepin hcl (sleep)</i>	57
.....	86	<i>doxorubicin hcl</i>	28
DIACOMIT	53	<i>doxorubicin hcl liposomal</i>	28
<i>diazepam</i>	53	DOXORUBICIN HYDROCHLORIDE	28
<i>diazepam (anticonvulsant)</i>	53	<i>doxy 100</i>	27
<i>diazepam inj</i>	53	<i>doxycycline (monohydrate)</i>	27
<i>diazepam intensol</i>	53	<i>doxycycline hyclate</i>	27
<i>diazoxide</i>	72	DRIZALMA SPRINKLE.....	48
<i>diclofenac potassium</i>	16	<i>dronabinol</i>	75
<i>diclofenac sodium</i>	16	<i>drospirenone-ethinyl estradiol tab 3-</i>	
<i>diclofenac sodium (ophth)</i>	89	0.02 mg	68
<i>diclofenac sodium (topical)</i>	97	<i>drospirenone-ethinyl estradiol tab 3-</i>	
<i>dicloxacillin sodium</i>	26	0.03 mg	68
<i>dicyclomine hcl</i>	76	DROXIA	80
DIFICID	25	<i>droxidopa</i>	46
<i>diflunisal</i>	16	DULERA AER 100-5MCG	94
<i>digoxin</i>	46	DULERA AER 200-5MCG	94
<i>dihydroergotamine mesylate</i>	58	DULERA AER 50-5MCG.....	94
DILANTIN.....	54	<i>duloxetine hcl</i>	48
DILANTIN INFATABS.....	54	DUPIXENT	81
DILANTIN-125	54	<i>dutasteride</i>	78
<i>diltiazem hcl</i>	44	<i>dutasteride-tamsulosin hcl cap 0.5-0.4</i>	
<i>diltiazem hcl coated beads</i>	45	mg	78
<i>diltiazem hcl extended release beads</i>	45	E	
<i>dilt-xr</i>	44	<i>e.e.s. 400</i>	25
DIP/TET PED INJ 25-5LFU	84	<i>ec-naproxen</i>	16
<i>diphenhydramine hcl</i>	91	EDURANT	21
<i>diphenoxylate w/ atropine liq 2.5-0.025</i>		<i>efavirenz</i>	21
mg/5ml	77		

<i>efavirenz-emtricitabine-tenofovir df tab</i> <i>600-200-300 mg</i>	22	ENTRESTO CAP 6-6MG.....	41
<i>efavirenz-lamivudine-tenofovir df tab</i> <i>400-300-300 mg</i>	22	ENTRESTO TAB 24-26MG	41
<i>efavirenz-lamivudine-tenofovir df tab</i> <i>600-300-300 mg</i>	22	ENTRESTO TAB 49-51MG	41
ELIGARD	29	ENTRESTO TAB 97-103MG	41
<i>elinest</i>	68	<i>enulose</i>	76
ELIQUIS	79	EPCLUSA PAK 150-37.5	23
ELIQUIS STARTER PACK.....	79	EPCLUSA PAK 200-50MG.....	23
ELLECE	28	EPCLUSA TAB 200-50MG.....	23
<i>eluryng</i>	68	EPCLUSA TAB 400-100	23
EMSAM	48	EPIDIOLEX	54
<i>emtricitabine</i>	21	<i>epinephrine (anaphylaxis)</i>	46, 92
<i>emtricitabine-tenofovir disoproxil</i> <i>fumarate tab 100-150 mg</i>	22	<i>epitol</i>	54
<i>emtricitabine-tenofovir disoproxil</i> <i>fumarate tab 133-200 mg</i>	22	<i>eplerenone</i>	40
<i>emtricitabine-tenofovir disoproxil</i> <i>fumarate tab 167-250 mg</i>	22	EPRONTIA	54
<i>emtricitabine-tenofovir disoproxil</i> <i>fumarate tab 200-300 mg</i>	22	<i>ergocalciferol</i>	98
EMTRIVA	21	<i>ergotamine w/ caffeine tab 1-100 mg</i>	58
EMVERM.....	19	ERIVEDGE	32
<i>emzahn</i>	68	ERLEADA.....	29
<i>enalapril maleate</i>	40	<i>erlotinib hcl</i>	32
<i>enalapril maleate & hydrochlorothiazide</i> <i>tab 10-25 mg</i>	39	<i>errin</i>	68
<i>enalapril maleate & hydrochlorothiazide</i> <i>tab 5-12.5 mg</i>	39	<i>ertapenem sodium</i>	19
ENBREL.....	81	<i>ery</i>	95
ENBREL MINI	81	<i>ery-tab</i>	25
ENBREL SURECLICK.....	81	ERYTHROCIN LACTOBIONATE	25
ENDARI.....	80	<i>erythromycin (acne aid)</i>	95
<i>endocet tab 10-325mg</i>	17	<i>erythromycin (ophth)</i>	88
<i>endocet tab 2.5-325mg</i>	17	<i>erythromycin base</i>	25
<i>endocet tab 5-325mg</i>	17	<i>erythromycin ethylsuccinate</i>	25
<i>endocet tab 7.5-325mg</i>	17	<i>erythromycin lactobionate</i>	25
ENGERIX-B.....	84	<i>escitalopram oxalate</i>	48
<i>enilloring</i>	68	<i>esomeprazole magnesium</i>	78
<i>enoxaparin sodium</i>	79	<i>estarylla</i>	68
<i>enpresse-28</i>	68	<i>estradiol</i>	71
<i>enskyce</i>	68	<i>estradiol & norethindrone acetate tab</i> <i>0.5-0.1 mg</i>	71
ENSTILAR AER	96	<i>estradiol & norethindrone acetate tab</i> <i>1-0.5 mg</i>	71
<i>entacapone</i>	50	<i>estradiol vaginal</i>	71
<i>entecavir</i>	23	<i>estradiol valerate</i>	71
ENTRESTO CAP 15-16MG	41	<i>ethambutol hcl</i>	23
		<i>ethosuximide</i>	54
		<i>ethynodiol diacetate & ethinyl estradiol</i> <i>tab 1 mg-35 mcg</i>	68
		<i>ethynodiol diacetate & ethinyl estradiol</i> <i>tab 1 mg-50 mcg</i>	68
		<i>etodolac</i>	16

<i>etonogestrel-ethinyl estradiol va ring</i>	
<i>0.12-0.015 mg/24hr</i>	68
<i>etoposide</i>	30
<i>etravirine</i>	21
EULEXIN	29
<i>euthyrox</i>	74
<i>everolimus</i>	32
<i>everolimus (immunosuppressant)</i>	84
EVOTAZ TAB 300-150	22
<i>exemestane</i>	29
EYSUVIS	89
<i>ezetimibe</i>	43
<i>ezetimibe-simvastatin tab 10-10 mg</i>	43
<i>ezetimibe-simvastatin tab 10-20 mg</i>	43
<i>ezetimibe-simvastatin tab 10-40 mg</i>	43
<i>ezetimibe-simvastatin tab 10-80 mg</i>	43
F	
FABRAZYME	73
<i>falmina</i>	68
<i>famciclovir</i>	23
<i>famotidine</i>	76
<i>famotidine in nacl 0.9% iv soln 20</i>	
<i>mg/50ml</i>	76
FANAPT	51
FANAPT PAK	51
FARXIGA	62
FASENRA	92
FASENRA PEN	92
<i>felbamate</i>	54
<i>felodipine</i>	45
<i>fenofibrate</i>	42
<i>fenofibrate micronized</i>	42
<i>fentanyl</i>	16
<i>fentanyl citrate</i>	17
FETZIMA	48
FETZIMA CAP TITRATIO	48
FIASP	65
FIASP FLEXTOUCH	65
FIASP PENFILL	65
FIASP PUMPCART	65
<i>finasteride</i>	78
<i> fingolimod hcl</i>	59
FINTEPLA	54
FIRMAGON	29
<i>flac</i>	90
FLAREX	89
FLEBOGAMMA DIF	83
<i>flecainide acetate</i>	42
<i>fluconazole</i>	20
<i>fluconazole in nacl 0.9% inj 200</i>	
<i>mg/100ml</i>	20
<i>fluconazole in nacl 0.9% inj 400</i>	
<i>mg/200ml</i>	20
<i>flucytosine</i>	20
<i>fludrocortisone acetate</i>	72
<i>flunisolide (nasal)</i>	93
<i>fluocinolone acetonide</i>	96
<i>fluocinolone acetonide (otic)</i>	90
<i>fluocinonide</i>	96
<i>fluocinonide emulsified base</i>	96
<i>fluorometholone (ophth)</i>	89
<i>fluorouracil</i>	28
<i>fluorouracil (topical)</i>	97
<i>fluoxetine hcl</i>	48
<i>fluphenazine decanoate</i>	51
<i>fluphenazine hcl</i>	51
<i>flurbiprofen</i>	16
<i>flurbiprofen sodium</i>	89
<i>fluticasone propionate</i>	96
<i>fluticasone propionate (nasal)</i>	93
<i>fluticasone-salmeterol aer powder ba</i>	
<i>100-50 mcg/act</i>	94
<i>fluticasone-salmeterol aer powder ba</i>	
<i>250-50 mcg/act</i>	94
<i>fluticasone-salmeterol aer powder ba</i>	
<i>500-50 mcg/act</i>	94
<i>fluvoxamine maleate</i>	47
<i>folic acid</i>	98
<i>fondaparinux sodium</i>	79
<i>fosamprenavir calcium</i>	21
<i>fosinopril sodium</i>	40
<i>fosinopril sodium & hydrochlorothiazide</i>	
<i>tab 10-12.5 mg</i>	39
<i>fosinopril sodium & hydrochlorothiazide</i>	
<i>tab 20-12.5 mg</i>	39
FOTIVDA	32
FRUZAQLA	32
<i>fulvestrant</i>	29
<i>furosemide</i>	45
<i>furosemide inj</i>	45
FUZEON	21
<i>fyavolv tab 0.5mg-2.5mcg</i>	71
<i>fyavolv tab 1mg-5mcg</i>	71
FYCOMPA	54

G	
<i>gabapentin</i>	54
<i>galantamine hydrobromide</i>	47
GAMASTAN INJ	83
GAMMAGARD LIQUID.....	83
GAMMAGARD S/D IGA LESS TH.....	83
GAMMAKED	83
GAMMAPLEX	83
GAMUNEX-C	83
<i>ganciclovir sodium</i>	23
GARDASIL 9 INJ.....	84
<i>gatifloxacin (ophth)</i>	88
GATTEX	77
GAUZE PADS 2.....	65
<i>gavilyte-c</i>	76
<i>gavilyte-g</i>	76
<i>gavilyte-n/flavor pack</i>	76
GAVRETO	32
<i>gefitinib</i>	33
<i>gemcitabine hcl</i>	28
<i>gemfibrozil</i>	42
GEMTESA	78
<i>generlac</i>	77
<i>gengraf</i>	84
GENOTROPIN.....	73
GENOTROPIN MINIQUICK.....	73
<i>gentamicin in saline inj 0.8 mg/ml</i>	19
<i>gentamicin in saline inj 1 mg/ml</i>	19
<i>gentamicin in saline inj 1.2 mg/ml</i>	19
<i>gentamicin in saline inj 1.6 mg/ml</i>	19
<i>gentamicin in saline inj 2 mg/ml</i>	19
<i>gentamicin sulfate</i>	19
<i>gentamicin sulfate (ophth)</i>	88
<i>gentamicin sulfate (topical)</i>	95
GENVOYA TAB	23
GILOTRIF	33
<i>glatiramer acetate</i>	59
<i>glatopa</i>	59
GLEOSTINE	28
<i>glimepiride</i>	62
<i>glipizide</i>	62
<i>glipizide xl</i>	62
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	62
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	62
<i>glipizide-metformin hcl tab 5-500 mg</i>	62
<i>glycopyrrolate</i>	76
<i>glydo</i>	97
GLYXAMBI TAB 10-5 MG	62
GLYXAMBI TAB 25-5 MG	62
<i>granisetron hcl</i>	75
<i>griseofulvin microsize</i>	20
<i>griseofulvin ultramicrosize</i>	20
<i>guanfacine hcl</i>	46
<i>guanfacine hcl (adhd)</i>	57
GVOKE HYPOPEN 2-PACK	72
GVOKE KIT	72
GVOKE PFS	72
H	
HAEGARDA.....	80
<i>hailey 1.5/30</i>	68
<i>halobetasol propionate</i>	96
<i>haloette</i>	68
<i>haloperidol</i>	51
<i>haloperidol decanoate</i>	51
<i>haloperidol lactate</i>	51
HARVONI PAK 33.75-150MG.....	23
HARVONI PAK 45-200MG	23
HARVONI TAB 45-200MG	23
HARVONI TAB 90-400MG	24
HAVRIX.....	84
<i>heather</i>	68
HEP SOD/D5W INJ 20000UNT.....	79
HEP SOD/D5W INJ 25000UNT.....	79
HEP SOD/NAACL INJ 12500UNT	79
HEP SOD/NAACL INJ 25000UNT	79
<i>heparin sodium (porcine)</i>	79
HEPARIN/NAACL INJ 25000UNT	79
HEPLISAV-B	84
HERCEP HYLEC SOL 60-10000	33
HERCEPTIN	33
HERZUMA.....	33
HIBERIX.....	84
HUMIRA	81
HUMIRA PEN.....	81
HUMIRA PEN KIT PS/UV	81
HUMIRA PEN-CD/UC/HS START.....	81
HUMIRA PEN-PEDIATRIC UC S	81
HUMULIN R U-500 (CONCENTR	65
HUMULIN R U-500 KWIKPEN	65
<i>hydralazine hcl</i>	46
<i>hydrochlorothiazide</i>	45
<i>hydrocodone bitartrate</i>	16

<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	17	INFANRIX INJ	84
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	17	INFLIXIMAB	81
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	17	INLYTA	33
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	17	INQOVI TAB 35-100MG	28
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	17	INREBIC.....	33
<i>hydrocortisone</i>	72	INSULIN PEN NEEDLES: BD/NOVO ...	65
<i>hydrocortisone (intrarectal)</i>	76	INSULIN SAFETY NEEDLES	65
<i>hydrocortisone (rectal)</i>	97	INSULIN SYRINGES: BD.....	65
<i>hydrocortisone (topical)</i>	96	INTELENCE.....	21
<i>hydromorphone hcl</i>	17	INTRALIPID	88
<i>hydroxychloroquine sulfate</i>	82	<i>introvale</i>	68
<i>hydroxyurea</i>	30	INVEGA HAFYERA.....	51
<i>hydroxyzine hcl</i>	91	INVEGA SUSTENNA	51
<i>hydroxyzine pamoate</i>	91	INVEGA TRINZA.....	51
HYSINGLA ER	16	IPOL INJ INACTIVE	84
I		<i>ipratropium bromide</i>	91
<i>ibandronate sodium</i>	66	<i>ipratropium bromide (nasal)</i>	91
IBRANCE	33	<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	91
<i>ibu</i>	16	<i>irbesartan</i>	42
<i>ibuprofen</i>	16	<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	41
<i>icatibant acetate</i>	80	<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	41
<i>iclevia</i>	68	<i>irinotecan hcl</i>	30
ICLUSIG.....	33	ISENTRESS	21
IDACIO (2 PEN)	81	ISENTRESS HD	21
IDACIO (2 SYRINGE)	81	<i>isibloom</i>	68
IDACIO CROHN INJ DISEASE	81	ISOLYTE-P INJ /D5W	86
IDACIO PLAQU INJ PSORIASIS.....	81	ISOLYTE-S INJ	86
IDHIFA.....	33	ISOLYTE-S INJ PH 7.4.....	86
<i>imatinib mesylate</i>	33	<i>isoniazid</i>	23
IMBRUVICA	33	<i>isosorbide dinitrate</i>	46
<i>imipenem-cilastatin intravenous for soln 250 mg</i>	19	<i>isosorbide mononitrate</i>	46
<i>imipenem-cilastatin intravenous for soln 500 mg</i>	19	<i>isotretinoin</i>	95
<i>imipramine hcl</i>	48	<i>itraconazole</i>	20
<i>imiquimod</i>	97	<i>ivabradine hcl</i>	46
IMOVAX RABIES (H.D.C.V.)	84	<i>ivermectin</i>	19
INBRIJA	50	IWILFIN	30
<i>incassia</i>	68	IXCHIQ INJ.....	84
INCRELEX.....	73	IXIARO INJ.....	84
INCRUSE ELLIPTA.....	91	J	
<i>indapamide</i>	45	JAKAFI.....	33
		<i>jantoven</i>	79
		JANUMET TAB 50-1000	62
		JANUMET TAB 50-500MG	62
		JANUMET XR TAB 100-1000.....	63

JANUMET XR TAB 50-1000	63	<i>kcl 40 meq/l (0.3%) in nacl 0.9% inj</i>	86
JANUMET XR TAB 50-500MG.....	62	KCL/D5W/NACL INJ 0.3/0.9%.....	86
JANUVIA	63	<i>kelnor 1/35</i>	68
JARDIANCE.....	63	<i>kelnor 1/50</i>	68
<i>jasmiel</i>	68	KERENDIA	40
<i>javygtor</i>	73	KESIMPTA	59
JAYPIRCA	33	<i>ketoconazole</i>	20
JENTADUETO TAB 2.5-1000.....	63	<i>ketoconazole (topical)</i>	95, 96
JENTADUETO TAB 2.5-500.....	63	<i>ketorolac tromethamine (ophth)</i>	89
JENTADUETO TAB 2.5-850.....	63	KEVZARA	81
JENTADUETO TAB XR 2.5-1000MG ...	63	KEYTRUDA	33
JENTADUETO TAB XR 5-1000MG	63	KINRIX INJ.....	84
<i>jinteli</i>	71	<i>kionex</i>	67
<i>jolessa</i>	68	KISQALI 200 DOSE	33
<i>juleber</i>	68	KISQALI 200 PAK FEMARA.....	30
JULUCA TAB 50-25MG.....	23	KISQALI 400 DOSE	34
<i>junel 1.5/30</i>	68	KISQALI 400 PAK FEMARA.....	30
<i>junel 1/20</i>	68	KISQALI 600 DOSE	34
<i>junel fe 1.5/30</i>	68	KISQALI 600 PAK FEMARA.....	30
<i>junel fe 1/20</i>	68	<i>klayesta</i>	95
JYLAMVO.....	82	<i>klor-con</i>	87
JYNNEOS.....	84	<i>klor-con 10</i>	87
K		<i>klor-con 8</i>	87
KADCYLA.....	33	<i>klor-con m10</i>	87
KALYDECO.....	92	<i>klor-con m15</i>	87
KANJINTI	33	<i>klor-con m20</i>	87
<i>kariva</i>	68	KORLYM.....	73
<i>kcl 10 meq/l (0.075%) in dextrose 5%</i> <i>& nacl 0.45% inj</i>	86	KOSELUGO.....	34
<i>kcl 20 meq/l (0.149%) in nacl 0.45%</i> <i>inj</i>	86	<i>kourzeq</i>	98
<i>kcl 20 meq/l (0.15%) in dextrose 5% &</i> <i>nacl 0.2% inj</i>	86	KRAZATI	34
<i>kcl 20 meq/l (0.15%) in dextrose 5% &</i> <i>nacl 0.45% inj</i>	86	<i>kurvelo</i>	69
<i>kcl 20 meq/l (0.15%) in dextrose 5% &</i> <i>nacl 0.9% inj</i>	86	L	
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	86	<i>labetalol hcl</i>	44
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	86	<i>lacosamide</i>	54
<i>kcl 30 meq/l (0.224%) in dextrose 5%</i> <i>& nacl 0.45% inj</i>	86	<i>lacosamide oral</i>	54
<i>kcl 40 meq/l (0.3%) in dextrose 5% &</i> <i>nacl 0.45% inj</i>	86	<i>lactated ringer's solution</i>	86
<i>kcl 40 meq/l (0.3%) in dextrose 5% &</i> <i>nacl 0.9% inj</i>	86	<i>lactic acid (ammonium lactate)</i>	97
		<i>lactulose</i>	77
		<i>lactulose (encephalopathy)</i>	77
		<i>lamivudine</i>	21
		<i>lamivudine (hbv)</i>	24
		<i>lamivudine-zidovudine tab 150-300 mg</i>	23
		<i>lamotrigine</i>	54
		<i>lanreotide acetate</i>	73
		<i>lansoprazole</i>	78
		<i>lanthanum carbonate</i>	74

LANTUS	65	<i>levonorgestrel & ethinyl estradiol tab</i>	
LANTUS SOLOSTAR	65	0.1 mg-20 mcg	69
<i>lapatinib ditosylate</i>	34	<i>levonorgestrel & ethinyl estradiol tab</i>	
<i>larin 1.5/30</i>	69	0.15 mg-30 mcg	69
<i>larin 1/20</i>	69	<i>levonorgestrel-eth estra tab 0.05-</i>	
<i>larin fe 1.5/30</i>	69	30/0.075-40/0.125-30mg-mcg	69
<i>larin fe 1/20</i>	69	<i>levora 0.15/30-28</i>	69
<i>latanoprost</i>	90	<i>levo-t</i>	74
<i>leena</i>	69	<i>levothyroxine sodium</i>	74
<i>leflunomide</i>	82	<i>levoxyl</i>	75
<i>lenalidomide</i>	29, 30	<i>l-glutamine (sickle cell)</i>	80
LENVIMA 10 MG DAILY DOSE	34	LIBERVANT	55
LENVIMA 12MG DAILY DOSE	34	<i>lidocaine</i>	97
LENVIMA 20 MG DAILY DOSE	34	<i>lidocaine hcl</i>	97
LENVIMA 4 MG DAILY DOSE	34	<i>lidocaine hcl (local anesth.)</i>	18
LENVIMA 8 MG DAILY DOSE	34	<i>lidocaine hcl (mouth-throat)</i>	98
LENVIMA CAP 14 MG	34	<i>lidocaine-prilocaine cream 2.5-2.5%</i>	97
LENVIMA CAP 18 MG	34	<i>lidocan</i>	97
LENVIMA CAP 24 MG	34	<i>linezolid</i>	19
<i>lessina</i>	69	LINEZOLID INJ 2MG/ML	19
<i>letrozole</i>	29	LINZESS	77
<i>leucovorin calcium</i>	38	<i>liothyronine sodium</i>	75
LEUKERAN	28	<i>lisinopril</i>	40
<i>leuprolide acetate</i>	29	<i>lisinopril & hydrochlorothiazide tab 10-</i>	
<i>levabuterol hcl</i>	92	12.5 mg	39
<i>levabuterol tartrate</i>	92	<i>lisinopril & hydrochlorothiazide tab 20-</i>	
<i>levetiracetam</i>	54	12.5 mg	39
<i>levetiracetam in sodium chloride iv soln</i>		<i>lisinopril & hydrochlorothiazide tab 20-</i>	
1000 mg/100ml	54	25 mg	39
<i>levetiracetam in sodium chloride iv soln</i>		<i>lithium</i>	59
1500 mg/100ml	55	<i>lithium carbonate</i>	59
<i>levetiracetam in sodium chloride iv soln</i>		<i>loestrin 1.5/30-21</i>	69
500 mg/100ml	54	<i>loestrin 1/20-21</i>	69
<i>levobunolol hcl</i>	90	<i>loestrin fe 1.5/30</i>	69
<i>levocarnitine (metabolic modifiers)</i>	73	<i>loestrin fe 1/20</i>	69
<i>levocetirizine dihydrochloride</i>	91	LOKELMA	67
<i>levofloxacin</i>	25	LONSURF TAB 15-6.14	28
<i>levofloxacin in d5w iv soln 250</i>		LONSURF TAB 20-8.19	28
mg/50ml	25	<i>loperamide hcl</i>	77
<i>levofloxacin in d5w iv soln 500</i>		<i>lopinavir-ritonavir soln 400-100</i>	
mg/100ml	25	mg/5ml (80-20 mg/ml)	23
<i>levofloxacin in d5w iv soln 750</i>		<i>lopinavir-ritonavir tab 100-25 mg</i>	23
mg/150ml	25	<i>lopinavir-ritonavir tab 200-50 mg</i>	23
<i>levonest</i>	69	<i>lorazepam</i>	47
<i>levonorgestrel & ethinyl estradiol (91-</i>		<i>lorazepam intensol</i>	47
<i>day) tab 0.15-0.03 mg</i>	69	LORBRENA	34
		<i>loryna</i>	69

<i>losartan potassium</i>	42	<i>medroxyprogesterone acetate</i>	
<i>losartan potassium &</i>		<i>(contraceptive)</i>	69
<i>hydrochlorothiazide tab 100-12.5 mg</i>		<i>mefloquine hcl</i>	21
.....	41	<i>megestrol acetate</i>	29, 74
<i>losartan potassium &</i>		<i>megestrol acetate (appetite)</i>	74
<i>hydrochlorothiazide tab 100-25 mg</i>	41	MEKINIST	35
<i>losartan potassium &</i>		MEKTOVI.....	35
<i>hydrochlorothiazide tab 50-12.5 mg</i>		<i>meloxicam</i>	16
.....	41	<i>memantine hcl</i>	47
LOTEMAX	89	MENACTRA INJ	85
<i>loteprednol etabonate</i>	89	MENQUADFI INJ.....	85
<i>lovastatin</i>	43	MENVEO INJ	85
<i>low-ogestrel</i>	69	MENVEO SOL	85
<i>loxapine succinate</i>	51	<i>mercaptopurine</i>	28
LUMAKRAS	34	<i>meropenem</i>	19
LUMIGAN	90	<i>mesalamine</i>	76
LUMIZYME	73	<i>mesalamine w/ cleanser</i>	76
LUPRON DEPOT (1-MONTH).....	29	MESNEX.....	38
LUPRON DEPOT (3-MONTH).....	29	<i>metformin hcl</i>	63
LUPRON DEPOT-PED (1-MONTH	73	<i>methadone hcl</i>	17
LUPRON DEPOT-PED (3-MONTH	73	<i>methadone hydrochloride i</i>	17
LUPRON DEPOT-PED (6-MONTH	73	<i>methazolamide</i>	45
<i>lurasidone hcl</i>	51	<i>methenamine hippurate</i>	19
<i>lutera</i>	69	<i>methimazole</i>	75
<i>lyleq</i>	69	<i>methotrexate sodium</i>	28, 83
<i>lyllana</i>	71	<i>methsuximide</i>	55
LYNPARZA	34	<i>methylphenidate hcl</i>	57
LYSODREN	29	<i>methylprednisolone</i>	72
LYTGOBI (12 MG DAILY DOSE)	34	<i>methylprednisolone acetate</i>	72
LYTGOBI (16 MG DAILY DOSE)	34	<i>methylprednisolone sod succ</i>	72
LYTGOBI (20 MG DAILY DOSE)	34	<i>methyltestosterone</i>	61
<i>lyza</i>	69	<i>metoclopramide hcl</i>	75
M		<i>metolazone</i>	45
<i>magnesium sulfate</i>	86	<i>metoprolol & hydrochlorothiazide tab</i>	
MAGNESIUM SULFATE.....	86	<i>100-25 mg</i>	44
<i>magnesium sulfate in dextrose 5% iv</i>		<i>metoprolol & hydrochlorothiazide tab</i>	
<i>soln 1 gm/100ml</i>	86	<i>100-50 mg</i>	44
<i>malathion</i>	98	<i>metoprolol & hydrochlorothiazide tab</i>	
<i>maraviroc</i>	21	<i>50-25 mg</i>	44
<i>marlissa</i>	69	<i>metoprolol succinate</i>	44
MARPLAN	48	<i>metoprolol tartrate</i>	44
MATULANE	30	<i>metronidazole</i>	19
MAVYRET PAK 50-20MG	24	<i>metronidazole (topical)</i>	97
MAVYRET TAB 100-40MG	24	<i>metronidazole vaginal</i>	78
<i>meclizine hcl</i>	75	<i>metyrosine</i>	46
<i>medroxyprogesterone acetate</i>	74	MG SO4/D5W INJ 10MG/ML.....	86
		<i>miconazole sodium</i>	20

<i>microgestin 1.5/30</i>	69	<i>naloxone hcl</i>	60
<i>microgestin 1/20</i>	69	<i>naltrexone hcl</i>	60
<i>microgestin fe 1.5/30</i>	69	NAMZARIC CAP 14-10MG	47
<i>microgestin fe 1/20</i>	69	NAMZARIC CAP 21-10MG	47
<i>midodrine hcl</i>	46	NAMZARIC CAP 28-10MG	47
MIEBO	90	NAMZARIC CAP 7-10MG	47
<i>mifepristone (hyperglycemia)</i>	73	NAMZARIC CAP PACK	47
<i>miglustat</i>	73	<i>naproxen</i>	16
<i>mili</i>	69	<i>naproxen dr</i>	16
<i>mimvey</i>	71	<i>naproxen sodium</i>	16
<i>minocycline hcl</i>	27	<i>naratriptan hcl</i>	58
<i>minoxidil</i>	46	NATACYN	88
<i>mirtazapine</i>	48	<i>nateglinide</i>	63
<i>misoprostol</i>	77	NATPARA	66
MITIGARE	16	NAYZILAM	55
M-M-R II INJ	85	<i>nebivolol hcl</i>	44
M-NATAL PLUS TAB	87	<i>necon 0.5/35-28</i>	69
<i>modafinil</i>	60	<i>nefazodone hcl</i>	48
<i>moexipril hcl</i>	40	<i>neomycin sulfate</i>	19
<i>molindone hcl</i>	51	<i>neomycin-bacitrac zn-polymyx</i> <i>5(3.5)mg-400unt-10000unt op oin</i>	88
<i>mometasone furoate</i>	97	<i>neomycin-polymy-gramicid op sol</i> <i>1.75-10000-0.025mg-unt-mg/ml</i> ..	88
MONJUVI	35	<i>neomycin-polymyxin-dexamethasone</i> <i>ophth oint 0.1%</i>	88
<i>mono-lynyah</i>	69	<i>neomycin-polymyxin-dexamethasone</i> <i>ophth susp 0.1%</i>	88
<i>montelukast sodium</i>	92	<i>neomycin-polymyxin-hc ophth susp</i> ..	88
<i>morphine sulfate</i>	17	<i>neomycin-polymyxin-hc otic soln 1%</i>	90
MORPHINE SULFATE	17	<i>neomycin-polymyxin-hc otic susp 3.5</i> <i>mg/ml-10000 unit/ml-1%</i>	90
MORPHINE SULFATE/SODIUM C	18	<i>neo-polycin 5(3.5)mg-400unt-</i> <i>10000unt op oin</i>	88
MOUNJARO	63	<i>neo-polycin hc ophth oint 1%</i>	88
MOVANTIK	77	NERLYNX	35
<i>moxifloxacin hcl</i>	25	NEUPRO	50
<i>moxifloxacin hcl (ophth)</i>	88	<i>nevirapine</i>	21
<i>moxifloxacin hcl 400 mg/250ml in</i> <i>sodium chloride 0.8% inj</i>	25	NEXAVAR	35
MRESVIA	85	NEXLETOL	43
MULTAQ	42	NEXLIZET TAB 180/10MG	43
<i>multiple electrolytes ph 5.5</i>	86	<i>niacin (antihyperlipidemic)</i>	43
<i>multiple electrolytes ph 7.4</i>	86	<i>nicardipine hcl</i>	45
<i>mupirocin</i>	95	NICOTROL INHALER	60
<i>mycophenolate mofetil</i>	84	NICOTROL NS	60
<i>mycophenolate sodium</i>	84	<i>nifedipine</i>	45
MYRBETRIQ	78	<i>nikki</i>	69
N		<i>nilutamide</i>	29
<i>nabumetone</i>	16		
<i>nadolol</i>	44		
<i>nafcillin sodium</i>	26		
NAGLAZYME	73		
<i>nalbuphine hcl</i>	18		

<i>nimodipine</i>	45	NOVOLOG	65
NINLARO	35	NOVOLOG FLEXPEN	65
<i>nitazoxanide</i>	19	NOVOLOG MIX INJ 70/30	65
<i>nitisinone</i>	73	NOVOLOG MIX INJ FLEXPEN	65
NITRO-BID	46	NOVOLOG PENFILL	65
<i>nitrofurantoin macrocrystal</i>	19	NUBEQA.....	29
<i>nitrofurantoin monohyd macro</i>	19	NUEDEXTA CAP 20-10MG	59
<i>nitroglycerin</i>	46	NULOJIX	84
<i>nitroglycerin (intra-anal)</i>	97	NUPLAZID	51
<i>nizatidine</i>	76	NURTEC	58
<i>nora-be</i>	69	NUTRILIPID	88
<i>norelgestromin-ethinyl estradiol td</i>		NUZYRA	27
<i>ptwk 150-35 mcg/24hr</i>	69	<i>nyamyc</i>	95
<i>norethindrone (contraceptive)</i>	69	<i>nylia 1/35</i>	70
<i>norethindrone ace & ethinyl estradiol</i>		<i>nylia 7/7/7</i>	70
<i>tab 1 mg-20 mcg</i>	70	NYMALIZE	45
<i>norethindrone ace & ethinyl estradiol</i>		<i>nymyo</i>	70
<i>tab 1.5 mg-30 mcg</i>	70	<i>nystatin</i>	20
<i>norethindrone ace & ethinyl estradiol-fe</i>		<i>nystatin (mouth-throat)</i>	98
<i>tab 1 mg-20 mcg</i>	70	<i>nystatin (topical)</i>	95
<i>norethindrone acetate</i>	74	<i>nystop</i>	95
<i>norethindrone acetate-ethinyl estradiol</i>		●	
<i>tab 0.5 mg-2.5 mcg</i>	71	<i>ocella</i>	70
<i>norethindrone acetate-ethinyl estradiol</i>		OCTAGAM	83
<i>tab 1 mg-5 mcg</i>	72	<i>octreotide acetate</i>	73
<i>norethindrone ac-ethinyl estrad-fe tab</i>		ODEFSEY TAB	23
<i>1-20/1-30/1-35 mg-mcg</i>	70	ODOMZO.....	35
<i>norgestimate & ethinyl estradiol tab</i>		OFEV	92
<i>0.25 mg-35 mcg</i>	70	<i>ofloxacin (ophth)</i>	88
<i>norgestimate-eth estrad tab 0.18-</i>		<i>ofloxacin (otic)</i>	90
<i>25/0.215-25/0.25-25 mg-mcg</i>	70	OGIVRI	35
<i>norgestimate-eth estrad tab 0.18-</i>		OGSIVEO	35
<i>35/0.215-35/0.25-35 mg-mcg</i>	70	OJEMDA	35
<i>norlyroc</i>	70	OJJAARA	35
NORPACE CR	42	<i>olanzapine</i>	51
<i>nortrel 0.5/35 (28)</i>	70	<i>olmesartan medoxomil</i>	42
<i>nortrel 1/35 (21)</i>	70	<i>olmesartan medoxomil-</i>	
<i>nortrel 1/35 (28)</i>	70	<i>hydrochlorothiazide tab 20-12.5 mg</i>	
<i>nortrel 7/7/7</i>	70	41
<i>nortriptyline hcl</i>	48	<i>olmesartan medoxomil-</i>	
NORVIR	21	<i>hydrochlorothiazide tab 40-12.5 mg</i>	
NOVOLIN INJ 70/30.....	65	41
NOVOLIN INJ 70/30 FP	65	<i>olmesartan medoxomil-</i>	
NOVOLIN N	65	<i>hydrochlorothiazide tab 40-25 mg</i> .	41
NOVOLIN N FLEXPEN	65	<i>olmesartan-amlodipine-</i>	
NOVOLIN R.....	65	<i>hydrochlorothiazide tab 20-5-12.5</i>	
NOVOLIN R FLEXPEN	65	<i>mg</i>	41

<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-10-12.5 mg</i>	41	ORKAMBI TAB 200-125	93
<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-10-25 mg</i>	41	ORSERDU.....	29
<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-5-12.5 mg</i>	41	<i>oseltamivir phosphate</i>	24
<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-5-25 mg</i>	41	OTEZLA.....	82
<i>omega-3-acid ethyl esters cap 1 gm</i> .	43	OTEZLA TAB 10/20.....	82
<i>omeprazole</i>	78	OTEZLA TAB 10/20/30	82
OMNIPOD 5 DX KIT INT G7G6.....	65	<i>oxacillin sodium</i>	26
OMNIPOD 5 DX MIS POD G7G6.....	66	<i>oxaliplatin</i>	28
OMNIPOD 5 G7 KIT INTRO	66	<i>oxcarbazepine</i>	55
OMNIPOD 5 G7 MIS PODS	66	<i>oxybutynin chloride</i>	78
OMNIPOD DASH KIT INTRO	66	<i>oxycodone hcl</i>	18
OMNIPOD DASH MIS PODS.....	66	<i>oxycodone w/ acetaminophen tab 10- 325 mg</i>	18
OMNIPOD GO KIT 10UNT/DY	66	<i>oxycodone w/ acetaminophen tab 2.5- 325 mg</i>	18
OMNIPOD GO KIT 15UNT/DY	66	<i>oxycodone w/ acetaminophen tab 5- 325 mg</i>	18
OMNIPOD GO KIT 20UNT/DY	66	<i>oxycodone w/ acetaminophen tab 7.5- 325 mg</i>	18
OMNIPOD GO KIT 25UNT/DY	66	OZEMPIC (0.25 OR 0.5 MG/DOSE) ...	63
OMNIPOD GO KIT 30UNT/DY	66	OZEMPIC (0.25 OR 0.5MG/DOSE) ...	63
OMNIPOD GO KIT 35UNT/DY	66	OZEMPIC (1MG/DOSE).....	63
OMNIPOD GO KIT 40UNT/DY	66	OZEMPIC (2MG/DOSE).....	63
OMNIPOD MIS CLASSIC	66	P	
<i>ondansetron</i>	75	<i>pacerone</i>	42
<i>ondansetron hcl</i>	75	<i>paclitaxel</i>	30
ONETOUCH KIT ULT MINI	61	<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	31
ONETOUCH KIT ULTRA 2	61	<i>paliperidone</i>	51
ONETOUCH KIT VERIO	61	<i>pamidronate disodium</i>	67
ONETOUCH KIT VERIO FL.....	61	PAMIDRONATE DISODIUM.....	67
ONETOUCH KIT VERIO IQ.....	61	PANRETIN	97
ONETOUCH KIT VERIO RE	61	<i>pantoprazole sodium</i>	78
ONETOUCH TES ULT BLUE.....	61	PANZYGA	83
ONETOUCH TES ULTRA	61	<i>paraplatin</i>	28
ONETOUCH TES VERIO	61	<i>paricalcitol</i>	75
ONTRUZANT	35	<i>paroxetine hcl</i>	48
ONUREG	28	PAXLOVID TAB 150-100.....	24
OPSUMIT.....	46	PAXLOVID TAB 300-100.....	24
ORGOVYX.....	29	<i>pazopanib hcl</i>	35
ORKAMBI GRA 100-125	92	PEDIARIX INJ 0.5ML	85
ORKAMBI GRA 150-188	92	PEDVAX HIB	85
ORKAMBI GRA 75-94MG.....	92	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	77
ORKAMBI TAB 100-125	93	<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	77
		PEGASYS.....	24

PEMAZYRE.....	35	<i>piperacillin sod-tazobactam sod for inj</i>	
<i>pemetrexed disodium</i>	28	40.5 gm (36-4.5 gm).....	27
PEN GK/DEXTR INJ 40000/ML.....	26	PIQRAY 200MG DAILY DOSE.....	35
PEN GK/DEXTR INJ 60000/ML.....	26	PIQRAY 250MG TAB DOSE.....	35
PENBRAYA INJ	85	PIQRAY 300MG DAILY DOSE.....	35
<i>penicillamine</i>	67	<i>pirfenidone</i>	93
<i>penicillin g potassium</i>	26	<i>piroxicam</i>	16
<i>penicillin g sodium</i>	26	PLASMA-LYTE INJ -148	86
<i>penicillin v potassium</i>	27	PLASMA-LYTE INJ -A.....	86
PENTACEL INJ.....	85	<i>plenamine</i>	88
<i>pentamidine isethionate inh</i>	19	PLENVU SOL.....	77
<i>pentamidine isethionate inj</i>	19	<i>podofilox</i>	97
<i>pentoxifylline</i>	80	<i>polycin ophth oint</i>	89
<i>perindopril erbumine</i>	40	<i>polymyxin b-trimethoprim ophth soln</i>	
<i>perio gard</i>	98	10000 unit/ml-0.1%	89
<i>permethrin</i>	98	POMALYST.....	30
<i>perphenazine</i>	51	<i>portia-28</i>	70
PERSERIS.....	51	<i>posaconazole</i>	20
<i>pfizerpen</i>	27	POT CHL 20MEQ/L IN NAACL 0.45% INJ	
<i>phenelzine sulfate</i>	48	86
<i>phenobarbital</i>	55	POT CHL 20MEQ/L IN NAACL 0.9% INJ	
<i>phenobarbital sodium</i>	55	86
<i>phenytek</i>	55	POT CHL 40MEQ/L IN NAACL 0.9% INJ	
<i>phenytoin</i>	55	86
<i>phenytoin sodium</i>	55	<i>potassium chloride</i>	87
<i>phenytoin sodium extended</i>	55	POTASSIUM CHLORIDE	87
PHESGO SOL	35	<i>potassium chloride 20 meq/l (0.15%)</i>	
<i>philith</i>	70	<i>in dextrose 5% inj</i>	87
PIFELTRO	21	<i>potassium chloride microencapsulated</i>	
<i>pilocarpine hcl</i>	90	<i>crystals er</i>	87
<i>pilocarpine hcl (oral)</i>	98	<i>potassium citrate (alkalinizer)</i>	78
<i>pimozide</i>	52	PRADAXA	79
<i>pimtrea</i>	70	<i>pramipexole dihydrochloride</i>	50
<i>pindolol</i>	44	<i>prasugrel hcl</i>	80
<i>pioglitazone hcl</i>	63	<i>pravastatin sodium</i>	43
<i>pioglitazone hcl-metformin hcl tab 15-</i>		<i>praziquantel</i>	19
500 mg	63	<i>prazosin hcl</i>	40
<i>pioglitazone hcl-metformin hcl tab 15-</i>		<i>prednisolone</i>	72
850 mg	64	<i>prednisolone acetate (ophth)</i>	89
<i>piperacillin sod-tazobactam na for inj</i>		PREDNISOLONE SODIUM PHOSP.....	89
3.375 gm (3-0.375 gm)	27	<i>prednisolone sodium phosphate</i>	72
<i>piperacillin sod-tazobactam sod for inj</i>		<i>prednisone</i>	72
13.5 gm (12-1.5 gm).....	27	PREDNISONE INTENSOL	72
<i>piperacillin sod-tazobactam sod for inj</i>		<i>pregabalin</i>	55
2.25 gm (2-0.25 gm)	27	PREHEVBRIO	85
<i>piperacillin sod-tazobactam sod for inj</i>		PREMASOL SOL 10%	88
4.5 gm (4-0.5 gm)	27	PRENATAL TAB 27-1MG.....	87

PRENATAL TAB PLUS.....	87
<i>prevalite</i>	43
PREVYMIS	24
PREZCOBIX TAB 800-150	23
PREZISTA.....	21, 22
PRIFTIN	23
<i>primaquine phosphate</i>	21
PRIMAQUINE PHOSPHATE	21
<i>primidone</i>	55
PRIORIX INJ	85
PRIVIGEN.....	83
<i>probenecid</i>	16
<i>prochlorperazine</i>	75
<i>prochlorperazine edisylate</i>	75
<i>prochlorperazine maleate</i>	75
PROCRIT	79
<i>proctocort</i>	97
<i>procto-med hc</i>	97
<i>proctosol hc</i>	98
<i>proctozone-hc</i>	98
<i>progesterone</i>	74
PROGRAF	84
PROLASTIN-C	93
PROLENSA.....	89
PROLIA	67
PROMACTA	80
<i>promethazine hcl</i>	76
<i>propafenone hcl</i>	42
<i>proparacaine hcl</i>	90
<i>propranolol hcl</i>	44
<i>propylthiouracil</i>	75
PROQUAD INJ	85
PROSOL INJ 20%	88
<i>protriptyline hcl</i>	48
PULMOZYME	93
PURIXAN	28
<i>pyrazinamide</i>	23
<i>pyridostigmine bromide</i>	59
Q	
QINLOCK.....	35
QUADRACEL INJ	85
QUADRACEL INJ 0.5ML	85
<i>quetiapine fumarate</i>	52
<i>quinapril hcl</i>	40
<i>quinidine sulfate</i>	42
<i>quinine sulfate</i>	21
QULIPTA	58

R	
RABAVERT INJ	85
<i>raloxifene hcl</i>	73
<i>ramipril</i>	40
<i>ranolazine</i>	46
<i>rasagiline mesylate</i>	50
RAYALDEE	75
<i>reclipsen</i>	70
RECOMBIVAX HB.....	85
RECTIV	98
REGRANEX	98
RELENZA DISKHALER	24
RELISTOR	77
REMICADE.....	82
RENFLEXIS	82
<i>repaglinide</i>	64
REPATHA.....	43
REPATHA PUSHTRONEX SYSTEM	43
REPATHA SURECLICK	43
RESTASIS	90
RESTASIS MULTIDOSE.....	90
RETEVMO.....	35, 36
REVLIMID.....	30
REXULTI	52
REYATAZ.....	22
REZLIDHIA	36
REZUROCK	84
RHOPRESSA	90
<i>ribavirin (hepatitis c)</i>	24
<i>rifabutin</i>	23
<i>rifampin</i>	23
<i>riluzole</i>	59
<i>rimantadine hydrochloride</i>	24
RINVOQ	82
RINVOQ LQ	82
<i>risperidone</i>	52
<i>risperidone microspheres</i>	52
<i>ritonavir</i>	22
<i>rivastigmine</i>	47
<i>rivastigmine tartrate</i>	47
<i>rizatriptan benzoate</i>	58
ROCKLATAN DRO	90
<i>roflumilast</i>	93
<i>ropinirole hydrochloride</i>	50
<i>rosuvastatin calcium</i>	43
ROTARIX SUS	85
ROTATEQ SOL.....	85

<i>roweepra</i>	55	<i>solifenacin succinate</i>	78
ROZLYTREK.....	36	SOLILQUA INJ 100/33.....	66
RUBRACA.....	36	SOLTAMOX.....	29
<i>rufinamide</i>	55	SOLU-CORTEF.....	72
RUKOBIA.....	22	SOMATULINE DEPOT.....	74
RYBELSUS.....	64	SOMAVERT.....	74
RYDAPT.....	36	<i>sorafenib tosylate</i>	36
S		<i>sorine</i>	42
<i>sajazir</i>	80	<i>sotalol hcl</i>	42
SANDIMMUNE.....	84	<i>sotalol hcl (afib/afI)</i>	42
SANTYL.....	98	<i>spironolactone</i>	40
<i>sapropterin dihydrochloride</i>	73	<i>spironolactone & hydrochlorothiazide</i>	
SCEMBLIX.....	36	<i>tab 25-25 mg</i>	45
<i>scopolamine</i>	76	<i>sprintec 28</i>	70
SECUADO.....	52	SPRITAM.....	55
<i>selegiline hcl</i>	50	SPRYCEL.....	36
<i>selenium sulfide</i>	96	<i>sps</i>	67
SELZENTRY.....	22	<i>sronyx</i>	70
SEREVENT DISKUS.....	92	<i>ssd</i>	95
<i>sertraline hcl</i>	49	STELARA.....	82
<i>setlakin</i>	70	STIVARGA.....	36
<i>sevelamer carbonate</i>	74	<i>streptomycin sulfate</i>	19
<i>sharobel</i>	70	STRIBILD TAB.....	23
SHINGRIX.....	85	<i>subvenite</i>	55
SIGNIFOR.....	73	<i>sucralfate</i>	77
<i>sildenafil citrate</i>	90	<i>sulfacetamide sodium (acne)</i>	95
<i>sildenafil citrate (pulmonary</i>		<i>sulfacetamide sodium (ophth)</i>	89
<i>hypertension)</i>	46	<i>sulfacetamide sodium-prednisolone</i>	
<i>silver sulfadiazine</i>	95	<i>ophth soln 10-0.23(0.25)%</i>	88
SIMBRINZA SUS 1-0.2%.....	90	<i>sulfadiazine</i>	19
<i>simliya</i>	70	<i>sulfamethoxazole-trimethoprim iv soln</i>	
<i>simvastatin</i>	43	<i>400-80 mg/5ml</i>	19
<i>sirolimus</i>	84	<i>sulfamethoxazole-trimethoprim susp</i>	
SIRTURO.....	23	<i>200-40 mg/5ml</i>	19
SIVEXTRO.....	19	<i>sulfamethoxazole-trimethoprim tab</i>	
SKYRIZI.....	82	<i>400-80 mg</i>	20
SKYRIZI PEN.....	82	<i>sulfamethoxazole-trimethoprim tab</i>	
<i>sod sulfate-pot sulf-mg sulf oral sol</i>		<i>800-160 mg</i>	20
<i>17.5-3.13-1.6 gm/177ml</i>	77	SULFAMYLON.....	95
<i>sodium chloride</i>	87	<i>sulfasalazine</i>	76
<i>sodium chloride (gu irrigant)</i>	98	<i>sulindac</i>	16
<i>sodium fluoride chew; tab; 1.1 (0.5 f)</i>		<i>sumatriptan</i>	58
<i>mg/ml soln</i>	87	<i>sumatriptan succinate</i>	58
SODIUM OXYBATE.....	60	<i>sunitinib malate</i>	36
<i>sodium phenylbutyrate</i>	74	SUNLENCA.....	22
<i>sodium polystyrene sulfonate powder</i>		<i>syeda</i>	70
.....	67	SYMDEKO TAB 100-150.....	93

SYMDEKO TAB 50-75MG	93	<i>tetrabenazine</i>	59
SYMPAZAN	55	<i>tetracycline hcl</i>	27
SYMTUZA TAB.....	23	THALOMID	30
SYNAREL.....	71	<i>theophylline</i>	93
SYNJARDY TAB 12.5-1000MG	64	<i>thioridazine hcl</i>	52
SYNJARDY TAB 12.5-500.....	64	<i>thiothixene</i>	52
SYNJARDY TAB 5-1000MG	64	<i>tiadylt er</i>	45
SYNJARDY TAB 5-500MG.....	64	<i>tiagabine hcl</i>	56
SYNJARDY XR TAB 10-1000.....	64	TIBSOVO.....	37
SYNJARDY XR TAB 12.5-1000	64	TICOVAC.....	85
SYNJARDY XR TAB 25-1000.....	64	<i>tigecycline</i>	27
SYNJARDY XR TAB 5-1000MG	64	<i>tilia fe</i>	70
SYNTHROID.....	75	<i>timolol maleate</i>	44
T		<i>timolol maleate (ophth)</i>	90
TABLOID	28	<i>tinidazole</i>	20
TABRECTA	36	TIVICAY	22
<i>tacrolimus</i>	84	TIVICAY PD	22
<i>tacrolimus (topical)</i>	98	<i>tizanidine hcl</i>	60
TAFINLAR.....	36	TOBRADEX OIN 0.3-0.1%	88
TAGRISSE	36	TOBRADEX ST SUS 0.3-0.05.....	88
TALTZ.....	82	<i>tobramycin</i>	20
TALZENNA	36, 37	<i>tobramycin (ophth)</i>	89
<i>tamoxifen citrate</i>	29	<i>tobramycin sulfate</i>	20
<i>tamsulosin hcl</i>	78	<i>tobramycin-dexamethasone ophth susp</i> <i>0.3-0.1%</i>	88
<i>tarina fe 1/20 eq</i>	70	<i>tolterodine tartrate</i>	78
TASIGNA.....	37	<i>topiramate</i>	56
<i>tasimelteon</i>	58	<i>toremifene citrate</i>	29
<i>tazarotene</i>	95	<i>torpenz</i>	37
<i>tazicef</i>	25	<i>torse mide</i>	45
TAZORAC	96	TOUJEO MAX SOLOSTAR	66
TAZVERIK	37	TOUJEO SOLOSTAR	66
TDVAX INJ 2-2 LF.....	85	TPN ELECTROL INJ	87
TECENTRIQ	37	TRADJENTA	64
TEFLARO	25	<i>tramadol hcl</i>	18
<i>telmisartan</i>	42	<i>tramadol-acetaminophen tab 37.5-325</i> <i>mg</i>	18
<i>temazepam</i>	58	<i>trandolapril</i>	40
TENIVAC INJ 5-2LF.....	85	<i>tranexamic acid</i>	80
<i>tenofovir disoproxil fumarate</i>	22	<i>tranylcypramine sulfate</i>	49
TEPMETKO.....	37	TRAVASOL INJ 10%.....	88
<i>terazosin hcl</i>	40	TRAZIMERA	37
<i>terbinafine hcl</i>	20	<i>trazodone hcl</i>	49
<i>terbutaline sulfate</i>	92	TRECATOR	23
<i>terconazole vaginal</i>	79	TRELEGY AER ELLIPTA 100-62.5-25 MCG	91
TERIPARATIDE.....	67		
<i>testosterone</i>	61, 62		
<i>testosterone cypionate</i>	62		
<i>testosterone enanthate</i>	62		

TRELEGY AER ELLIPTA 200-62.5-25 MCG	91	<i>tri-sprintec</i>	71
TREMFYA.....	82	TRIUMEQ PD TAB	23
<i>treprostinil</i>	47	TRIUMEQ TAB	23
TRESIBA	66	<i>trivora-28</i>	71
TRESIBA FLEXTOUCH.....	66	<i>tri-vylibra</i>	71
<i>tretinoin</i>	95	<i>tri-vylibra lo</i>	71
<i>tretinoin (chemotherapy)</i>	30	TRIZIVIR TAB	23
<i>triamcinolone acetonide (mouth)</i>	98	TROGARZO.....	22
<i>triamcinolone acetonide (topical)</i>	97	TROPHAMINE INJ 10%.....	88
<i>triamterene & hydrochlorothiazide cap</i> <i>37.5-25 mg</i>	45	<i>tropium chloride</i>	78
<i>triamterene & hydrochlorothiazide tab</i> <i>37.5-25 mg</i>	45	TRULICITY.....	64
<i>triamterene & hydrochlorothiazide tab</i> <i>75-50 mg</i>	45	TRUMENBA INJ	85
<i>tridacaine ii</i>	97	TRUQAP	37
<i>trientine hcl</i>	67	TRUXIMA.....	37
<i>tri-estarylla</i>	70	TUKYSA	37
<i>trifluoperazine hcl</i>	52	TURALIO	37
<i>trifluridine</i>	89	<i>turqoz</i>	71
<i>trihexyphenidyl hcl</i>	50	TWINRIX INJ	85
TRIJARDY XR TAB ER 24HR 10-5- 1000MG	64	TYBOST	22
TRIJARDY XR TAB ER 24HR 12.5-2.5- 1000MG	64	TYPHIM VI.....	85
TRIJARDY XR TAB ER 24HR 25-5- 1000MG	64	TYRVAYA.....	90
TRIJARDY XR TAB ER 24HR 5-2.5- 1000MG	64	U	
TRIKAFTA PAK 59.5MG.....	93	UBRELVY.....	58
TRIKAFTA PAK 75MG	93	<i>unithroid</i>	75
TRIKAFTA TAB 100-50-75MG & 150MG	93	<i>ursodiol</i>	77
TRIKAFTA TAB 50-25-37.5MG & 75MG	93	V	
<i>tri-legest fe</i>	70	<i>valacyclovir hcl</i>	24
<i>tri-linyah</i>	70	VALCHLOR	98
<i>tri-lo-estarylla</i>	70	<i>valganciclovir hcl</i>	24
<i>tri-lo-marzia</i>	70	<i>valproate sodium</i>	56
<i>tri-lo-mili</i>	70	<i>valproic acid</i>	56
<i>tri-lo-sprintec</i>	70	<i>valsartan</i>	42
<i>trimethoprim</i>	20	<i>valsartan-hydrochlorothiazide tab 160- 12.5 mg</i>	41
<i>tri-mili</i>	70	<i>valsartan-hydrochlorothiazide tab 160- 25 mg</i>	41
<i>trimipramine maleate</i>	49	<i>valsartan-hydrochlorothiazide tab 320- 12.5 mg</i>	41
TRINTELLIX	49	<i>valsartan-hydrochlorothiazide tab 320- 25 mg</i>	41
<i>tri-nymyo</i>	70	<i>valsartan-hydrochlorothiazide tab 80- 12.5 mg</i>	41
		VALTOCO 10 MG DOSE	56
		VALTOCO 15 MG DOSE	56
		VALTOCO 20 MG DOSE	56
		VALTOCO 5 MG DOSE	56
		<i>vancomycin hcl</i>	20

VANCOMYCIN HYDROCHLORIDE.....	20	VOSEVI TAB	24
VANCOMYCIN INJ 1 GM.....	20	VRAYLAR.....	52
VANCOMYCIN INJ 500MG	20	VRAYLAR CAP 1.5-3MG	52
VANCOMYCIN INJ 750MG	20	<i>vyfemla</i>	71
VANFLYTA	37	<i>vylibra</i>	71
VAQTA.....	85	VYZULTA.....	90
<i>varenicline tartrate</i>	61	W	
<i>varenicline tartrate tab 11 x 0.5 mg &</i> <i>42 x 1 mg start pack</i>	61	<i>warfarin sodium</i>	79
VARIVAX	85	<i>water for irrigation, sterile irrigation</i> <i>soln</i>	98
VASCEPA.....	43	WELIREG	30
VAXCHORA SUS	85	<i>wera</i>	71
<i>velivet</i>	71	<i>wixela inhub</i>	94
VELPHORO	74	X	
VELTASSA	67	XALKORI	38
VEMLIDY	24	XARELTO.....	79
VENCLEXTA	37	XARELTO STAR TAB 15/20MG	79
VENCLEXTA TAB START PK.....	37	XATMEP	83
<i>venlafaxine hcl</i>	49	XCOPRI.....	56
VENTAVIS	47	XCOPRI PAK 100-150	56
VENTOLIN HFA.....	92	XCOPRI PAK 12.5-25	56
VENTOLIN HFA (INSTITUTIONAL PACK)	92	XCOPRI PAK 150-200MG (MAINTENANCE).....	56
<i>verapamil hcl</i>	45	XCOPRI PAK 150-200MG (TITRATION)	56
VERQUVO.....	46	XCOPRI PAK 50-100MG	56
VERSACLOZ.....	52	XDEMVY.....	89
VERZENIO	37	XELJANZ	82
<i>vestura</i>	71	XELJANZ XR	82
V-GO 20 KIT	66	XERMELO	77
V-GO 30 KIT	66	XGEVA.....	67
V-GO 40 KIT	66	XHANCE	93
<i>vienva</i>	71	XIFAXAN	77
<i>vigabatrin</i>	56	XIGDUO XR TAB 10-1000.....	65
<i>vigadrone</i>	56	XIGDUO XR TAB 10-500MG	64
VIGAFYDE	56	XIGDUO XR TAB 2.5-1000.....	64
<i>vigpoder</i>	56	XIGDUO XR TAB 5-1000MG	64
<i>vilazodone hcl</i>	49	XIGDUO XR TAB 5-500MG	64
<i>vincristine sulfate</i>	31	XIIDRA	90
<i>vinorelbine tartrate</i>	31	XOLAIR.....	93
<i>viorele</i>	71	XOSPATA	38
VIRACEPT.....	22	XPOVIO 100 MG ONCE WEEKLY	38
VIREAD	22	XPOVIO 40 MG ONCE WEEKLY	38
VITRAKVI	37	XPOVIO 40 MG TWICE WEEKLY	38
VIVITROL	61	XPOVIO 60 MG ONCE WEEKLY	38
VIZIMPRO	37	XPOVIO 60 MG TWICE WEEKLY	38
VONJO	38	XPOVIO 80 MG ONCE WEEKLY	38
<i>voriconazole</i>	20, 21		

XPOVIO 80 MG TWICE WEEKLY	38	ZENPEP CAP 5000UNIT	77
XTANDI.....	29	ZENPEP CAP 60000UNT.....	78
<i>xulane</i>	71	ZERVIAE	89
XULTOPHY INJ 100/3.6	66	<i>zidovudine</i>	22
Y		ZIEXTENZO	79
<i>yargesa</i>	74	<i>ziprasidone hcl</i>	52
YF-VAX INJ	85	<i>ziprasidone mesylate</i>	52
<i>yuvaferm</i>	72	ZIRABEV	38
Z		ZIRGAN	89
<i>zafemy</i>	71	<i>zoledronic acid</i>	67
<i>zafirlukast</i>	92	ZOLINZA.....	38
ZARXIO.....	79	<i>zolpidem tartrate</i>	58
ZEJULA	38	ZONISADE	56
ZELBORAF	38	<i>zonisamide</i>	56
ZEMAIRA.....	93	<i>zovia 1/35</i>	71
<i>zenatane</i>	95	ZTALMY	56
ZENPEP CAP 10000UNT.....	77	<i>zumandimine</i>	71
ZENPEP CAP 15000UNT.....	77	ZURZUVAE	49
ZENPEP CAP 20000UNT.....	77	ZYDELIG	38
ZENPEP CAP 25000UNT.....	78	ZYKADIA.....	38
ZENPEP CAP 3000UNIT	77	ZYLET SUS 0.5-0.3%.....	88
ZENPEP CAP 40000UNT.....	78	ZYPREXA RELPREVV	52

Multi-Language Insert Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-280-5555 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-280-5555 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-844-280-5555 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-844-280-5555 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-280-5555 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-280-5555 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-844-280-5555 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-280-5555 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-280-5555 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-280-5555 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على [1-448-082-5555 (TTY: 117)]. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-280-5555 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-280-5555 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-280-5555 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-280-5555 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-280-5555 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、

1-844-280-5555 (TTY: 711)にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Non-Discrimination Notice

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

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

If you need these services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free) (TTY:711).

If you believe that GlobalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

ATTN: Medicare Compliance Officer
210 Park Ave, Ste. 2900
Oklahoma City, OK 73102-5621
or E-mail: compliance@globalhealth.com

You can file a grievance in person or by mail, fax or e-mail. If you need help filing a grievance, Customer Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-280-5555 (TTY: 711)。

GlobalHealth cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, o sexo. GlobalHealth no excluye a las personas ni las trata de forma diferente por motivos de raza, color, nacionalidad, edad, discapacidad, o sexo.

GlobalHealth:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
 - Intérpretes de lenguaje de señas capacitados.
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
 - Intérpretes capacitados.
 - Información escrita en otros idiomas

Si necesita recibir estos servicios, comuníquese con Servicio al cliente de GlobalHealth al 1-844-280-5555 (Libre de Cargos) (TTY:711).

Si considera que GlobalHealth no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona:

ATTN: Medicare Compliance Officer
210 Park Ave, Ste. 2900
Oklahoma City, OK 73102-5621
or E-mail: compliance@globalhealth.com

Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Servicio al Cliente está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web <http://www.hhs.gov/ocr/office/file/index.html>.

This formulary was updated on 10/22/2024. For more recent information or other questions, please contact Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit www.GlobalHealth.com.

Esta lista se actualizó el 10/22/2024. Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio de Atención al Cliente al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite www.GlobalHealth.com.