



GlobalHealth 2019 Formulary

(List of
Covered Drugs)

For Generations
Classic (HMO)



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

This formulary was updated
on 08/01/2019. For more
recent information or other
questions, please contact
GlobalHealth Customer Care at
1-866-494-3927 or,
for TTY users, 711

24 hours a day, seven days a week
www.GlobalHealth.com/medicare

HPMS Formulary File Submission ID: 00019290
Version 14

GlobalHealth is an HMO plan with
a Medicare contract. Enrollment in
GlobalHealth depends on contract
renewal.

GlobalHealth

2019 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 00019290, Version Number 14.

This formulary was updated on 08/01/2019. For more recent information or other questions, please contact us, GlobalHealth Customer Care at 1-866-494-3927 (toll-free) or, for TTY users, 711, 24 hours a day, seven days a week or visit www.GlobalHealth.com/medicare.

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth is dependent on contract renewal.

The formulary may change at any time, you will receive notice when necessary.

H3706_COMPFORMULARY_CLASSIC_2019_C

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 Classic (HMO).

This document includes a list of the drugs (formulary) for our plan which is current as of 08/01/2019. 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, 2019, and from time to time during the year.

What is the Generations Classic (HMO) 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. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2019 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2019 coverage year except when a new, less expensive generic drug becomes available, when new information about the safety or effectiveness of a drug is released, or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.) Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. Below are changes to the drug list that will also affect members currently taking a drug:

- **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 the steps you may take to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Generations Classic (HMO) 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 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 we may make changes based on new clinical guidelines. If we remove drugs from our formulary, 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.

The enclosed formulary is current as of 08/01/2019. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 7. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiovascular Agents. If you know what your drug is used for, look for the category name in the list that begins on page 7. 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 71. 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 GlobalHealth before you fill your prescriptions. If you don't get approval, our plan 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 tablets per prescription for Januvia. 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, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan 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 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted on line 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 Classic (HMO) formulary?" on page 5 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. For more information, 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 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 him or her to prescribe a similar drug that is covered by our plan.
- You can ask GlobalHealth 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 Classic (HMO) 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 if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, 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, or utilization restriction exception. **When you request a formulary 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 (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with 31-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If 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 (unless you have a prescription for fewer days) 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 Classic (HMO) 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 days a week. TTY users should call 1-877-486-2048. Or, visit <http://www.medicare.gov>.

Generations Classic (HMO) Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 71.

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

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

- LA – Limited Access drugs are designated with the abbreviation LA. This prescription may be available only at certain pharmacies. For more information consult your Provider & Pharmacy Directory or call Customer Care, at 1-866-494-3927 (toll-free) 24 hours a day, seven days a week. TTY users should call 711.
- PA - Prior Authorization drugs are designated with the abbreviation PA;
- QL - Quantity Limit drugs are designated with the abbreviation QL and the limit is designated for each drug;
- ST - Step Therapy drugs are designated with the abbreviation ST;
- NM – Drugs that are not available by mail-order are designated with the abbreviation NM;
- B/D – Drugs that require coverage determination for Medicare Part B or Part D are designated with the abbreviation B/D;
- GC - We provide additional 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
-----------	-----------	---------------------

ANALGESICS

GOUT

<i>allopurinol tab</i>	1	
<i>colchicine w/ probenecid</i>	2	
COLCRYS	3	QL (120 tabs / 30 days)
MITIGARE	3	QL (60 caps / 30 days)
<i>probenecid</i>	2	
ULORIC	3	ST

NSAIDS

<i>celecoxib CAPS 50mg</i>	2	QL (240 caps / 30 days)
<i>celecoxib CAPS 100mg</i>	2	QL (120 caps / 30 days)
<i>celecoxib CAPS 200mg</i>	2	QL (60 caps / 30 days)
<i>celecoxib CAPS 400mg</i>	2	QL (30 caps / 30 days)
<i>diclofenac potassium</i>	2	QL (120 tabs / 30 days)
<i>diclofenac sodium TB24; TBEC</i>	2	
<i>diflunisal TABS</i>	2	
<i>etodolac</i>	2	
<i>etodolac er</i>	2	
<i>flurbiprofen TABS</i>	2	
<i>ibu tab 600mg</i>	1	
<i>ibu tab 800mg</i>	1	
<i>ibuprofen SUSP</i>	2	
<i>ibuprofen TABS 400mg, 600mg, 800mg</i>	1	
<i>meloxicam TABS</i>	1	
<i>nabumetone TABS</i>	2	
<i>naproxen TABS</i>	1	
<i>naproxen dr</i>	1	
<i>naproxen sodium TABS 275mg, 550mg</i>	2	
<i>piroxicam CAPS</i>	2	
<i>sulindac TABS</i>	1	

OPIOID ANALGESICS

<i>acetaminophen w/ codeine 300-15mg</i>	2	QL (400 tabs / 30 days)
<i>acetaminophen w/ codeine 300-30mg</i>	2	QL (360 tabs / 30 days)
<i>acetaminophen w/ codeine 300-60mg</i>	2	QL (180 tabs / 30 days)
<i>acetaminophen w/ codeine soln</i>	2	QL (2700 mL / 30 days)
<i>butorphanol tartrate SOLN 1mg/ml, 2mg/ml</i>	4	
<i>nalbuphine hcl SOLN</i>	4	
<i>tramadol hcl tab 50 mg</i>	2	QL (240 tabs / 30 days)
<i>tramadol-acetaminophen</i>	2	QL (240 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 **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
OPIOID ANALGESICS, CII		
<i>endocet 2.5-325mg</i>	2	QL (360 tabs / 30 days)
<i>endocet 5-325mg</i>	2	QL (360 tabs / 30 days)
<i>endocet 7.5-325mg</i>	2	QL (240 tabs / 30 days)
<i>endocet 10-325mg</i>	2	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP	5	QL (120 lozenges / 30 days), PA
<i>fentanyl patch 12 mcg/hr</i>	2	QL (10 patches / 30 days), PA
<i>fentanyl patch 25 mcg/hr</i>	2	QL (10 patches / 30 days), PA
<i>fentanyl patch 50 mcg/hr</i>	2	QL (10 patches / 30 days), PA
<i>fentanyl patch 75 mcg/hr</i>	2	QL (10 patches / 30 days), PA
<i>fentanyl patch 100 mcg/hr</i>	2	QL (10 patches / 30 days), PA
FENTORA	5	QL (120 tabs / 30 days), PA
<i>hydroco/apap tab 5-325mg</i>	2	QL (240 tabs / 30 days)
<i>hydroco/apap tab 7.5-325</i>	2	QL (180 tabs / 30 days)
<i>hydroco/apap tab 10-325mg</i>	2	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen 7.5-325 mg/15ml</i>	2	QL (2700 mL / 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	2	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD	2	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> SOLN 10mg/ml, 50mg/5ml, 500mg/50ml	4	B/D
<i>hydromorphone hcl</i> TABS	2	QL (180 tabs / 30 days)
HYSINGLA ER	3	QL (30 tabs / 30 days), PA
<i>lorcet hd tab 10-325mg</i>	2	QL (180 tabs / 30 days)
<i>lorcet plus tab 7.5-325</i>	2	QL (180 tabs / 30 days)
<i>lorcet tab 5-325mg</i>	2	QL (240 tabs / 30 days)
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	2	QL (450 mL / 30 days), PA
<i>methadone hcl 5mg</i>	2	QL (90 tabs / 30 days), PA
<i>methadone hcl 10mg</i>	2	QL (90 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 **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 intensol</i>	2	QL (90 mL / 30 days), PA
<i>morphine ext-rel tab 15mg, 30mg, 60mg, 100mg</i>	2	QL (90 tabs / 30 days), PA
<i>morphine ext-rel tab 200mg</i>	2	QL (60 tabs / 30 days), PA
<i>morphine sul inj 1mg/ml</i>	4	B/D
MORPHINE SUL INJ 4MG/ML	4	B/D
<i>morphine sul inj 10mg/ml</i>	4	B/D
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml, 150mg/30ml	4	B/D
<i>morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml</i>	4	B/D
<i>morphine sulfate TABS 15mg</i>	2	QL (180 tabs / 30 days)
<i>morphine sulfate TABS 30mg</i>	2	QL (90 tabs / 30 days)
<i>morphine sulfate oral soln 10mg/5ml</i>	2	QL (900 mL / 30 days)
<i>morphine sulfate oral soln 20mg/5ml</i>	2	QL (750 mL / 30 days)
<i>morphine sulfate oral soln 100mg/5ml</i>	2	QL (180 mL / 30 days)
NUCYNTA ER 50mg, 100mg, 200mg, 250mg	3	QL (60 tabs / 30 days), PA
NUCYNTA ER 150mg	3	QL (90 tabs / 30 days), PA
<i>oxycodone hcl CAPS</i>	2	QL (180 caps / 30 days)
<i>oxycodone hcl CONC</i>	2	QL (180 mL / 30 days)
<i>oxycodone hcl SOLN</i>	2	QL (900 mL / 30 days)
<i>oxycodone hcl TABS</i>	2	QL (180 tabs / 30 days)
<i>oxycodone w/ acetaminophen 2.5-325mg</i>	2	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen 5-325mg</i>	2	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen 7.5-325mg</i>	2	QL (240 tabs / 30 days)
<i>oxycodone w/ acetaminophen 10-325mg</i>	2	QL (180 tabs / 30 days)

ANESTHETICS

LOCAL ANESTHETICS

<i>lidocaine hcl (local anesth.)</i>	2	B/D
<i>lidocaine inj 0.5%</i>	2	B/D
<i>lidocaine inj 1%</i>	2	B/D
<i>lidocaine inj 1.5% preservative free (pf)</i>	2	B/D

ANTI-INFECTIVES

ANTI-BACTERIALS - MISCELLANEOUS

<i>amikacin sulfate SOLN</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 **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>gentamicin in saline</i>	2	
<i>gentamicin sulfate SOLN</i>	2	
<i>neomycin sulfate TABS</i>	2	
<i>paromomycin sulfate CAPS</i>	2	
<i>streptomycin sulfate SOLR</i>	5	
SULFADIAZINE TABS	4	
<i>tobramycin NEBU</i>	5	NM, PA
<i>tobramycin inj 1.2 gm/30ml</i>	2	
<i>tobramycin inj 1.2gm</i>	5	
<i>tobramycin inj 10mg/ml</i>	2	
<i>tobramycin inj 40mg/ml</i>	2	
<i>tobramycin inj 80mg/2ml</i>	2	
ANTI-INFECTIVES - MISCELLANEOUS		
<i>albendazole TABS</i>	5	
ALINIA	5	
<i>atovaquone SUSP</i>	5	
AZACTAM IN ISO-OSMOTIC DE	4	
AZACTAM/DEX INJ	4	
<i>aztreonam</i>	2	
CAYSTON	5	NM, LA, PA
<i>clindamycin cap 75mg</i>	2	
<i>clindamycin cap 300mg</i>	2	
<i>clindamycin hcl cap 150 mg</i>	2	
<i>clindamycin phosphate in d5w</i>	2	
CLINDAMYCIN PHOSPHATE IN NAACL	4	
<i>clindamycin phosphate inj</i>	2	
<i>clindamycin soln 75mg/5ml</i>	2	
<i>colistimethate sodium SOLR</i>	2	
<i>dapsone TABS</i>	2	
DAPTOMYCIN 350mg	5	
<i>daptomycin 500mg</i>	5	
EMVERM	5	
<i>ertapenem sodium</i>	2	
<i>imipenem-cilastatin</i>	2	
<i>ivermectin TABS</i>	2	
<i>linezolid in sodium chloride</i>	4	
<i>linezolid inj</i>	2	
<i>linezolid susp</i>	5	
<i>linezolid tab 600mg</i>	5	
<i>meropenem</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 **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>methenamine hippurate</i>	2	
<i>metronidazole</i> TABS	1	
<i>metronidazole in nacl</i>	2	
NEBUPENT	4	B/D
<i>nitrofurantoin macrocrystal</i> 50mg, 100mg	3	PA; PA applies if 70 years and older after a 90 day supply in a calendar year
<i>nitrofurantoin monohyd macro</i>	3	PA; PA applies if 70 years and older after a 90 day supply in a calendar year
PENTAM 300	4	
<i>pentamidine isethionate</i>	2	
<i>praziquantel</i> TABS	2	
SIVEXTRO	5	
<i>sulfamethoxazole-trimethop ds</i>	1	
<i>sulfamethoxazole-trimethoprim inj</i>	2	
<i>sulfamethoxazole-trimethoprim susp</i>	2	
<i>sulfamethoxazole-trimethoprim tab 400-80mg</i>	1	
SYNERCID	5	
<i>tigecycline</i>	5	
<i>trimethoprim</i> TABS	1	
<i>vancomycin hcl</i> CAPS 125mg	2	
<i>vancomycin hcl</i> CAPS 250mg	5	
<i>vancomycin hcl</i> SOLR 1gm, 5gm, 10gm, 500mg, 750mg	2	
VANCOMYCIN IN NACL	4	
ANTIFUNGALS		
ABELCET	5	B/D
AMBISOME	5	B/D
<i>amphotericin b</i> SOLR	2	B/D
<i>caspofungin acetate</i>	5	
<i>fluconazole</i> SUSR	2	
<i>fluconazole</i> TABS 50mg, 100mg, 200mg	2	
<i>fluconazole</i> TABS 150mg	1	
<i>fluconazole in dextrose</i>	2	
<i>fluconazole inj nacl 200</i>	2	
<i>fluconazole inj nacl 400</i>	2	
<i>flucytosine</i> CAPS	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 **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>griseofulvin microsize</i>	2	
<i>griseofulvin ultramicrosize</i>	2	
<i>itraconazole</i> CAPS	2	PA
<i>ketoconazole</i> TABS	2	PA
MYCAMINE	5	
NOXAFIL SUSP	5	QL (630 mL / 30 days)
NOXAFIL TBEC	5	QL (93 tabs / 30 days)
<i>nystatin</i> TABS	2	
<i>terbinafine hcl</i> TABS	1	QL (90 tabs / year)
<i>voriconazole</i> SOLR	2	
<i>voriconazole</i> SUSR; TABS	5	

ANTIMALARIALS

<i>atovaquone-proguanil hcl</i>	2	
<i>chloroquine phosphate</i> TABS	2	
COARTEM	4	
<i>mefloquine hcl</i>	2	
<i>primaquine phosphate</i> 26.3mg	2	
PRIMAQUINE PHOSPHATE 26.3mg	3	
<i>quinine sulfate</i> CAPS	2	PA

ANTIRETROVIRAL AGENTS

<i>abacavir sulfate</i>	2	
APTIVUS	5	
<i>atazanavir sulfate</i>	5	
CRIXIVAN	4	
<i>didanosine</i>	2	
EDURANT	5	
<i>efavirenz</i> CAPS 50mg	2	
<i>efavirenz</i> CAPS 200mg	5	
<i>efavirenz</i> TABS	5	
EMTRIVA	3	
<i>fosamprenavir tab 700 mg</i>	5	
FUZEON	5	NM
INTELENCE 25mg	4	
INTELENCE 100mg, 200mg	5	
INVIRASE	5	
ISENRESS CHEW 25mg	3	
ISENRESS CHEW 100mg	5	
ISENRESS PACK	3	
ISENRESS TABS	5	
ISENRESS HD	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 **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>lamivudine</i>	2	
LEXIVA SUSP	4	
<i>nevirapine susp 50 mg/5ml</i>	2	
<i>nevirapine tab 100mg er</i>	2	
<i>nevirapine tab 200mg</i>	2	
<i>nevirapine tab 400mg er</i>	2	
NORVIR PACK	4	
NORVIR SOLN	4	
PIFELTRO	5	
PREZISTA SUSP	5	QL (400 mL / 30 days)
PREZISTA TABS 75mg	3	QL (480 tabs / 30 days)
PREZISTA TABS 150mg	5	QL (240 tabs / 30 days)
PREZISTA TABS 600mg	5	QL (60 tabs / 30 days)
PREZISTA TABS 800mg	5	QL (30 tabs / 30 days)
RESCRIPTOR	4	
REYATAZ PACK	5	
<i>ritonavir</i>	2	
SELZENTRY SOLN	5	
SELZENTRY TABS 25mg	4	
SELZENTRY TABS 75mg, 150mg, 300mg	5	
<i>stavudine</i>	2	
<i>tenofovir disoproxil fumarate</i>	5	
TIVICAY 10mg	3	
TIVICAY 25mg, 50mg	5	
TROGARZO	5	NM, LA
TYBOST	4	
VIDEX EC 125mg	4	
VIDEX PEDIATRIC	4	
VIRACEPT	5	
VIRAMUNE SUSP	4	
VIREAD POWD	5	
VIREAD TABS 150mg, 200mg, 250mg	5	
<i>zidovudine cap 100mg</i>	2	
<i>zidovudine syp 50mg/5ml</i>	2	
<i>zidovudine tab 300mg</i>	2	
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine</i>	2	
<i>abacavir sulfate-lamivudine-zidovudine</i>	5	
ATRIPLA	5	
BIKTARVY	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 **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
CIMDUO	5	
COMPLERA	5	
DELSTRIGO	5	
DESCOVY	5	
DOVATO	5	
EVOTAZ	5	
GENVOYA	5	
JULUCA	5	
KALETRA TAB 100-25MG	4	
KALETRA TAB 200-50MG	5	
<i>lamivudine-zidovudine</i>	2	
<i>lopinavir-ritonavir</i>	2	
ODEFSEY	5	
PREZCOBIX	5	
STRIBILD	5	
SYMFI	5	
SYMFI LO	5	
SYMTUZA	5	
TRIUMEQ	5	
TRUVADA TAB 100-150	5	QL (60 tabs / 30 days)
TRUVADA TAB 133-200	5	QL (30 tabs / 30 days)
TRUVADA TAB 167-250	5	QL (30 tabs / 30 days)
TRUVADA TAB 200-300	5	QL (30 tabs / 30 days)
ANTITUBERCULAR AGENTS		
<i>cycloserine</i> CAPS	5	
<i>ethambutol hcl</i> TABS	2	
<i>isoniazid</i> TABS	1	
<i>isoniazid syp 50mg/5ml</i>	2	
PASER D/R	4	
PRIFTIN	4	
<i>pyrazinamide</i> TABS	2	
<i>rifabutin</i>	2	
<i>rifampin</i> CAPS; SOLR	2	
RIFATER	4	
SIRTURO	5	LA, PA
TRECTOR	4	
ANTIVIRALS		
<i>acyclovir</i> CAPS; TABS	1	
<i>acyclovir</i> SUSP	2	
<i>acyclovir sodium</i>	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 **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>adefovir dipivoxil</i>	5	
BARACLUDE SOLN	5	
<i>entecavir</i>	5	
EPCLUSA	5	NM, PA
EPIVIR HBV SOLN	4	
<i>famciclovir</i>	2	
<i>ganciclovir sodium</i>	2	B/D
HARVONI	5	NM, PA
<i>lamivudine (hbv)</i>	2	
MAVYRET	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	2	QL (1080 mL / year)
PEGASYS	5	NM, PA
PEGASYS PROCLICK	5	NM, PA
REBETOL SOLN	5	NM
RELENZA DISKHALER	3	QL (6 inhalers / year)
<i>ribasphere</i> CAPS	2	NM
<i>ribasphere</i> TABS 200mg	2	NM
<i>ribasphere</i> TABS 600mg	5	NM
<i>ribavirin 200mg</i>	2	NM
<i>rimantadine hydrochloride</i>	2	
<i>valacyclovir hcl</i> TABS	2	
<i>valganciclovir hcl</i>	5	
VEMLIDY	5	
VOSEVI	5	NM, PA
ZEPATIER	5	NM, PA

CEPHALOSPORINS

<i>cefaclor</i>	2	
CEFACLOR MONOHYDRATE ER	4	
<i>cefadroxil</i> CAPS	1	
<i>cefadroxil</i> SUSR; TABS	2	
CEFAZOLIN IN DEXTROSE 2GM/100ML-4%	3	
<i>cefazolin inj</i>	2	
<i>cefazolin sodium</i> SOLR 1gm, 20gm	2	
CEFAZOLIN SODIUM 1 GM/50ML	3	
<i>cefdinir</i>	2	
<i>cefepime hcl</i>	2	
<i>cefixime cap 400mg</i>	2	
<i>cefixime susr</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 **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>cefotaxime sodium</i>	2	
<i>cefoxitin sodium</i>	2	
<i>cefpodoxime proxetil</i>	2	
<i>cefprozil</i>	2	
<i>ceftazidime</i> SOLR	2	
CEFTAZIDIME/DEXTROSE	4	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	2	
<i>cefuroxime axetil</i>	2	
<i>cefuroxime sodium</i>	2	
<i>cephalexin</i> CAPS 250mg, 500mg	1	
<i>cephalexin</i> SUSR	2	
SUPRAX CAPS	3	
SUPRAX CHEW	4	
SUPRAX SUSR 500mg/5ml	3	
<i>tazicef</i> SOLR	2	
TEFLARO	5	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i> PACK; SOLR; SUSR	2	
<i>azithromycin</i> TABS	1	
<i>clarithromycin</i> TABS	2	
<i>clarithromycin er</i>	2	
<i>clarithromycin for susp</i>	2	
DIFICID	5	
<i>e.e.s 400</i>	2	
<i>ery-tab</i>	2	
ERYTHROCIN LACTOBIONATE	4	
<i>erythrocin stearate</i>	2	
<i>erythromycin base</i>	2	
<i>erythromycin cap 250mg ec</i>	2	
<i>erythromycin ethylsuccinate</i> TABS	2	
FLUOROQUINOLONES		
<i>ciprofloxacin</i> SUSR	2	
<i>ciprofloxacin hcl tab</i> 100mg	2	
<i>ciprofloxacin hcl tab</i> 250mg, 500mg, 750mg	1	
<i>ciprofloxacin in d5w</i>	2	
<i>levofloxacin</i> TABS	1	
<i>levofloxacin in d5w</i>	2	
<i>levofloxacin inj 25mg/ml</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 **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>levofloxacin oral soln 25 mg/ml</i>	2	
PENICILLINS		
<i>amoxicillin CAPS; SUSR; TABS</i>	1	
<i>amoxicillin CHEW</i>	2	
<i>amoxicillin & pot clavulanate</i>	2	
<i>ampicillin & sulbactam sodium</i>	2	
<i>ampicillin cap 500mg</i>	2	
<i>ampicillin inj</i>	2	
<i>ampicillin sodium</i>	2	
BICILLIN L-A	4	
<i>dicloxacillin sodium</i>	2	
<i>nafcillin sodium 1gm, 2gm</i>	2	
<i>nafcillin sodium 10gm</i>	5	
NAFCILLIN SODIUM FOR INJ 10GM	4	
<i>oxacillin sodium 1gm, 2gm</i>	2	
<i>oxacillin sodium 10gm</i>	5	
PENICILLIN G POT IN DEXTROSE 2MU	4	
PENICILLIN G POT IN DEXTROSE 3MU	4	
PENICILLIN G PROCAINE	4	
<i>penicillin g sodium</i>	2	
<i>penicillin v potassium SOLR</i>	2	
<i>penicillin v potassium TABS</i>	1	
<i>penicillin gk inj 5mu</i>	2	
<i>penicillin gk inj 20mu</i>	2	
<i>pfizerpen-g inj 5mu</i>	2	
<i>pfizerpen-g inj 20mu</i>	2	
<i>piper/tazoba inj 2-0.25gm</i>	2	
<i>piper/tazoba inj 3-0.375gm</i>	2	
<i>piper/tazoba inj 4-0.5gm</i>	2	
PIPER/TAZOBA INJ 12-1.5GM	4	
<i>piper/tazoba inj 36-4.5gm</i>	2	
TETRACYCLINES		
<i>doxy 100</i>	2	
<i>doxycycline (monohydrate) CAPS 50mg, 100mg</i>	2	
<i>doxycycline (monohydrate) TABS</i>	2	
<i>doxycycline hyclate CAPS</i>	2	
<i>doxycycline hyclate SOLR</i>	2	
<i>doxycycline hyclate TABS 20mg, 100mg</i>	2	
<i>minocycline hcl CAPS</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 **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>mondoxylene nl cap 100mg</i>	2	
<i>morgidox cap 1x50mg</i>	2	
<i>tetracycline hcl CAPS</i>	2	

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

BENDEKA	5	B/D, NM
<i>cyclophosphamide CAPS</i>	2	B/D
<i>cyclophosphamide SOLR</i>	5	B/D
<i>dacarbazine 100mg</i>	2	B/D
EMCYT	4	
GLEOSTINE	4	
IFEX INJ 3GM	4	B/D
<i>ifosfamide inj 1gm/20ml</i>	2	B/D
IFOSFAMIDE INJ 3GM	4	B/D
<i>ifosfamide inj 3gm/60ml</i>	2	B/D
LEUKERAN	5	

ANTHRACYCLINES

<i>adriamycin SOLN</i>	2	B/D
<i>doxorubicin hcl</i>	2	B/D
<i>doxorubicin hcl liposomal</i>	5	B/D
<i>epirubicin hcl</i>	2	B/D

ANTIBIOTICS

<i>bleomycin sulfate</i>	2	B/D
<i>mitomycin SOLR</i>	5	B/D

ANTIMETABOLITES

<i>adrucil</i>	2	B/D
ALIMTA	5	B/D
<i>azacitidine</i>	5	B/D
<i>cytarabine 20mg/ml</i>	2	B/D
<i>fluorouracil SOLN</i>	2	B/D
<i>gemcitabine inj soln</i>	2	B/D
<i>gemcitabine inj solr</i>	2	B/D
<i>mercaptopurine TABS</i>	2	
<i>methotrexate sodium inj</i>	2	B/D
PURIXAN	5	NM
TABLOID	4	

ANTIMITOTIC, TAXOIDS

ABRAXANE	5	B/D
<i>docetaxel CONC 20mg/ml, 80mg/4ml</i>	5	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 **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
DOCETAXEL CONC 80mg/4ml, 160mg/8ml, 200mg/10ml	5	B/D
<i>docetaxel</i> SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
DOCETAXEL SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
<i>paclitaxel</i>	2	B/D
TAXOTERE 80mg/4ml	5	B/D

ANTIMITOTIC, VINCA ALKALOIDS

<i>vinblastine sulfate</i>	2	B/D
<i>vincasar pfs</i>	2	B/D
<i>vincristine sulfate</i>	2	B/D
<i>vinorelbine tartrate</i>	2	B/D

BIOLOGIC RESPONSE MODIFIERS

AVASTIN	5	LA, PA
BORTEZOMIB	5	PA
DAURISMO	5	NM, LA, PA
ERIVEDGE	5	NM, LA, PA
FARYDAK	5	NM, LA, PA
HERCEPTIN	5	PA
HERCEPTIN HYLECTA	5	PA
IBRANCE	5	NM, LA, PA
IDHIFA	5	NM, LA, PA
KADCYLA	5	B/D
KEYTRUDA	5	NM, PA
KISQALI	5	NM, PA
KISQALI FEMARA 200 DOSE	5	NM, PA
KISQALI FEMARA 400 DOSE	5	NM, PA
KISQALI FEMARA 600 DOSE	5	NM, PA
LYNPARZA	5	NM, LA, PA
MYLOTARG	5	NM, LA, PA
NINLARO	5	NM, PA
ODOMZO	5	NM, LA, PA
RITUXAN	5	LA, PA
RITUXAN HYCELA	5	NM, LA, PA
RUBRACA	5	NM, LA, PA
TALZENNA	5	NM, LA, PA
TECENTRIQ	5	NM, LA, PA
TIBSOVO	5	NM, LA, PA
VELCADE	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 **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
VENCLEXTA 10mg, 50mg	4	NM, LA, PA
VENCLEXTA 100mg	5	NM, LA, PA
VENCLEXTA STARTING PACK	5	NM, LA, PA
VERZENIO	5	NM, LA, PA
ZEJULA	5	NM, LA, PA
ZOLINZA	5	NM, PA

HORMONAL ANTINEOPLASTIC AGENTS

<i>abiraterone acetate</i>	5	NM, PA
<i>anastrozole</i> TABS	2	
<i>bicalutamide</i>	2	
DEPO-PROVERA INJ 400/ML	4	B/D
ERLEADA	5	NM, LA, PA
<i>exemestane</i>	2	
FASLODEX	5	B/D
<i>flutamide</i>	2	
<i>fulvestrant</i>	5	B/D
<i>letrozole</i> TABS	2	
<i>leuprolide inj 1mg/0.2</i>	2	NM, PA
LUPRON DEPOT (1-MONTH) 3.75mg	5	NM, PA
LUPRON DEPOT INJ 11.25MG (3-MONTH)	5	NM, PA
LYSODREN	3	
<i>megestrol ac sus 40mg/ml</i>	4	
<i>megestrol ac tab 20mg</i>	3	
<i>megestrol ac tab 40mg</i>	3	
<i>megestrol sus 625mg/5ml</i>	4	PA
<i>nilutamide</i>	5	
SOLTAMOX	5	
<i>tamoxifen citrate</i> TABS	1	
<i>toremifene citrate</i>	5	
TRELSTAR DEP INJ 3.75MG	5	NM, PA
TRELSTAR LA INJ 11.25MG	5	NM, PA
XTANDI	5	NM, LA, PA
ZYTIGA 500mg	5	NM, LA, PA

IMMUNOMODULATORS

POMALYST CAP 1MG	5	NM, LA, PA
POMALYST CAP 2MG	5	NM, LA, PA
POMALYST CAP 3MG	5	NM, LA, PA
POMALYST CAP 4MG	5	NM, LA, PA
REVLIMID	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 **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
THALOMID 50mg, 100mg	5	QL (30 caps / 30 days), NM, PA
THALOMID 150mg, 200mg	5	QL (60 caps / 30 days), NM, PA

KINASE INHIBITORS

AFINITOR	5	QL (30 tabs / 30 days), NM, PA
AFINITOR DISPERZ 2mg	5	QL (150 tabs / 30 days), NM, PA
AFINITOR DISPERZ 3mg	5	QL (90 tabs / 30 days), NM, PA
AFINITOR DISPERZ 5mg	5	QL (60 tabs / 30 days), NM, PA
ALECENSA	5	NM, LA, PA
ALUNBRIG	5	NM, LA, PA
BALVERSA	5	NM, LA, PA
BOSULIF	5	NM, PA
BRAFTOVI	5	NM, LA, PA
CABOMETYX	5	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE	5	NM, LA, PA
CAPRELSA	5	NM, LA, PA
COMETRIQ	5	NM, LA, PA
COPIKTRA	5	NM, LA, PA
COTELLIC	5	NM, LA, PA
<i>erlotinib hcl</i> 25mg	5	QL (90 tabs / 30 days), NM, PA
<i>erlotinib hcl</i> 100mg, 150mg	5	QL (30 tabs / 30 days), NM, PA
GILOTRIF TAB 20MG	5	NM, LA, PA
GILOTRIF TAB 30MG	5	NM, LA, PA
GILOTRIF TAB 40MG	5	NM, LA, PA
ICLUSIG	5	NM, LA, PA
<i>imatinib mesylate</i> 100mg	5	QL (90 tabs / 30 days), NM, PA
<i>imatinib mesylate</i> 400mg	5	QL (60 tabs / 30 days), NM, PA
IMBRUVICA	5	NM, LA, PA
INLYTA 1mg	5	QL (180 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 **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
INLYTA 5mg	5	QL (120 tabs / 30 days), NM, LA, PA
IRESSA	5	NM, LA, PA
JAKAFI	5	QL (60 tabs / 30 days), NM, LA, PA
LENVIMA 4 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 8 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 10 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 12MG DAILY DOSE	5	NM, LA, PA
LENVIMA 14 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 18 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 20 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 24 MG DAILY DOSE	5	NM, LA, PA
LORBRENA	5	NM, LA, PA
MEKINIST	5	NM, LA, PA
MEKTOVI	5	NM, LA, PA
NERLYNX	5	NM, LA, PA
NEXAVAR	5	NM, LA, PA
RYDAPT	5	NM, PA
SPRYCEL	5	NM, PA
STIVARGA	5	NM, LA, PA
SUTENT	5	NM, PA
TAFINLAR	5	NM, LA, PA
TAGRISO	5	NM, LA, PA
TARCEVA 25mg	5	QL (90 tabs / 30 days), NM, LA, PA
TARCEVA 100mg, 150mg	5	QL (30 tabs / 30 days), NM, LA, PA
TASIGNA	5	NM, PA
TYKERB	5	NM, LA, PA
VITRAKVI	5	NM, LA, PA
VIZIMPRO	5	NM, LA, PA
VOTRIENT	5	NM, LA, PA
XALKORI	5	NM, LA, PA
XOSPATA	5	NM, LA, PA
ZELBORAF	5	NM, LA, PA
ZYDELIG	5	NM, LA, PA
ZYKADIA	5	NM, LA, PA
MISCELLANEOUS		
<i>bexarotene</i>	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 **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>hydroxyurea</i> CAPS	2	
LONSURF	5	NM, PA
MATULANE	5	LA
SYLATRON KIT 200MCG	5	PA
SYLATRON KIT 300MCG	5	PA
SYLATRON KIT 600MCG	5	PA
SYNRIBO	5	NM, PA
<i>tretinoin</i> (chemotherapy)	5	

PLATINUM-BASED AGENTS

<i>carboplatin</i>	2	B/D
<i>cisplatin</i> SOLN	2	B/D
<i>oxaliplatin inj</i> 50mg	5	B/D
<i>oxaliplatin inj</i> 50mg/10ml	2	B/D
<i>oxaliplatin inj</i> 100mg	5	B/D
<i>oxaliplatin inj</i> 100mg/20ml	2	B/D

PROTECTIVE AGENTS

<i>dexrazoxane hcl</i>	5	B/D
<i>leucovorin calcium</i> SOLR	2	B/D
<i>leucovorin calcium</i> TABS	2	
<i>leucovorin calcium solr</i>	2	B/D
MESNEX TABS	5	

TOPOISOMERASE INHIBITORS

<i>etoposide</i> SOLN	2	B/D
<i>irinotecan hcl</i>	2	B/D
<i>toposar</i>	2	B/D
<i>topotecan hcl</i>	5	B/D
TOPOTECAN INJ 4MG/4ML	5	B/D

CARDIOVASCULAR

ACE INHIBITOR COMBINATIONS

<i>amlodipine--benazepril hcl cap</i> 10-20 mg	1	
<i>amlodipine-benazepril hcl cap</i> 2.5-10 mg	1	
<i>amlodipine-benazepril hcl cap</i> 5-10 mg	1	
<i>amlodipine-benazepril hcl cap</i> 5-20 mg	1	
<i>amlodipine-benazepril hcl cap</i> 5-40 mg	1	
<i>amlodipine-benazepril hcl cap</i> 10-40mg	1	
<i>benazepril & hydrochlorothiazide</i>	1	
<i>captopril & hydrochlorothiazide</i>	1	
<i>enalapril maleate & hydrochlorothiazide</i>	1	
<i>fosinopril sodium & hydrochlorothiazide</i>	1	

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 **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>lisinopril & hydrochlorothiazide</i>	6	GC
<i>moexipril-hydrochlorothiazide</i>	1	
<i>quinapril-hydrochlorothiazide</i>	1	
ACE INHIBITORS		
<i>benazepril hcl TABS</i>	6	GC
<i>captopril TABS</i>	1	
<i>enalapril maleate TABS</i>	1	
<i>fosinopril sodium</i>	6	GC
<i>lisinopril TABS</i>	6	GC
<i>moexipril hcl</i>	1	
<i>perindopril erbumine</i>	1	
<i>quinapril hcl</i>	6	GC
<i>ramipril</i>	6	GC
<i>trandolapril</i>	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i>	2	
<i>spironolactone TABS</i>	1	
ALPHA BLOCKERS		
<i>doxazosin mesylate TABS</i>	2	
<i>prazosin hcl</i>	2	
<i>terazosin hcl</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-olmesartan medoxomil</i>	1	
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-12.5mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-25mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-12.5mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-25mg</i>	1	

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 **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>amlodipine-valsartan-hydrochlorothiazide</i> 10-320-25mg	1	
ENTRESTO	3	
<i>irbesartan-hydrochlorothiazide</i>	6	GC
<i>losartan-hydrochlorothiazide</i>	6	GC
<i>olmesartan medoxomil-amlodipine-hydrochlorothiazide</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide</i>	1	
<i>valsartan-hydrochlorothiazide</i>	6	GC
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>irbesartan</i>	6	GC
<i>losartan potassium</i>	6	GC
<i>olmesartan medoxomil</i> TABS	1	
<i>telmisartan</i>	1	
<i>valsartan</i>	1	
ANTIARRHYTHMICS		
<i>amiodarone hcl soln</i>	2	
<i>amiodarone tab 100mg</i>	2	
<i>amiodarone tab 200mg</i>	1	
<i>amiodarone tab 400mg</i>	2	
<i>disopyramide phosphate</i>	4	
<i>dofetilide</i>	2	
<i>flecainide acetate</i>	2	
<i>mexiletine hcl</i>	2	
MULTAQ	4	
NORPACE CR	4	
<i>pacerone 100mg, 400mg</i>	2	
<i>pacerone 200mg</i>	1	
<i>propafenone hcl</i>	2	
<i>propafenone hcl 12hr</i>	2	
<i>quinidine gluconate</i>	2	
<i>quinidine sulfate</i>	2	
<i>sorine</i>	2	
<i>sotalol hcl</i>	2	
<i>sotalol hcl (afib/afl)</i>	2	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
<i>atorvastatin calcium</i> TABS	6	GC
<i>lovastatin</i>	6	GC
<i>pravastatin sodium</i>	6	GC
<i>rosuvastatin calcium</i>	1	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 **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>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg	6	GC
<i>simvastatin</i> TABS 80mg	6	GC, QL (30 tabs / 30 days)

ANTILIPEMICS, MISCELLANEOUS

<i>cholestyramine</i>	2	
<i>cholestyramine light</i>	2	
<i>colesevelam hcl</i>	2	
<i>colestipol hcl gran</i>	2	
<i>colestipol hcl pack</i>	2	
<i>colestipol hcl tabs</i>	2	
<i>ezetimibe</i>	2	
<i>fenofibrate</i> TABS 48mg, 54mg, 145mg, 160mg	2	
<i>fenofibrate micronized</i> 67mg, 134mg, 200mg	2	
<i>gemfibrozil</i> TABS	1	
JUXTAPID	5	NM, LA, PA
KYNAMRO	5	PA
<i>niacin er (antihyperlipidemic)</i> 500mg	2	QL (90 tabs / 30 days)
<i>niacin er (antihyperlipidemic)</i> 750mg, 1000mg	2	
<i>niacor</i>	2	
PRALUENT	5	PA; Lower cost version - Tier 4
<i>prevalite</i>	2	
VASCEPA	4	

BETA-BLOCKER/DIURETIC COMBINATIONS

<i>atenolol & chlorthalidone</i>	2	
<i>bisoprolol & hydrochlorothiazide</i>	1	
<i>metoprolol & hctz tab 50-25mg</i>	2	
<i>metoprolol & hctz tab 100-25mg</i>	2	
<i>metoprolol & hctz tab 100-50mg</i>	2	
<i>propranolol & hydrochlorothiazide</i>	2	

BETA-BLOCKERS

<i>acebutolol hcl</i> CAPS	2	
<i>atenolol</i> TABS	1	
<i>bisoprolol fumarate</i>	2	
BYSTOLIC 2.5mg, 5mg, 10mg	4	QL (30 tabs / 30 days)
BYSTOLIC 20mg	4	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 **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>carvedilol</i>	1	
<i>labetalol hcl</i> TABS	2	
<i>metoprolol succinate</i>	2	
<i>metoprolol tartrate</i> SOCT	2	
<i>metoprolol tartrate</i> SOLN	2	
<i>metoprolol tartrate</i> TABS 25mg, 50mg, 100mg	1	
<i>nadolol</i> TABS	2	
<i>pindolol</i>	2	
<i>propranolol cap er</i>	2	
<i>propranolol hcl</i> TABS	2	
<i>propranolol oral sol</i>	2	
<i>timolol maleate</i> TABS	2	
CALCIUM CHANNEL BLOCKERS		
<i>amlodipine besylate</i> TABS	1	
<i>cartia xt cap</i> 120/24hr	2	
<i>cartia xt cap</i> 180/24hr	2	
<i>cartia xt cap</i> 240/24hr	2	
<i>cartia xt cap</i> 300/24hr	2	
<i>dilt-xr cap</i>	2	
<i>diltiazem cap</i> 180mg cd	2	
<i>diltiazem cap</i> 240mg cd	2	
<i>diltiazem cap</i> 360mg cd	2	
<i>diltiazem cap er</i> /12hr	2	
<i>diltiazem hcl</i> TABS	2	
<i>diltiazem hcl cap sr</i> 24hr	2	
<i>diltiazem hcl coated beads cap sr</i> 24hr	2	
<i>diltiazem hcl extended release beads cap sr</i>	2	
<i>diltiazem inj</i>	2	
<i>felodipine</i>	2	
<i>isradipine</i>	2	
<i>nicardipine hcl</i> CAPS	2	
<i>nifedipine</i> TB24	2	
<i>nifedipine er</i>	2	
<i>nimodipine</i> CAPS	5	
NYMALIZE	5	
<i>taztia xt</i>	2	
<i>verapamil cap er</i>	2	
<i>verapamil hcl</i> SOLN	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 **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>verapamil hcl</i> TABS	1	
<i>verapamil hcl tab er</i>	1	
<i>DIGITALIS GLYCOSIDES</i>		
<i>digitek</i> .25mg	2	PA; PA if 70 years and older
<i>digitek</i> .125mg	2	QL (30 tabs / 30 days)
<i>digox</i> 125mcg	2	QL (30 tabs / 30 days)
<i>digox</i> 250mcg	2	PA; PA if 70 years and older
<i>digoxin</i> TABS 125mcg	2	QL (30 tabs / 30 days)
<i>digoxin</i> TABS 250mcg	2	PA; PA if 70 years and older
<i>digoxin inj</i>	2	
<i>digoxin sol</i> 50mcg/ml	2	PA; PA if 70 years and older
<i>DIRECT RENIN INHIBITORS/COMBINATIONS</i>		
<i>aliskiren fumarate</i>	2	
TEKTURNA	4	
TEKTURNA HCT	4	
<i>DIURETICS</i>		
<i>acetazolamide</i> CP12; TABS	2	
<i>amiloride & hydrochlorothiazide</i>	2	
<i>amiloride hcl</i> TABS	2	
<i>bumetanide</i>	2	
<i>chlorothiazide tabs</i>	2	
<i>chlorthalidone</i>	2	
<i>furosemide</i> SOLN; TABS	1	
<i>furosemide inj</i>	2	
<i>hydrochlorothiazide</i> CAPS; TABS	1	
<i>indapamide</i>	2	
<i>methazolamide</i> TABS	2	
<i>methyclothiazide</i>	2	
<i>metolazone</i>	2	
<i>spironolactone & hydrochlorothiazide</i>	2	
<i>torsemide tabs</i>	2	
<i>triamterene & hydrochlorothiazide cap</i> 37.5-25 mg	1	
<i>triamterene & hydrochlorothiazide tabs</i>	1	
<i>MISCELLANEOUS</i>		
<i>clonidine hcl</i> TABS	1	

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 **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>clonidine hcl ptwk</i>	2	
CORLANOR	4	
DEMSER	5	PA
<i>hydralazine hcl SOLN; TABS</i>	2	
<i>midodrine hcl</i>	2	
<i>minoxidil TABS</i>	2	
NORTHERA	5	NM, LA, PA
<i>ranolazine</i>	2	
NITRATES		
<i>isosorb mononitrate tab</i>	1	
<i>isosorbide dinitrate</i>	2	
<i>isosorbide dinitrate er</i>	2	
<i>isosorbide mononitrate er</i>	2	
<i>minitran</i>	2	
NITRO-BID	3	
NITRO-DUR DIS 0.3MG/HR	4	
NITRO-DUR DIS 0.8MG/HR	4	
<i>nitroglycerin SUBL</i>	2	
<i>nitroglycerin td patch</i>	2	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS	5	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i>	5	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan 62.5mg</i>	5	QL (120 tabs / 30 days), NM, LA, PA
<i>bosentan 125mg</i>	5	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT	5	QL (30 tabs / 30 days), NM, LA, PA
REMODULIN	5	NM, LA, PA
<i>sildenafil citrate tab 20 mg (pulmonary hypertension)</i>	2	QL (90 tabs / 30 days), NM, PA
TRACLEER TABS 62.5mg	5	QL (120 tabs / 30 days), NM, LA, PA
TRACLEER TABS 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>treprostinil</i>	5	NM, LA, PA
VENTAVIS	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 **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
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
<i>alprazolam tab 0.5mg</i>	2	QL (150 tabs / 30 days)
<i>alprazolam tab 0.25mg</i>	2	QL (150 tabs / 30 days)
<i>alprazolam tab 1mg</i>	2	QL (150 tabs / 30 days)
<i>alprazolam tab 2mg</i>	2	QL (150 tabs / 30 days)
<i>buspirone hcl TABS</i>	2	
<i>fluvoxamine maleate TABS</i>	2	
<i>lorazepam SOLN</i>	2	
<i>lorazepam TABS</i>	2	QL (150 tabs / 30 days)
<i>lorazepam intensol</i>	2	QL (150 mL / 30 days)
ANTICONVULSANTS		
APTIOM 200mg	5	QL (180 tabs / 30 days)
APTIOM 400mg	5	QL (90 tabs / 30 days)
APTIOM 600mg, 800mg	5	QL (60 tabs / 30 days)
BANZEL SUS 40MG/ML	5	PA
BANZEL TAB 200MG	5	PA
BANZEL TAB 400MG	5	PA
BRIVIACT INJ 50MG/5ML	4	PA
BRIVIACT SOL 10MG/ML	5	PA
BRIVIACT TAB 10MG	5	PA
BRIVIACT TAB 25MG	5	PA
BRIVIACT TAB 50MG	5	PA
BRIVIACT TAB 75MG	5	PA
BRIVIACT TAB 100MG	5	PA
<i>carbamazepine CHEW; CP12; SUSP; TABS; TB12</i>	2	
CELONTIN	4	
<i>clobazam</i>	2	PA
<i>clonazepam TABS 2mg</i>	2	QL (300 tabs / 30 days)
<i>clonazepam TABS .5mg, 1mg</i>	2	QL (90 tabs / 30 days)
<i>clonazepam TBDP 2mg</i>	2	QL (300 tabs / 30 days)
<i>clonazepam TBDP .125mg, .25mg, .5mg, 1mg</i>	2	QL (90 tabs / 30 days)
<i>clorazepate dipotassium</i>	2	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIASTAT ACUDIAL	4	
DIASTAT PEDIATRIC	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 **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>diazepam</i> TABS	2	QL (120 tabs / 30 days), PA; PA if 65 years and older
<i>diazepam gel</i>	2	
<i>diazepam inj</i>	2	
<i>diazepam intensol</i>	2	QL (240 mL / 30 days), PA; PA if 65 years and older
<i>diazepam oral soln 1 mg/ml</i>	2	QL (1200 mL / 30 days), PA; PA if 65 years and older
DILANTIN CAP 30MG	3	
DILANTIN CAP 100MG	3	
DILANTIN CHEW TAB 50MG	3	
DILANTIN-125 SUSP	4	
<i>divalproex sodium</i> CSDR; TB24; TBEC	2	
EPIDIOLEX	5	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i>	2	
<i>ethosuximide</i> CAPS; SOLN	2	
<i>felbamate</i> SUSP	5	
<i>felbamate</i> TABS	2	
FYCOMPA SUSP	5	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg	5	QL (60 tabs / 30 days), PA
FYCOMPA TABS 8mg, 10mg, 12mg	5	QL (30 tabs / 30 days), PA
<i>gabapentin</i> CAPS 100mg	1	QL (1080 caps / 30 days)
<i>gabapentin</i> CAPS 300mg	1	QL (360 caps / 30 days)
<i>gabapentin</i> CAPS 400mg	1	QL (270 caps / 30 days)
<i>gabapentin</i> SOLN	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>lamotrigine</i> CHEW; TB24	2	
<i>lamotrigine</i> TABS	1	
<i>levetiracetam</i> SOLN; TABS; TB24	2	
<i>levetiracetam in sodium chloride</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 **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 oral soln 100 mg/ml</i>	2	
LYRICA CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days)
LYRICA CAPS 200mg	3	QL (90 caps / 30 days)
LYRICA CAPS 225mg, 300mg	3	QL (60 caps / 30 days)
LYRICA SOLN	3	QL (946 mL / 30 days)
<i>oxcarbazepine</i>	2	
PEGANONE	4	
<i>phenobarbital ELIX</i>	4	PA; PA if 70 years and older
<i>phenobarbital TABS</i>	3	PA; PA if 70 years and older
PHENOBARBITAL SODIUM SOLN 65mg/ml	4	PA; PA if 70 years and older
<i>phenobarbital sodium SOLN 130mg/ml</i>	4	PA; PA if 70 years and older
PHENYTEK	3	
<i>phenytoin CHEW; SUSP</i>	2	
<i>phenytoin sodium extended</i>	2	
<i>phenytoin sodium inj 50mg/ml</i>	2	
<i>primidone TABS</i>	2	
<i>roweepra</i>	2	
<i>roweepra xr</i>	2	
SPRITAM	4	
<i>subvenite tab</i>	1	
SYMPAZAN 5mg	4	PA
SYMPAZAN 10mg, 20mg	5	PA
<i>tiagabine hcl</i>	2	
<i>topiramate CPSP</i>	2	
<i>topiramate TABS</i>	1	
<i>valproate sodium SOLN</i>	2	
<i>valproic acid CAPS</i>	2	
<i>vigabatrin powd pack 500mg</i>	5	QL (180 packets / 30 days), NM, LA, PA
<i>vigabatrin tab 500mg</i>	5	QL (180 tabs / 30 days), NM, LA, PA
<i>vigadrone</i>	5	QL (180 packets / 30 days), NM, LA, PA
VIMPAT 50mg	4	QL (120 tabs / 30 days)
VIMPAT 100mg, 150mg, 200mg	5	QL (60 tabs / 30 days)
VIMPAT INJ 200MG/20ML	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 **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
VIMPAT SOL 10MG/ML	5	QL (1200 mL / 30 days)
zonisamide CAPS	2	
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg	2	QL (30 tabs / 30 days)
donepezil hydrochloride TABS 10mg	2	
donepezil hydrochloride TBDP 5mg	2	QL (30 tabs / 30 days)
donepezil hydrochloride TBDP 10mg	2	
galantamine hydrobromide SOLN	2	
galantamine hydrobromide TABS	2	QL (60 tabs / 30 days)
galantamine hydrobromide er	2	QL (30 caps / 30 days)
memantine hcl cp24	2	PA; PA if < 30 yrs
memantine soln	2	PA; PA if < 30 yrs
memantine tabs	2	PA; PA if < 30 yrs
NAMZARIC	4	
rivastigmine tartrate 1.5mg, 3mg	2	QL (90 caps / 30 days)
rivastigmine tartrate 4.5mg, 6mg	2	QL (60 caps / 30 days)
rivastigmine td patch 24hr 4.6 mg/24hr	2	QL (30 patches / 30 days)
rivastigmine td patch 24hr 9.5 mg/24hr	2	QL (30 patches / 30 days)
rivastigmine td patch 24hr 13.3 mg/24hr	2	QL (30 patches / 30 days)
ANTIDEPRESSANTS		
amitriptyline hcl TABS	3	
amoxapine tab 25mg	3	
amoxapine tab 50mg	3	
amoxapine tab 100mg	3	
amoxapine tab 150mg	3	
bupropion hcl TABS	2	
bupropion hcl TB12	2	
bupropion hcl TB24 150mg, 300mg	2	
citalopram hydrobromide SOLN	2	
citalopram hydrobromide TABS	1	
clomipramine hcl CAPS	4	PA
desipramine hcl TABS	4	
desvenlafaxine succinate	2	QL (30 tabs / 30 days), PA
doxepin hcl CAPS; CONC	3	
duloxetine hcl CPEP 20mg	2	QL (180 caps / 30 days)
duloxetine hcl CPEP 30mg	2	QL (120 caps / 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 **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>duloxetine hcl</i> CPEP 60mg	2	QL (60 caps / 30 days)
EMSAM	5	QL (30 patches / 30 days), PA
<i>escitalopram oxalate</i> SOLN	2	
<i>escitalopram oxalate</i> TABS	1	
FETZIMA 20mg	4	QL (180 caps / 30 days), PA
FETZIMA 40mg	4	QL (90 caps / 30 days), PA
FETZIMA 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA TITRATION PACK	4	PA
<i>fluoxetine cap 10mg</i>	1	
<i>fluoxetine cap 20mg</i>	1	
<i>fluoxetine cap 40mg</i>	1	
<i>fluoxetine hcl</i> SOLN	2	
<i>imipramine hcl</i> TABS	3	
<i>maprotiline hcl</i>	2	
MARPLAN TAB 10MG	4	QL (180 tabs / 30 days)
<i>mirtazapine</i> TABS	1	
<i>mirtazapine</i> TBDP	2	
<i>nefazodone hcl</i>	2	
<i>nortriptyline hcl</i> CAPS	2	
<i>nortriptyline hcl</i> SOLN	4	
<i>paroxetine hcl tabs</i>	2	
PAXIL SUSP	4	QL (900 mL / 30 days)
<i>phenelzine sulfate</i> TABS	2	
<i>protriptyline hcl</i>	4	
<i>sertraline hcl</i> CONC	2	
<i>sertraline hcl</i> TABS	1	
<i>tranylcypromine sulfate</i>	2	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	
<i>trimipramine maleate</i> CAPS 25mg	4	QL (240 caps / 30 days)
<i>trimipramine maleate</i> CAPS 50mg	4	QL (120 caps / 30 days)
<i>trimipramine maleate</i> CAPS 100mg	4	QL (60 caps / 30 days)
TRINTELLIX 5mg	4	QL (120 tabs / 30 days)
TRINTELLIX 10mg	4	QL (60 tabs / 30 days)
TRINTELLIX 20mg	4	QL (30 tabs / 30 days)
<i>venlafaxine hcl</i> CP24	1	
<i>venlafaxine hcl</i> TABS	2	
VIIBRYD STARTER PACK	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 **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
VIIBRYD TAB	4	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
<i>amantadine hcl</i> CAPS	2	QL (120 caps / 30 days)
<i>amantadine hcl</i> SYRP; TABS	2	
APOKYN	5	QL (20 cartridges / 30 days), NM, LA, PA
<i>benztropine mesylate inj</i>	2	
<i>benztropine mesylate tab 0.5mg</i>	3	PA; PA if 70 years and older
<i>benztropine mesylate tab 1mg</i>	3	PA; PA if 70 years and older
<i>benztropine mesylate tab 2mg</i>	3	PA; PA if 70 years and older
<i>bromocriptine mesylate</i> CAPS; TABS	2	
<i>carbidopa-levodopa</i>	2	
<i>carbidopa/levodopa/entacapone</i>	2	
<i>entacapone</i>	2	
NEUPRO	4	
<i>pramipexole tab 0.5mg</i>	2	
<i>pramipexole tab 0.25mg</i>	2	
<i>pramipexole tab 0.75mg</i>	2	
<i>pramipexole tab 0.125mg</i>	2	
<i>pramipexole tab 1.5mg</i>	2	
<i>pramipexole tab 1mg</i>	2	
<i>rasagiline mesylate</i> TABS	2	
<i>ropinirole tab 0.5mg</i>	2	
<i>ropinirole tab 0.25mg</i>	2	
<i>ropinirole tab 1mg</i>	2	
<i>ropinirole tab 2mg</i>	2	
<i>ropinirole tab 3mg</i>	2	
<i>ropinirole tab 4mg</i>	2	
<i>ropinirole tab 5mg</i>	2	
<i>selegiline hcl</i> CAPS; TABS	2	
<i>trihexyphenidyl hcl</i>	3	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA	5	QL (1 injection / 28 days)
<i>aripiprazole odt</i>	5	QL (60 tabs / 30 days)
<i>aripiprazole oral solution 1 mg/ml</i>	5	QL (900 mL / 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 **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>aripiprazole tab</i>	2	QL (30 tabs / 30 days)
ARISTADA 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	5	QL (1 injection / 28 days)
ARISTADA 1064mg/3.9ml	5	QL (1 injection / 56 days)
ARISTADA INITIO	5	
<i>chlorpromazine hcl TABS</i>	2	
CHLORPROMAZINE INJ	4	
<i>clozapine odt 12.5mg, 25mg</i>	2	PA
<i>clozapine odt 100mg</i>	2	QL (270 tabs / 30 days), PA
<i>clozapine odt 150mg</i>	2	QL (180 tabs / 30 days), PA
<i>clozapine odt 200mg</i>	5	QL (135 tabs / 30 days), PA
<i>clozapine tab 25mg</i>	2	
<i>clozapine tab 50mg</i>	2	
<i>clozapine tab 100mg</i>	2	QL (270 tabs / 30 days)
<i>clozapine tab 200mg</i>	2	QL (135 tabs / 30 days)
FANAPT	4	QL (60 tabs / 30 days)
FANAPT TITRATION PACK	4	
<i>fluphenazine decanoate SOLN</i>	2	
<i>fluphenazine hcl</i>	2	
GEODON SOLR	4	QL (6 mL / 3 days)
<i>haloperidol TABS</i>	2	
<i>haloperidol conc 2mg/ml</i>	2	
<i>haloperidol decanoate SOLN</i>	2	
<i>haloperidol lactate inj 5mg/ml</i>	2	
INVEGA SUST INJ 39 MG/0.25 ML	4	QL (1 injection / 28 days)
INVEGA SUST INJ 78 MG/0.5 ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 117 MG/0.75 ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 156MG/ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 234 MG/1.5 ML	5	QL (1 injection / 28 days)
INVEGA TRINZA	5	QL (1 injection / 90 days)
LATUDA 20mg, 60mg, 80mg	4	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 **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
LATUDA 40mg, 120mg	4	QL (30 tabs / 30 days)
<i>loxapine succinate</i>	2	
<i>molindone hcl</i>	2	
NUPLAZID CAPS	5	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10MG	5	QL (30 tabs / 30 days), NM, LA, PA
NUPLAZID TABS 17MG	5	QL (60 tabs / 30 days), NM, LA, PA
<i>olanzapine SOLR</i>	2	QL (3 vials / 1 day)
<i>olanzapine TABS 2.5mg</i>	2	QL (240 tabs / 30 days)
<i>olanzapine TABS 5mg</i>	2	QL (120 tabs / 30 days)
<i>olanzapine TABS 7.5mg, 15mg, 20mg</i>	2	QL (30 tabs / 30 days)
<i>olanzapine TABS 10mg</i>	2	QL (60 tabs / 30 days)
<i>olanzapine TBDP 5mg, 15mg, 20mg</i>	2	QL (30 tabs / 30 days)
<i>olanzapine TBDP 10mg</i>	2	QL (60 tabs / 30 days)
<i>paliperidone 1.5mg, 3mg, 9mg</i>	5	QL (30 tabs / 30 days)
<i>paliperidone 6mg</i>	5	QL (60 tabs / 30 days)
<i>perphenazine TABS</i>	2	
PERSERIS	5	QL (1 injection / 30 days)
<i>pimozide</i>	2	
<i>quetiapine fumarate TABS</i>	2	
<i>quetiapine fumarate TB24 50mg, 300mg, 400mg</i>	2	QL (60 tabs / 30 days)
<i>quetiapine fumarate TB24 150mg, 200mg</i>	2	QL (30 tabs / 30 days)
REXULTI 1mg	5	QL (90 tabs / 30 days)
REXULTI 2mg	5	QL (60 tabs / 30 days)
REXULTI 3mg, 4mg	5	QL (30 tabs / 30 days)
REXULTI .5mg	5	QL (180 tabs / 30 days)
REXULTI .25mg	5	QL (360 tabs / 30 days)
RISPERDAL INJ 12.5MG	4	QL (2 injections / 28 days)
RISPERDAL INJ 25MG	4	QL (2 injections / 28 days)
RISPERDAL INJ 37.5MG	5	QL (2 injections / 28 days)
RISPERDAL INJ 50MG	5	QL (2 injections / 28 days)
<i>risperidone SOLN</i>	2	QL (240 mL / 30 days)
<i>risperidone TABS</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 **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>risperidone</i> TBDP .5mg	2	QL (90 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, 1mg, 2mg, 3mg, 4mg	2	QL (60 tabs / 30 days)
SAPHRIS 2.5mg	4	QL (240 tabs / 30 days)
SAPHRIS 5mg	4	QL (120 tabs / 30 days)
SAPHRIS 10mg	4	QL (60 tabs / 30 days)
<i>thioridazine hcl</i> TABS	2	
<i>thiothixene</i>	2	
<i>trifluoperazine hcl</i>	2	
VERSACLOZ	5	QL (600 mL / 30 days), PA
VRAYLAR 1.5mg	5	QL (60 caps / 30 days), PA
VRAYLAR 3mg, 4.5mg, 6mg	5	QL (30 caps / 30 days), PA
VRAYLAR THERAPY PACK	4	PA
<i>ziprasidone hcl</i>	2	QL (60 caps / 30 days)
ZYPREXA RELPREVV 300mg	5	QL (2 vials / 28 days), PA
ZYPREXA RELPREVV 405mg	5	QL (1 vial / 28 days), PA
ZYPREXA RELPREVV INJ 210MG	4	QL (2 vials / 28 days), PA

ATTENTION DEFICIT HYPERACTIVITY DISORDER

<i>amphetamine-dextroamphetamine cap sr</i> 24hr 5 mg	2	QL (90 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr</i> 24hr 10 mg	2	QL (90 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr</i> 24hr 15 mg	2	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr</i> 24hr 20 mg	2	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr</i> 24hr 25 mg	2	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr</i> 24hr 30 mg	2	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine tab</i> 5 mg	2	QL (360 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab</i> 7.5 mg	2	QL (240 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab</i> 10 mg	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 **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 tab 12.5 mg</i>	2	QL (90 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 15 mg</i>	2	QL (120 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 20 mg</i>	2	QL (90 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 30 mg</i>	2	QL (60 tabs / 30 days)
<i>atomoxetine hcl 10mg, 18mg, 25mg</i>	2	QL (120 caps / 30 days)
<i>atomoxetine hcl 40mg</i>	2	QL (60 caps / 30 days)
<i>atomoxetine hcl 60mg, 80mg, 100mg</i>	2	QL (30 caps / 30 days)
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i>	2	QL (120 tabs / 30 days)
<i>dexmethylphenidate hcl TABS 10mg</i>	2	QL (60 tabs / 30 days)
<i>guanfacine er (adhd)</i>	3	PA; PA if 70 years and older
<i>metadate er tab 20mg</i>	2	QL (90 tabs / 30 days)
<i>methylphenidate hcl TABS 5mg, 10mg</i>	2	QL (180 tabs / 30 days)
<i>methylphenidate hcl TABS 20mg</i>	2	QL (90 tabs / 30 days)
<i>methylphenidate hcl oral soln 5mg/5ml</i>	2	QL (1800 mL / 30 days)
<i>methylphenidate hcl oral soln 10mg/5ml</i>	2	QL (900 mL / 30 days)
<i>methylphenidate tab 10mg er</i>	2	QL (90 tabs / 30 days)
<i>methylphenidate tab 20mg er</i>	2	QL (90 tabs / 30 days)

HYPNOTICS

<i>HETLIOZ</i>	5	NM, LA, PA
<i>SILENOR 3mg</i>	3	QL (60 tabs / 30 days)
<i>SILENOR 6mg</i>	3	QL (30 tabs / 30 days)
<i>temazepam 7.5mg</i>	2	QL (30 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
<i>temazepam 15mg</i>	2	QL (60 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
<i>zolpidem tartrate TABS</i>	2	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 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 **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
MIGRAINE		
AIMOVIG	3	QL (1 pen / 30 days), PA
<i>dihydroergotamine mesylate inj 1 mg/ml</i>	5	
<i>dihydroergotamine mesylate nasal</i>	5	QL (8 mL / 30 days)
<i>eletriptan hydrobromide</i>	2	QL (12 tabs / 30 days)
EMGALITY SOAJ	3	QL (2 pens / 30 days), PA
EMGALITY SOSY 120mg/ml	3	QL (2 syringes / 30 days), PA
<i>ergotamine w/ caffeine TABS</i>	2	
<i>naratriptan hcl</i>	2	QL (12 tabs / 30 days)
<i>rizatriptan benzoate</i>	2	QL (18 tabs / 30 days)
<i>rizatriptan benzoate odt</i>	2	QL (18 tabs / 30 days)
<i>sumatriptan SOLN 5mg/act</i>	2	QL (24 inhalers / 30 days)
<i>sumatriptan SOLN 20mg/act</i>	2	QL (12 inhalers / 30 days)
<i>sumatriptan inj 4mg/0.5ml</i>	2	QL (18 injections / 30 days)
<i>sumatriptan inj 6mg/0.5ml</i>	2	QL (12 injections / 30 days)
<i>sumatriptan succinate TABS</i>	2	QL (12 tabs / 30 days)
<i>zolmitriptan TABS</i>	2	QL (12 tabs / 30 days)
<i>zolmitriptan odt</i>	2	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO 6mg	5	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO 9mg, 12mg	5	QL (120 tabs / 30 days), NM, LA, PA
<i>lithium carbonate CAPS; TABS</i>	1	
<i>lithium carbonate er</i>	2	
LITHIUM SOLN 8MEQ/5ML	4	
LYRICA CR 82.5mg, 165mg	3	QL (90 tabs / 30 days), PA
LYRICA CR 330mg	3	QL (60 tabs / 30 days), PA
NUDEXTA	4	QL (60 caps / 30 days), PA
<i>pyridostigmine tab 60mg</i>	2	
<i>riluzole</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 **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>tetrabenazine</i> 12.5mg	5	QL (240 tabs / 30 days), NM, PA
<i>tetrabenazine</i> 25mg	5	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BETASERON	5	QL (14 syringes / 28 days), NM, PA
<i>dalfampridine</i>	5	NM, PA
GILENYA CAP 0.5MG	5	QL (28 caps / 28 days), NM, PA
<i>glatiramer acetate</i> 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatiramer acetate</i> 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
<i>glatopa</i> 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
<i>glatopa</i> 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
MUSCULOSKELETAL THERAPY AGENTS		
<i>baclofen</i> TABS 10mg, 20mg	2	
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	3	PA; PA if 70 years and older
<i>dantrolene sodium</i> CAPS	2	
<i>tizanidine hcl</i> TABS	2	
NARCOLEPSY/CATAPLEXY		
<i>armodafinil</i> 50mg	2	QL (90 tabs / 30 days), PA
<i>armodafinil</i> 150mg, 200mg, 250mg	2	QL (30 tabs / 30 days), PA
XYREM	5	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium</i>	2	
<i>buprenorphine hcl</i> SUBL	2	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 2-0.5mg	2	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 4-1mg	2	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 8-2mg	2	QL (90 films / 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 **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>buprenorphine hcl-naloxone hcl dihydrate</i> 12-3mg	2	QL (60 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl</i>	2	QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent)</i>	2	
CHANTIX	4	PA
CHANTIX CONTINUING MONTH	4	PA
CHANTIX STARTER PACK	4	PA
<i>disulfiram</i> TABS	2	
<i>naloxone inj 0.4mg/ml</i>	2	
<i>naloxone inj 1mg/ml</i>	2	
<i>naltrexone hcl</i> TABS	2	
NARCAN	3	
NICOTROL INHALER	4	
NICOTROL NS	4	
VIVITROL	5	

ENDOCRINE AND METABOLIC

ANDROGENS

ANADROL-50	5	PA
ANDRODERM	4	QL (30 patches / 30 days), PA
<i>oxandrolone</i> TABS	2	PA
<i>testosterone</i> GEL 1%, 25mg/2.5gm, 50mg/5gm	2	QL (300 grams / 30 days), PA
<i>testosterone cypionate</i> SOLN 100mg/ml, 200mg/ml	2	PA
<i>testosterone enanthate</i> SOLN	2	PA

ANTIDIABETICS, INJECTABLE

ALCOHOL SWABS	3	
BASAGLAR KWIKPEN	3	
BD ULTRAFINE INSULIN SYRINGE	3	
BD ULTRAFINE/NANO PEN NEEDLES	3	
BYDUREON BCISE	3	QL (4 pens / 28 days)
BYDUREON INJ	3	QL (4 vials / 28 days)
BYDUREON PEN	3	QL (4 pens / 28 days)
BYETTA	4	QL (1 pen / 30 days)
FIASP	3	
FIASP FLEXTOUCH	3	
GAUZE PADS 2" X 2"	3	
HUMULIN R INJ U-500	5	B/D
HUMULIN R U-500 KWIKPEN	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 **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
INSULIN PEN NEEDLE	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGE	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	3	
NOVOLIN 70/30	3	(brand RELION not covered)
NOVOLIN 70/30 FLEXPEN	3	(brand RELION not covered)
NOVOLIN N	3	(brand RELION not covered)
NOVOLIN R	3	(brand RELION not covered)
NOVOLOG	3	
NOVOLOG 70/30 FLEXPEN	3	
NOVOLOG FLEXPEN	3	
NOVOLOG MIX 70/30	3	
NOVOLOG PENFILL	3	
OZEMPIC INJ 0.25 OR 0.5MG/DOSE	3	QL (1 pen / 28 days)
OZEMPIC INJ 1MG/DOSE	3	QL (2 pens / 28 days)
SOLIQUA 100/33	3	QL (10 pens / 30 days)
TRESIBA FLEXTOUCH	3	
TRESIBA INJ	3	
TRULICITY	3	QL (4 pens / 28 days)
VICTOZA	3	QL (3 pens / 30 days)
XULTOPHY 100/3.6	3	QL (5 pens / 30 days)

ANTIDIABETICS, ORAL

<i>acarbose</i> TABS	2	
FARXIGA 5mg	3	QL (60 tabs / 30 days)
FARXIGA 10mg	3	QL (30 tabs / 30 days)
<i>glimepiride</i> 1mg	6	GC, QL (240 tabs / 30 days)
<i>glimepiride</i> 2mg	6	GC, QL (120 tabs / 30 days)
<i>glimepiride</i> 4mg	6	GC, QL (60 tabs / 30 days)
<i>glip/metform tab 2.5-250mg</i>	1	QL (240 tabs / 30 days)
<i>glip/metform tab 2.5-500mg</i>	1	QL (120 tabs / 30 days)
<i>glip/metform tab 5-500mg</i>	1	QL (120 tabs / 30 days)
<i>glipizide</i> TABS 5mg	6	GC, QL (240 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 **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>glipizide</i> TABS 10mg	6	GC, QL (120 tabs / 30 days)
<i>glipizide</i> TB24 2.5mg	6	GC, QL (240 tabs / 30 days)
<i>glipizide</i> TB24 5mg	6	GC, QL (120 tabs / 30 days)
<i>glipizide</i> TB24 10mg	6	GC, QL (60 tabs / 30 days)
<i>glipizide xl</i> 2.5mg	6	GC, QL (240 tabs / 30 days)
<i>glipizide xl</i> 5mg	6	GC, QL (120 tabs / 30 days)
<i>glipizide xl</i> 10mg	6	GC, QL (60 tabs / 30 days)
JANUMET	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	QL (30 tabs / 30 days)
JANUVIA	3	QL (30 tabs / 30 days)
JARDIANCE 10mg	3	QL (60 tabs / 30 days)
JARDIANCE 25mg	3	QL (30 tabs / 30 days)
JENTADUETO	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000 MG	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000 MG	3	QL (30 tabs / 30 days)
<i>metformin er</i> 500mg	6	GC, QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin er</i> 750mg	6	GC, QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl</i> TABS 500mg	6	GC, QL (150 tabs / 30 days)
<i>metformin hcl</i> TABS 850mg	6	GC, QL (90 tabs / 30 days)
<i>metformin hcl</i> TABS 1000mg	6	GC, QL (75 tabs / 30 days)
<i>nateglinide</i>	1	QL (90 tabs / 30 days)
<i>pioglitazone hcl</i>	6	GC, QL (30 tabs / 30 days)
<i>repaglinide</i> 2mg	1	QL (240 tabs / 30 days)
<i>repaglinide</i> .5mg, 1mg	1	QL (120 tabs / 30 days)
SYNJARDY TAB 5-500MG	3	QL (120 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 **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
SYNJARDY TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000MG	3	QL (30 tabs / 30 days)
TRADJENTA	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 2.5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000MG	3	QL (30 tabs / 30 days)

BISPHOSPHONATES

<i>alendronate sodium</i> TABS	1	
<i>ibandronate sodium</i> TABS	2	B/D
PAMIDRONATE DISODIUM 6mg/ml	3	B/D
<i>pamidronate disodium</i> 30mg/10ml, 90mg/10ml	2	B/D
<i>pamidronate inj</i> 30mg	2	B/D
<i>pamidronate inj</i> 90mg	2	B/D
<i>zoledronic acid inj</i> 5mg/100ml	2	B/D, NM
<i>zoledronic inj</i> 4mg/5ml	2	B/D, NM

CALCIUM RECEPTOR AGONISTS

<i>cinacalcet hcl</i> 30mg, 90mg	5	B/D, QL (120 tabs / 30 days), NM
<i>cinacalcet hcl</i> 60mg	5	B/D, QL (60 tabs / 30 days), NM
SENSIPAR 30mg, 90mg	5	B/D, QL (120 tabs / 30 days), NM
SENSIPAR 60mg	5	B/D, QL (60 tabs / 30 days), NM

CHELATING AGENTS

CHEMET	4	
DEPEN TITRATABS	5	
JADENU	5	NM, LA, PA
JADENU SPRINKLE	5	NM, LA, PA
<i>kionex sus</i> 15gm/60ml	2	
<i>sodium polystyrene sulfonate powder</i>	2	
<i>sodium polystyrene sulfonate susp</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 **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>sps susp 15gm/60ml</i>	2	
<i>trientine hcl</i>	5	PA
CONTRACEPTIVES		
<i>altavera tab</i>	2	
<i>alyacen 1/35</i>	2	
<i>apri</i>	2	
<i>aranelle</i>	2	
<i>aubra</i>	2	
<i>aviane</i>	2	
<i>balziva</i>	2	
<i>bekyree</i>	2	
<i>blisovi fe 1.5/30</i>	2	
<i>briellyn</i>	2	
<i>camila</i>	2	
<i>caziant pak</i>	2	
<i>cryselle-28</i>	2	
<i>cyclafem 1/35</i>	2	
<i>cyclafem 7/7/7</i>	2	
<i>cyred tab</i>	2	
<i>dasetta 1/35</i>	2	
<i>dasetta 7/7/7</i>	2	
<i>deblitane</i>	2	
<i>delyla</i>	2	
<i>desogestrel & ethinyl estradiol</i>	2	
<i>desogestrel-ethinyl estradiol (biphasic)</i>	2	
<i>drospirenone-ethinyl estradiol</i>	2	
<i>ELLA</i>	4	
<i>emoquette</i>	2	
<i>enpresse-28</i>	2	
<i>enskyce</i>	2	
<i>errin</i>	2	
<i>estarylla tab 0.25-35</i>	2	
<i>ethynodiol diacet & eth estrad</i>	2	
<i>ethynodiol tab 1-50</i>	2	
<i>falmina</i>	2	
<i>femynor</i>	2	
<i>gianvi</i>	2	
<i>heather</i>	2	
<i>incassia</i>	2	
<i>introvale</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 **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>isibloom</i>	2	
<i>jasmiel</i>	2	
<i>jolessa tab 0.15-0.03 mg</i>	2	
<i>jolivette</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	
<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>larissia tab</i>	2	
<i>leena</i>	2	
<i>lessina</i>	2	
<i>levonest</i>	2	
<i>levonor/ethi tab</i>	2	
<i>levonorgestrel & eth estradiol</i>	2	
<i>levonorgestrel-ethinyl estradiol (91-day)</i>	2	
<i>levora 0.15/30-28</i>	2	
<i>loryna</i>	2	
<i>low-ogestrel</i>	2	
<i>lutra</i>	2	
<i>lyza</i>	2	
<i>marlissa</i>	2	
<i>medroxyprogesterone acetate (contraceptive)</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-lynyah tab 0.25-35</i>	2	
<i>mononessa</i>	2	
<i>myzilra</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 **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>necon 0.5/35-28</i>	2	
<i>necon 7/7/7</i>	2	
<i>nikki</i>	2	
<i>nora-be tab</i>	2	
<i>norethindrone (contraceptive)</i>	2	
<i>norethindrone acet & eth estra</i>	2	
<i>norgest/ethi tab 0.25/35</i>	2	
<i>norgestimate-ethinyl estradiol (triphasic) 0.18-25/0.215-25/0.25-25 mg-mcg</i>	2	
<i>norgestimate-ethinyl estradiol (triphasic) 0.18-35/0.215-35/0.25-35 mg-mcg</i>	2	
<i>norlyroc</i>	2	
<i>nortrel 0.5/35 (28)</i>	2	
<i>nortrel 1/35</i>	2	
<i>nortrel 7/7/7</i>	2	
<i>NUVARING</i>	4	
<i>ocella tab 3-0.03mg</i>	2	
<i>orsythia</i>	2	
<i>philith</i>	2	
<i>pimtrea</i>	2	
<i>pirmella 1/35</i>	2	
<i>portia-28</i>	2	
<i>previfem</i>	2	
<i>quasense</i>	2	
<i>reclipsen</i>	2	
<i>setlakin tab</i>	2	
<i>sharobel</i>	2	
<i>sprintec 28</i>	2	
<i>sronyx</i>	2	
<i>syeda</i>	2	
<i>tarina fe 1/20</i>	2	
<i>tilia fe</i>	2	
<i>tri-estarylla</i>	2	
<i>tri-legest fe</i>	2	
<i>tri-lynyah</i>	2	
<i>tri-lo marzia</i>	2	
<i>tri-lo-estarylla</i>	2	
<i>tri-lo-sprintec</i>	2	
<i>tri-mili</i>	2	
<i>tri-previfem</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 **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>trinessa</i>	2	
<i>trinessa lo</i>	2	
<i>trivora-28</i>	2	
<i>tulana</i>	2	
<i>velivet</i>	2	
<i>vienva</i>	2	
<i>viorele</i>	2	
<i>vyfemla</i>	2	
<i>vylibra</i>	2	
<i>xulane</i>	2	
<i>zarah</i>	2	
<i>zovia 1/35e</i>	2	
ENDOMETRIOSIS		
<i>danazol CAPS</i>	2	
SYNAREL	5	
ENZYME REPLACEMENTS		
ALDURAZYME	5	NM, LA, PA
CARBAGLU	5	NM, LA, PA
CERDELGA	5	NM, PA
CEREZYME	5	NM, LA, PA
CYSTADANE	5	NM, LA
CYSTAGON	4	NM, LA, PA
FABRAZYME	5	NM, LA, PA
KUVAN	5	NM, LA, PA
<i>levocarnitine (metabolic modifiers)</i>	2	B/D
LUMIZYME	5	NM, LA, PA
<i>miglustat</i>	5	NM, PA
NAGLAZYME	5	NM, LA, PA
NITYR	5	NM, LA, PA
ORFADIN	5	NM, LA, PA
<i>sodium phenylbutyrate</i>	5	NM, PA
ESTROGENS		
DELESTROGEN 10mg/ml	4	
<i>estradiol PTWK</i>	3	
<i>estradiol TABS</i>	2	
<i>estradiol vaginal cream</i>	2	
<i>estradiol vaginal tab</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 **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>estradiol valerate OIL</i>	2	
<i>fyavolv</i>	3	
<i>jinteli</i>	3	
<i>norethindrone acetate-ethinyl estradiol</i>	3	
<i>yuvaferm vaginal tablet 10 mcg</i>	2	
GLUCOCORTICOIDS		
<i>cortisone acetate TABS</i>	2	
DEXAMETHASONE CONC	4	
<i>dexamethasone ELIX; SOLN</i>	2	
<i>dexamethasone TABS</i>	1	
<i>dexamethasone sodium phosphate</i>	2	
<i>fludrocortisone acetate TABS</i>	2	
<i>hydrocortisone TABS</i>	2	
<i>methylpr ss inj</i>	2	B/D
<i>methylpred pak 4mg</i>	2	
<i>methylpred tab 4mg</i>	2	B/D
<i>methylpred tab 8mg</i>	2	B/D
<i>methylpred tab 16mg</i>	2	B/D
<i>methylpred tab 32mg</i>	2	B/D
<i>methylprednisolone acetate</i>	2	B/D
<i>pred sod pho sol 5mg/5ml</i>	2	B/D
<i>prednisolone sodium phosphate SOLN</i> 15mg/5ml	2	B/D
<i>prednisolone sol 15mg/5ml</i>	2	B/D
<i>prednisolone sol 25mg/5ml</i>	2	B/D
PREDNISONE CON 5MG/ML	4	B/D
<i>prednisone pak 5mg</i>	2	
<i>prednisone pak 10mg</i>	2	
<i>prednisone sol 5mg/5ml</i>	2	B/D
<i>prednisone tab 1mg</i>	1	B/D
<i>prednisone tab 2.5mg</i>	1	B/D
<i>prednisone tab 5mg</i>	1	B/D
<i>prednisone tab 10mg</i>	1	B/D
<i>prednisone tab 20mg</i>	1	B/D
<i>prednisone tab 50mg</i>	1	B/D
SOLU-CORTEF	4	
GLUCOSE ELEVATING AGENTS		
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
PROGLYCEM SUS 50MG/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 **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>cabergoline</i>	2	
<i>calcitonin (salmon)</i>	2	B/D
FORTEO	5	NM, PA
GENOTROPIN	5	NM, PA
GENOTROPIN MINIQUICK .2mg	3	NM, PA
GENOTROPIN MINIQUICK .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NM, PA
INCRELEX	5	NM, LA, PA
KORLYM	5	NM, LA, PA
LUPRON DEP-PED INJ 7.5MG	5	NM, PA
LUPRON DEP-PED INJ 11.25MG (3-MONTH)	5	NM, PA
LUPRON DEPOT-PED (1-MONTH)	5	NM, PA
LUPRON DEPOT-PED (3-MONTH)	5	NM, PA
NATPARA	5	NM, PA
<i>octreotide acetate</i> 50mcg/ml, 100mcg/ml, 200mcg/ml	2	NM, PA
<i>octreotide acetate</i> 500mcg/ml, 1000mcg/ml	5	NM, PA
PROLIA	4	QL (1 injection / 180 days), NM
<i>raloxifene hcl</i>	2	
SIGNIFOR	5	NM, LA, PA
SOMATULINE DEPOT	5	NM, PA
SOMAVERT	5	NM, LA, PA
TYMLOS	5	NM, PA
XGEVA	5	NM, PA
PHOSPHATE BINDER AGENTS		
AURYXIA	5	QL (360 tabs / 30 days), PA
<i>calcium acetate (phosphate binder)</i> CAPS	2	QL (360 caps / 30 days)
<i>calcium acetate (phosphate binder)</i> TABS	2	QL (360 tabs / 30 days)
<i>sevelamer carbonate</i> PACK 2.4gm	5	QL (180 packets / 30 days)
<i>sevelamer carbonate</i> PACK .8gm	5	QL (540 packets / 30 days)
<i>sevelamer carbonate</i> TABS	2	QL (540 tabs / 30 days)
PROGESTINS		
<i>medroxyprogesterone acetate tab</i>	1	

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 **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</i> TABS	2	
<u>THYROID AGENTS</u>		
<i>levo-t</i>	2	
<i>levothyroxine sodium</i> TABS	2	
<i>levoxyl</i>	2	
<i>liothyronine sodium</i> TABS	2	
<i>methimazole</i> TABS	1	
<i>propylthiouracil</i> TABS	2	
SYNTHROID	4	
<i>unithroid</i>	2	
<u>VASOPRESSINS</u>		
<i>desmopressin acetate spray</i>	2	
<i>desmopressin acetate spray refrigerated</i>	2	
<i>desmopressin acetate tabs</i>	2	
<i>desmopressin inj 4mcg/ml</i>	2	
STIMATE	5	NM
<u>GASTROINTESTINAL</u>		
<u>ANTIEMETICS</u>		
<i>aprepitant</i>	2	B/D
<i>aprepitant pak 80mg & 125mg</i>	2	B/D
<i>compro</i>	2	
<i>dronabinol</i>	2	B/D, QL (60 caps / 30 days)
EMEND SUSR	4	B/D
<i>granisetron hcl</i> SOLN	2	
<i>granisetron hcl</i> TABS	2	B/D
<i>meclizine hcl</i> TABS	2	
<i>metoclopramide hcl</i> SOLN	2	
<i>metoclopramide hcl</i> TABS	1	
<i>metoclopramide hcl inj</i>	2	
<i>ondansetron hcl</i> TABS	2	B/D
<i>ondansetron hcl inj</i>	2	
<i>ondansetron hcl oral soln</i>	2	B/D
<i>ondansetron odt</i>	2	B/D
<i>prochlorperazine inj</i>	2	
<i>prochlorperazine maleate</i> TABS	1	
<i>prochlorperazine supp</i>	2	
<i>promethazine hcl</i> SYRP; TABS	2	PA; PA if 70 years and older

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 **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 inj</i>	4	PA; PA if 70 years and older
<i>scopolamine patch</i>	4	QL (10 patches / 30 days), PA; PA if 70 years and older
TRANSDERM-SCOP	4	QL (10 patches / 30 days), PA; PA if 70 years and older

ANTISPASMODICS

<i>dicyclomine hcl cap 10mg</i>	3	
<i>dicyclomine hcl soln 10mg/5ml</i>	4	
<i>dicyclomine hcl tab 20mg</i>	3	
<i>glycopyrrolate tab 1mg</i>	2	
<i>glycopyrrolate tab 2mg</i>	2	

H2-RECEPTOR ANTAGONISTS

<i>famotidine SUSR</i>	2	
<i>famotidine TABS 20mg, 40mg</i>	1	
<i>famotidine in nacl</i>	2	
<i>famotidine inj</i>	2	
<i>ranitidine hcl TABS 150mg, 300mg</i>	1	
<i>ranitidine hcl inj</i>	2	
<i>ranitidine inj</i>	2	
<i>ranitidine syrup</i>	2	

INFLAMMATORY BOWEL DISEASE

APRISO	3	QL (120 caps / 30 days)
<i>balsalazide disodium</i>	2	
<i>budesonide ec</i>	5	
<i>colocort enema 100mg</i>	2	
DELZICOL	4	
<i>hydrocortisone (enema)</i>	2	
<i>mesalamine CPDR</i>	2	
<i>mesalamine ENEM</i>	2	
<i>mesalamine SUPP</i>	2	
<i>mesalamine TBEC 800mg</i>	2	
<i>mesalamine w/ cleanser</i>	2	
<i>sulfasalazine TABS</i>	2	
<i>sulfasalazine ec</i>	2	

LAXATIVES

<i>constulose</i>	2	
<i>enulose</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 **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>gavilyte-c</i>	2	
<i>gavilyte-g</i>	2	
<i>gavilyte-n/flavor pack</i>	2	
<i>generlac</i>	2	
GOLYTELY	3	
<i>lactulose SOLN</i>	2	
<i>lactulose (encephalopathy)</i>	2	
MOVIPREP	4	
NULYTELY/FLAVOR PACKS	3	
<i>peg 3350-kcl-sod bicarb-sod chloride-sod sulfate</i>	2	
<i>peg 3350-potassium chloride-sod bicarbonate-sod chloride</i>	2	
<i>peg 3350/electrolytes</i>	2	
SUPREP BOWEL PREP KIT	4	
<i>trilyte</i>	2	
MISCELLANEOUS		
<i>alosetron hcl</i>	5	PA
AMITIZA CAP 8MCG	3	QL (180 caps / 30 days)
AMITIZA CAP 24MCG	3	QL (60 caps / 30 days)
<i>cromolyn sodium (mastocytosis)</i>	5	
<i>diphenoxylate w/ atropine LIQD</i>	4	
<i>diphenoxylate w/ atropine TABS</i>	3	
GATTEX	5	NM, LA, PA
LINZESS	3	QL (30 caps / 30 days)
<i>loperamide hcl CAPS</i>	2	
<i>misoprostol TABS</i>	2	
MOVANTIK 12.5mg	3	QL (60 tabs / 30 days)
MOVANTIK 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN	5	PA
<i>sucrafate TABS</i>	2	
SYMPROIC	3	
<i>ursodiol CAPS; TABS</i>	2	
XIFAXAN 550mg	5	PA
PANCREATIC ENZYMES		
CREON	3	
ZENPEP	4	
PROTON PUMP INHIBITORS		
DEXILANT	4	QL (30 caps / 30 days)
<i>esomeprazole magnesium</i>	2	QL (30 caps / 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 **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>esomeprazole sodium inj</i>	2	
<i>lansoprazole CPDR</i>	2	QL (30 caps / 30 days)
<i>omeprazole cap 10mg</i>	1	
<i>omeprazole cap 20mg</i>	1	
<i>omeprazole cap 40mg</i>	1	
<i>pantoprazole sodium SOLR</i>	2	
<i>pantoprazole sodium tbec</i>	1	

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

<i>alfuzosin hcl</i>	2	QL (30 tabs / 30 days)
<i>dutasteride CAPS</i>	2	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl</i>	2	QL (30 caps / 30 days)
<i>finasteride TABS 5mg</i>	1	
<i>tamsulosin hcl</i>	2	

MISCELLANEOUS

<i>bethanechol chloride TABS</i>	2	
<i>potassium citrate (alkalinizer) er tabs</i>	2	

URINARY ANTISPASMODICS

MYRBETRIQ 25mg	4	QL (60 tabs / 30 days)
MYRBETRIQ 50mg	4	QL (30 tabs / 30 days)
<i>oxybutynin chloride SYRP</i>	2	
<i>oxybutynin chloride TABS</i>	2	
<i>oxybutynin chloride TB24 5mg</i>	2	QL (30 tabs / 30 days)
<i>oxybutynin chloride TB24 10mg, 15mg</i>	2	QL (60 tabs / 30 days)
<i>solifenacin succinate</i>	2	QL (30 tabs / 30 days)
<i>tolterodine tartrate cap er</i>	2	QL (30 caps / 30 days), ST
<i>tolterodine tartrate tabs</i>	2	ST
TOVIAZ	3	QL (30 tabs / 30 days)
<i>trospium chloride TABS</i>	2	QL (60 tabs / 30 days)

VAGINAL ANTI-INFECTIVES

<i>clindamycin phosphate vaginal</i>	2	
<i>metronidazole vaginal</i>	2	
<i>terconazole vaginal</i>	2	
<i>vandazole</i>	2	

HEMATOLOGIC

ANTICOAGULANTS

COUMADIN	3	
ELIQUIS	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 **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
ELIQUIS STARTER PACK	3	
<i>enoxaparin sodium</i>	2	
<i>fondaparinux sodium</i> 2.5mg/0.5ml	2	
<i>fondaparinux sodium</i> 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	
<i>heparin sod (porcine) in d5w</i>	3	
<i>heparin sod inj 1000/ml</i>	2	B/D
<i>heparin sod inj 5000/ml</i>	2	B/D
<i>heparin sod inj 10000/ml</i>	2	B/D
<i>heparin sod inj 20000/ml</i>	2	B/D
HEPARIN SODIUM/NACL 0.45%	3	
<i>jantoven</i>	1	
PRADAXA	4	
<i>warfarin sodium</i>	1	
XARELTO	3	
XARELTO STARTER PACK	3	

HEMATOPOIETIC GROWTH FACTORS

GRANIX	5	NM, PA
NEUPOGEN	5	NM, PA
PROCRIT 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	NM, PA
PROCRIT 20000unit/ml, 40000unit/ml	5	NM, PA

MISCELLANEOUS

<i>anagrelide hcl</i>	2	
BERINERT	5	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i>	2	
DROXIA	3	
ENDARI	5	NM, LA, PA
FIRAZYR	5	QL (9 syringes / 30 days), NM, PA
HAEGARDA 2000unit	5	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
<i>pentoxifylline</i> TBCR	2	
PROMACTA PACK	5	QL (360 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg	5	QL (360 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 **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
PROMACTA TABS 25mg	5	QL (180 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg	5	QL (90 tabs / 30 days), NM, LA, PA
PROMACTA TABS 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>tranexamic acid</i> SOLN; TABS	2	

PLATELET AGGREGATION INHIBITORS

<i>aspirin-dipyridamole</i>	2	
BRILINTA	3	
<i>clopidogrel tab 75mg</i>	1	
<i>prasugrel hcl</i>	2	
ZONTIVITY	4	

IMMUNOLOGIC AGENTS

DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)

HUMIRA 10mg/0.1ml, 20mg/0.2ml	5	QL (2 injections / 28 days), NM, PA
HUMIRA 40mg/0.4ml	5	QL (6 injections / 28 days), NM, PA
HUMIRA INJ 10MG/0.2ML	5	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 20MG/0.4ML	5	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 40MG/0.8ML	5	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIATRIC CROHNS DISEASE	5	NM, PA
HUMIRA PEN	5	QL (6 pens / 28 days), NM, PA
HUMIRA PEN CD/UC/HS STARTER	5	NM, PA
HUMIRA PEN INJ CD/UC/HS STARTER	5	NM, PA
HUMIRA PEN INJ PS/UV STARTER	5	NM, PA
HUMIRA PEN-PS/UV STARTER	5	NM, PA
<i>hydroxychloroquine sulfate</i>	2	
<i>leflunomide</i> TABS	2	
<i>methotrexate sodium tabs</i>	2	
REMICADE	5	NM, PA
XATMEP	4	B/D
XELJANZ	5	QL (60 tabs / 30 days), NM, PA
XELJANZ XR	5	QL (30 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 **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
IMMUNOGLOBULINS		
BIVIGAM	5	NM, PA
CARIMUNE NANOFILTERED 12gm	5	NM, PA
FLEBOGAMMA DIF	5	NM, PA
GAMASTAN S/D	3	B/D, NM
GAMMAGARD LIQUID	5	NM, PA
GAMMAGARD S/D	5	NM, PA
GAMMAKED	5	NM, PA
GAMMAPLEX	5	NM, PA
GAMMAPLEX 10GM/100ML	5	NM, PA
GAMUNEX-C	5	NM, PA
OCTAGAM	5	NM, PA
PANZYGA	5	NM, PA
PRIVIGEN	5	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE	5	NM, LA, PA
ARCALYST	5	NM, PA
INTRON-A INJ 10MU	5	B/D
INTRON-A INJ 18MU	5	B/D
INTRON-A INJ 25MU	5	B/D
INTRON-A INJ 50MU	5	B/D
IMMUNOSUPPRESSANTS		
<i>azathioprine</i> TABS	2	B/D
BENLYSTA	5	NM, PA
<i>cyclosporine</i> CAPS; SOLN	2	B/D
<i>cyclosporine modified (for microemulsion)</i>	2	B/D
<i>engraf</i>	2	B/D
<i>mycophenolate mofetil</i> CAPS; TABS	2	B/D
<i>mycophenolate mofetil</i> SUSR	5	B/D
<i>mycophenolate sodium tbec</i>	2	B/D
NULOJIX	5	B/D
PROGRAF PACK	4	B/D
RAPAMUNE SOLN	5	B/D
SANDIMMUNE SOLN 100mg/ml	3	B/D
<i>sirolimus</i> SOLN	5	B/D
<i>sirolimus</i> TABS 2mg	5	B/D
<i>sirolimus</i> TABS .5mg, 1mg	2	B/D
<i>tacrolimus</i> CAPS	2	B/D
ZORTRESS TAB 0.5MG	5	B/D
ZORTRESS TAB 0.25MG	5	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 **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
ZORTRESS TAB 0.75MG	5	B/D
ZORTRESS TAB 1MG	5	B/D
VACCINES		
ACTHIB	3	
ADACEL	3	
BCG VACCINE	3	
BEXSERO	3	
BOOSTRIX	3	
DAPTACEL	3	
DIPHThERIA/TETANUS TOXOID	3	B/D
ENGRIX-B SUSP	3	B/D
GARDASIL 9	3	
HAVRIX	3	
HIBERIX	3	
IMOVAX RABIES (H.D.C.V.)	3	B/D
INFANRIX	3	
IPOL INACTIVATED IPV	3	
IXIARO	3	
KINRIX	3	
M-M-R II	3	
MENACTRA	3	
MENVEO	3	
PEDIARIX	3	
PEDVAX HIB	3	
PENTACEL	3	
PROQUAD	3	
QUADRACEL	3	
RABAVERT	3	B/D
RECOMBIVAX HB	3	B/D
ROTARIX	3	
ROTATEQ	3	
SHINGRIX	3	QL (2 vials per lifetime)
TDVAX	3	B/D
TENIVAC	3	B/D
TRUMENBA	3	
TWINRIX INJ	3	
TYPHIM VI	3	
VAQTA	3	
VARIVAX	3	
YF-VAX	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 **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
ZOSTAVAX	3	QL (1 vial per lifetime)
<u>NUTRITIONAL/SUPPLEMENTS</u>		
<u>ELECTROLYTES</u>		
<i>klor-con 8</i>	2	
<i>klor-con 10</i>	2	
<i>klor-con m10</i>	2	
<i>klor-con m15</i>	3	
<i>klor-con m20</i>	2	
<i>klor-con pak 20meq</i>	2	
<i>klor-con spr cap 8meq</i>	2	
<i>klor-con spr cap 10meq</i>	2	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
<i>magnesium sulfate</i> SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	3	
MAGNESIUM SULFATE IN D5W	3	
<i>magnesium sulfate in dextrose</i>	3	
<i>magnesium sulfate inj 50%</i>	3	
<i>potassium chloride</i> CPCR	2	
<i>potassium chloride</i> PACK	2	
<i>potassium chloride</i> SOLN 10%, 20%	2	
<i>potassium chloride</i> TBCR	2	
<i>potassium chloride microencapsulated crystals er</i>	2	
<i>potassium chloride tab cr 10 meq</i>	2	
<i>sodium chloride</i> SOLN 2.5meq/ml	2	
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	2	
<i>tpn electrolytes</i>	4	B/D
<u>IV NUTRITION</u>		
AMINOSYN II INJ 10%	4	B/D
AMINOSYN-PF 7%	4	B/D
AMINOSYN-PF INJ 10%	4	B/D
CLINIMIX 4.25%/DEXTROSE 5%	4	B/D
CLINIMIX 4.25%/DEXTROSE 25%	4	B/D
CLINIMIX 5%/DEXTROSE 15%	4	B/D
CLINIMIX 5%/DEXTROSE 20%	4	B/D
CLINIMIX 5%/DEXTROSE 25%	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 **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
CLINIMIX INJ 4.25/D10	4	B/D
FREAMINE HBC 6.9%	4	B/D
FREAMINE III	4	B/D
<i>hepatamine</i>	4	B/D
INTRALIPID 30%	4	B/D
<i>intralipid inj 20%</i>	4	B/D
NEPHRAMINE	4	B/D
<i>nutrilipid inj 20%</i>	4	B/D
<i>premasol sol 6%</i>	2	B/D
PREMASOL SOL 10%	4	B/D
PROCALAMINE	4	B/D
PROSOL	4	B/D
TRAVASOL	4	B/D
TROPHAMINE INJ 10%	4	B/D

IV REPLACEMENT SOLUTIONS

<i>dextrose 2.5%/nacl 0.45%</i>	2
<i>dextrose 5%</i>	2
DEXTROSE 5% /ELECTROLYTE	3
<i>dextrose 5%/nacl 0.2%</i>	2
DEXTROSE 5%/NACL 0.3%	4
<i>dextrose 5%/nacl 0.9%</i>	2
<i>dextrose 5%/nacl 0.33%</i>	2
<i>dextrose 5%/nacl 0.45%</i>	2
<i>dextrose 5%/nacl 0.225%</i>	2
<i>dextrose 5%/potassium chl</i>	2
<i>dextrose 10% flex contain</i>	2
DEXTROSE 10%/NACL 0.2%	3
<i>dextrose 10%/nacl 0.45%</i>	2
<i>dextrose 50%</i>	2
<i>dextrose in lactated ringers</i>	2
<i>dextrose inj 70%</i>	2
IONOSOL-MB/DEXTROSE 5%	4
ISOLYTE P	4
ISOLYTE S	4
<i>kcl 0.15%/d5w/nacl 0.2%</i>	2
KCL 0.3%/D5W/NACL 0.9%	4
<i>kcl 0.3%/d5w/nacl 0.45%</i>	2
<i>kcl 0.15%/d5w/nacl 0.9%</i>	2
KCL 0.15%/D5W/NACL 0.225%	3
<i>kcl 0.075%/d5w/nacl 0.45%</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 **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>kcl/d5w inj 0.3%</i>	2	
<i>kcl/d5w/nacl inj 0.22%/0.45%</i>	2	
<i>kcl/d5w/nacl inj .15/.33%</i>	2	
<i>kcl/d5w/nacl inj .15/.45%</i>	2	
<i>kcl/nacl inj 0.3-0.9</i>	2	
<i>kcl/nacl inj 0.15%-0.9%</i>	2	
<i>lactated ringer's</i>	2	
NORMOSOL-M IN D5W	4	
NORMOSOL-R	4	
NORMOSOL-R IN D5W	4	
PLASMA-LYTE A	4	
PLASMA-LYTE-148	4	
<i>pot chloride inj 2meq/ml</i>	2	
<i>potassium chloride SOLN .4meq/ml, 2meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 40meq/100ml</i>	2	
<i>potassium chloride in nacl</i>	2	
<i>sodium chloride SOLN 3%, 5%</i>	2	
<i>sodium chloride 0.45%</i>	2	
<i>sodium chloride inj 0.9%</i>	2	

VITAMINS

<i>calcitriol CAPS</i>	2	B/D
<i>calcitriol inj</i>	2	B/D
<i>calcitriol oral soln 1 mcg/ml</i>	2	B/D
M-NATAL PLUS	3	
<i>paricalcitol CAPS</i>	2	B/D
PNV FOLIC ACID + IRON MUL	3	
PRENATAL	3	
PRENATAL PLUS	3	
PRENATAL PLUS LOW IRON	3	
RAYALDEE	5	
TRICARE	3	

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

<i>bacitracin-poly-neomycin-hc</i>	2	
BLEPHAMIDE OINT	4	
<i>neomycin-polymyx-dexameth</i>	2	
<i>neomycin-polymyxin-hc (ophth)</i>	2	
<i>sulfacetamide sod-prednisolone</i>	2	
TOBRADEX OINT	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 **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
TOBRADEX ST	3	
<i>tobramycin-dexamethasone</i>	2	
ZYLET	3	
ANTI-INFECTIVES		
AZASITE	4	
<i>bacitracin (ophthalmic)</i>	2	
<i>bacitracin-polymyxin b (ophth)</i>	2	
BESIVANCE	3	
CILOXAN OINT	3	
<i>ciprofloxacin hcl (ophth)</i>	1	
<i>erythromycin (ophth)</i>	1	
<i>gatifloxacin (ophth)</i>	2	
<i>gentak</i>	2	
<i>gentamicin sulfate soln (ophth)</i>	1	
MOXEZA	3	
<i>moxifloxacin hcl (ophth)</i>	2	
NATACYN	4	
<i>neomycin-bacitracin zn-polymyxin</i>	2	
<i>neomycin-polymyxin-gramicidin</i>	2	
<i>ofloxacin (ophth)</i>	2	
<i>polymyxin b-trimethoprim</i>	1	
<i>sulfacetamide sodium (ophth)</i>	2	
<i>tobramycin (ophth)</i>	1	
<i>trifluridine</i>	2	
ZIRGAN	4	
ANTI-INFLAMMATORIES		
ALREX	3	
<i>bromfenac sodium (ophth)</i>	2	
BROMSITE	4	
<i>dexamethasone sodium phosphate (ophth)</i>	2	
<i>diclofenac sodium (ophth)</i>	2	
DUREZOL	3	
<i>fluorometholone</i>	2	
<i>flurbiprofen sodium</i>	2	
ILEVRO	3	
<i>ketorolac tromethamine (ophth)</i>	2	
LOTEMAX	3	
<i>loteprednol etabonate</i>	2	
<i>prednisolone acetate (ophth)</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 **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
PREDNISOLONE SODIUM PHOSPHATE (OPHTH)	3	
PROLENSA	3	
ANTIALLERGICS		
<i>azelastine drop 0.05%</i>	2	
BEPREVE	3	
<i>cromolyn sodium (ophth)</i>	1	
LASTACAFT	4	
<i>olopatadine hcl 0.2%</i>	2	
PAZEO	3	
ANTIGLAUCOMA		
ALPHAGAN P SOL 0.1%	3	
AZOPT	3	
<i>betaxolol hcl (ophth)</i>	2	
BETOPTIC-S	3	
<i>brimonidine sol 0.2%</i>	1	
<i>brimonidine sol 0.15%</i>	2	
<i>carteolol hcl (ophth)</i>	2	
COMBIGAN	3	
<i>dorzolamide hcl</i>	2	
<i>dorzolamide hcl-timolol maleate</i>	2	
<i>latanoprost SOLN</i>	1	
<i>levobunolol hcl</i>	2	
LUMIGAN	3	
PHOSPHOLINE IODIDE	4	
<i>pilocarpine hcl SOLN</i>	2	
RHOPRESSA	3	
SIMBRINZA	3	
<i>timolol maleate (ophth) soln</i>	1	
<i>timolol maleate gel</i>	2	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	2	
TRAVATAN Z	3	
MISCELLANEOUS		
CYSTARAN	5	NM, LA, PA
<i>proparacaine hcl SOLN</i>	2	
RESTASIS	3	QL (60 single use vials / 30 days)
RESTASIS MULTIDOSE	3	QL (1 bottle / 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 **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
-----------	-----------	---------------------

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

ANORO ELLIPTA	3	QL (60 blisters / 30 days)
BEVESPI AEROSPHERE	3	QL (1 inhaler / 30 days)
COMBIVENT RESPIMAT	4	QL (2 inhalers / 30 days)
<i>ipratropium-albuterol nebu</i>	2	B/D
TRELEGY ELLIPTA	3	QL (60 blisters / 30 days)

ANTICHOLINERGICS

ATROVENT HFA	4	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA	3	QL (30 blisters / 30 days)
<i>ipratropium bromide SOLN</i>	2	B/D
<i>ipratropium bromide (nasal)</i>	2	

ANTI-HISTAMINES

<i>azelastine spr 0.1%</i>	2	
<i>azelastine spr 0.15%</i>	2	
<i>cetirizine syrup</i>	1	
<i>cyproheptadine hcl</i> SYRP; TABS	3	PA; PA if 70 years and older
<i>diphenhydramine hcl inj 50mg/ml</i>	2	
<i>hydroxyzine hcl</i> SYRP	3	PA; PA if 70 years and older
<i>hydroxyzine hcl</i> TABS	2	PA; PA if 70 years and older
<i>hydroxyzine hcl inj</i>	4	PA; PA if 70 years and older
<i>hydroxyzine pamoate</i> CAPS 25mg, 50mg	2	PA; PA if 70 years and older
<i>levocetirizine dihydrochloride</i>	2	

BETA AGONISTS

<i>albuterol sulfate</i> AERS 108mcg/act	2	QL (2 inhalers / 30 days); (generic of Proair HFA)
<i>albuterol sulfate</i> AERS 108mcg/act	2	QL (2 inhalers / 30 days); (generic of Ventolin HFA)
<i>albuterol sulfate</i> NEBU	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 **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> SYRP	2	
<i>albuterol sulfate</i> TABS	2	
<i>albuterol sulfate</i> TB12	2	
<i>levalbuterol hcl</i> NEBU 1.25mg/3ml	2	B/D
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml</i>	2	B/D
<i>levalbuterol tartrate hfa</i>	2	QL (2 inhalers / 30 days)
SEREVENT DISKUS	3	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS	2	
VENTOLIN HFA	3	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> CHEW; PACK; TABS	2	
<i>zafirlukast</i>	2	
MAST CELL STABILIZERS		
<i>cromolyn sodium nebu</i>	2	B/D
MISCELLANEOUS		
<i>acetylcysteine</i> SOLN 10%, 20%	2	B/D
ARALAST NP	5	NM, LA, PA
DALIRESP	4	
<i>epinephrine (anaphylaxis)</i> .15mg/0.15ml, .3mg/0.3ml	2	(generic of Adrenaclick)
ESBRIET	5	NM, PA
KALYDECO	5	NM, PA
OFEV	5	NM, PA
ORKAMBI	5	NM, PA
PROLASTIN-C	5	NM, LA, PA
PULMOZYME	5	NM, PA
SYMDEKO	5	NM, LA, PA
THEO-24	4	
<i>theophylline</i>	2	
XOLAIR	5	NM, LA, PA
ZEMAIRA	5	NM, LA, PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i>	2	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i>	2	QL (1 bottle / 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 **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
STEROID INHALANTS		
ARNUITY ELLIPTA	3	QL (30 inhalations / 30 days)
<i>budesonide (inhalation)</i> .25mg/2ml, .5mg/2ml	2	B/D
FLOVENT DISKUS 50mcg/blist, 100mcg/blist	3	QL (120 inhalations / 30 days)
FLOVENT DISKUS 250mcg/blist	3	QL (240 inhalations / 30 days)
FLOVENT HFA	3	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER	4	QL (2 inhalers / 30 days)

STEROID/BETA-AGONIST COMBINATIONS

ADVAIR DISKUS	3	QL (60 inhalations / 30 days)
ADVAIR HFA	3	QL (1 inhaler / 30 days)
BREO ELLIPTA	3	QL (60 blisters / 30 days)
SYMBICORT	3	QL (1 inhaler / 30 days)

TOPICAL

DERMATOLOGY, ACNE

<i>amnestem</i>	2	PA
<i>avita</i>	2	PA
<i>benzoyl peroxide-erythromycin</i>	2	
<i>claravis</i>	2	PA
<i>clindacin-p</i>	2	
<i>clindamycin phosphate (topical)</i> GEL; LOTN; SOLN; SWAB	2	
<i>ery pad 2%</i>	2	
<i>erythromycin (acne aid)</i>	2	
<i>isotretinoin</i> CAPS	2	PA
<i>myorisan</i>	2	PA
<i>sulfacetamide sodium (acne)</i>	2	
<i>tretinoin</i> CREA	2	PA
<i>tretinoin</i> GEL .01%, .025%	2	PA
<i>zenatane</i>	2	PA

DERMATOLOGY, ANTIBIOTICS

<i>gentamicin sulfate (topical)</i>	2	
<i>mupirocin</i> OINT	1	

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 **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>silver sulfadiazine</i> CREA	2	
<i>ssd</i>	2	
SULFAMYLON CREA	4	
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox</i> CREA; GEL; SUSP	2	
<i>ciclopirox shampoo 1%</i>	2	
<i>clotrimazole (topical)</i>	2	
<i>clotrimazole w/ betamethasone</i> CREA	2	
<i>ketoconazole cream</i>	2	
<i>nyamyc</i>	2	
<i>nystatin (topical)</i>	2	
<i>nystatin pow 100000</i>	2	
<i>nystop</i>	2	
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin</i>	5	PA
<i>calcipotriene</i> CREA; OINT	2	QL (120 gm / 30 days), PA
<i>calcipotriene</i> SOLN	2	QL (120 mL / 30 days), PA
<i>calcitrene</i>	2	QL (120 gm / 30 days), PA
<i>tazarotene</i> CREA	2	PA
TAZORAC CREA .05%	4	PA
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole shampoo</i>	1	
<i>selenium sulfide</i> LOTN	1	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort</i>	1	
<i>alclometasone dipropionate</i>	2	
<i>betamethasone dipropionate (topical)</i>	2	
<i>betamethasone dipropionate augmented</i>	2	
<i>betamethasone valerate</i> CREA; LOTN; OINT	2	
ENSTILAR	4	PA
<i>fluocinolone acetonide</i> CREA; OIL; OINT; SOLN	2	
<i>fluocinolone acetonide oil body</i>	2	
<i>fluocinonide</i> CREA .05%	2	
<i>fluocinonide</i> GEL	2	
<i>fluocinonide</i> SOLN	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 **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>fluocinonide emulsified base</i>	2	
<i>fluticasone propionate</i> CREA; OINT	2	
<i>halobetasol propionate</i> CREA; OINT	2	
<i>hydrocortisone (topical)</i> CREA	1	
<i>hydrocortisone (topical)</i> LOTN	2	
<i>hydrocortisone (topical)</i> OINT 2.5%	1	
<i>hydrocortisone butyrate cream 0.1%</i>	2	
<i>hydrocortisone butyrate oint 0.1%</i>	2	
<i>hydrocortisone valerate</i>	2	
<i>mometasone furoate</i> CREA; OINT; SOLN	2	
TEXACORT SOLN 2.5%	4	
<i>triamcinolone acetonide (topical)</i> CREA; OINT	1	
<i>triamcinolone acetonide (topical)</i> LOTN	2	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo</i>	2	QL (30 mL / 30 days), PA
<i>lidocaine</i> PTCH	2	QL (3 patches / 1 day), PA
<i>lidocaine hcl</i> GEL	2	QL (30 mL / 30 days), PA
<i>lidocaine hcl</i> SOLN 4%	2	QL (50 mL / 30 days), PA
<i>lidocaine oint 5%</i>	2	QL (50 grams / 30 days), PA
<i>lidocaine-prilocaine</i>	2	QL (30 grams / 30 days), PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>ammonium lactate</i> CREA; LOTN	2	
<i>diclofenac sodium (topical) 1% gel</i>	2	PA
<i>fluorouracil (topical)</i> CREA 5%	2	
<i>fluorouracil (topical)</i> SOLN	2	
<i>imiquimod</i> CREA 5%	2	
<i>metronidazole (topical)</i> CREA; LOTN	2	
<i>metronidazole gel 0.75%</i>	2	
PANRETIN	5	
PICATO .05%	3	QL (2 tubes / 30 days)
PICATO .015%	3	QL (3 tubes / 30 days)
<i>podofilox</i> SOLN	2	
<i>procto-med hc</i>	2	
<i>procto-pak</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 **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 cre 2.5%</i>	2	
<i>proctozone-hc</i>	2	
<i>rosadan</i>	2	
<i>tacrolimus (topical)</i>	2	
TARGRETIN GEL	5	NM, PA
VALCHLOR	5	NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i>	2	
<i>permethrin cre 5%</i>	2	
DERMATOLOGY, WOUND CARE AGENTS		
<i>acetic acid .25%</i>	2	
REGRANEX	5	PA
SANTYL	4	
<i>sodium chlor sol 0.9% irr</i>	2	
<i>water for irrigation, sterile</i>	2	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl</i>	2	
<i>chlorhexidine gluconate (mouth-throat)</i>	1	
<i>clotrimazole LOZG</i>	2	
<i>lidocaine hcl (mouth-throat)</i>	2	
<i>nystatin (mouth-throat)</i>	2	
<i>paroex sol 0.12%</i>	1	
<i>periogard</i>	1	
<i>pilocarpine hcl (oral)</i>	2	
<i>triamcinolone acetonide (mouth)</i>	2	
OTIC		
<i>acetic acid (otic)</i>	2	
CIPRODEX	3	
<i>flac</i>	2	
<i>fluocinolone acetonide (otic)</i>	2	
<i>neomycin-polymyxin-hc (otic)</i>	2	
<i>ofloxacin (otic)</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 **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 of Drugs

<i>abacavir sulfate</i>	12	<i>alendronate sodium</i>	45
<i>abacavir sulfate-lamivudine</i>	13	<i>alfuzosin hcl</i>	55
<i>abacavir sulfate-lamivudine-zidovudine</i>	13	ALIMTA	18
ABELCET	11	ALINIA	10
ABILIFY MAINTENA	35	<i>aliskiren fumarate</i>	28
<i>abiraterone acetate</i>	20	<i>allopurinol tab</i>	7
ABRAXANE	18	<i>alosetron hcl</i>	54
<i>acamprosate calcium</i>	41	ALPHAGAN P SOL 0.1%	64
<i>acarbose</i>	43	<i>alprazolam tab 0.25mg</i>	30
<i>acebutolol hcl</i>	26	<i>alprazolam tab 0.5mg</i>	30
<i>acetaminophen w/ codeine 300-15mg</i> 7		<i>alprazolam tab 1mg</i>	30
<i>acetaminophen w/ codeine 300-30mg</i> 7		<i>alprazolam tab 2mg</i>	30
<i>acetaminophen w/ codeine 300-60mg</i> 7		ALREX	63
<i>acetaminophen w/ codeine soln</i>	7	<i>altavera tab</i>	46
<i>acetazolamide</i>	28	ALUNBRIG	21
<i>acetic acid</i>	70	<i>alyacen 1/35</i>	46
<i>acetic acid (otic)</i>	70	<i>amantadine hcl</i>	35
<i>acetylcysteine</i>	66	AMBISOME	11
<i>acitretin</i>	68	<i>ambrisentan</i>	29
ACTHIB	59	<i>amikacin sulfate</i>	9
ACTIMMUNE	58	<i>amiloride & hydrochlorothiazide</i>	28
<i>acyclovir</i>	14	<i>amiloride hcl</i>	28
<i>acyclovir sodium</i>	14	AMINOSYN II INJ 10%	60
ADACEL	59	AMINOSYN-PF 7%	60
<i>adefovir dipivoxil</i>	15	AMINOSYN-PF INJ 10%	60
ADEMPAS	29	<i>amiodarone hcl soln</i>	25
<i>adriamycin</i>	18	<i>amiodarone tab 100mg</i>	25
<i>adrucil</i>	18	<i>amiodarone tab 200mg</i>	25
ADVAIR DISKUS	67	<i>amiodarone tab 400mg</i>	25
ADVAIR HFA	67	AMITIZA CAP 24MCG	54
AFINITOR	21	AMITIZA CAP 8MCG	54
AFINITOR DISPERZ	21	<i>amitriptyline hcl</i>	33
AIMOVIG	40	<i>amlodipine besylate</i>	27
<i>ala-cort</i>	68	<i>amlodipine besylate-olmesartan</i> <i>medoxomil</i>	24
<i>albendazole</i>	10	<i>amlodipine besylate-valsartan tab 10-</i> <i>160 mg</i>	24
<i>albuterol sulfate</i>	65, 66	<i>amlodipine besylate-valsartan tab 10-</i> <i>320 mg</i>	24
<i>alclometasone dipropionate</i>	68	<i>amlodipine besylate-valsartan tab 5-</i> <i>160 mg</i>	24
ALCOHOL SWABS	42		
ALDURAZYME	49		
ALECENSA	21		

<i>amlodipine besylate-valsartan tab 5-320 mg</i>	24
<i>amlodipine--benazepril hcl cap 10-20 mg</i>	23
<i>amlodipine-benazepril hcl cap 10-40mg</i>	23
<i>amlodipine-benazepril hcl cap 2.5-10 mg</i>	23
<i>amlodipine-benazepril hcl cap 5-10 mg</i>	23
<i>amlodipine-benazepril hcl cap 5-20 mg</i>	23
<i>amlodipine-benazepril hcl cap 5-40 mg</i>	23
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-12.5mg</i> ..	24
<i>amlodipine-valsartan-hydrochlorothiazide 10-160-25mg</i>	24
<i>amlodipine-valsartan-hydrochlorothiazide 10-320-25mg</i>	25
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-12.5mg</i>	24
<i>amlodipine-valsartan-hydrochlorothiazide 5-160-25mg</i>	24
<i>ammonium lactate</i>	69
<i>amnestem</i>	67
<i>amoxapine tab 100mg</i>	33
<i>amoxapine tab 150mg</i>	33
<i>amoxapine tab 25mg</i>	33
<i>amoxapine tab 50mg</i>	33
<i>amoxicillin</i>	17
<i>amoxicillin & pot clavulanate</i>	17
<i>amphetamine-dextroamphetamine cap sr 24hr 10 mg</i>	38
<i>amphetamine-dextroamphetamine cap sr 24hr 15 mg</i>	38
<i>amphetamine-dextroamphetamine cap sr 24hr 20 mg</i>	38
<i>amphetamine-dextroamphetamine cap sr 24hr 25 mg</i>	38
<i>amphetamine-dextroamphetamine cap sr 24hr 30 mg</i>	38
<i>amphetamine-dextroamphetamine cap sr 24hr 5 mg</i>	38

<i>amphetamine-dextroamphetamine tab 10 mg</i>	38
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	39
<i>amphetamine-dextroamphetamine tab 15 mg</i>	39
<i>amphetamine-dextroamphetamine tab 20 mg</i>	39
<i>amphetamine-dextroamphetamine tab 30 mg</i>	39
<i>amphetamine-dextroamphetamine tab 5 mg</i>	38
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	38
<i>amphotericin b</i>	11
<i>ampicillin & sulbactam sodium</i>	17
<i>ampicillin cap 500mg</i>	17
<i>ampicillin inj</i>	17
<i>ampicillin sodium</i>	17
<i>ANADROL-50</i>	42
<i>anagrelide hcl</i>	56
<i>anastrozole</i>	20
<i>ANDRODERM</i>	42
<i>ANORO ELLIPTA</i>	65
<i>APOKYN</i>	35
<i>aprepitant</i>	52
<i>aprepitant pak 80mg & 125mg</i>	52
<i>apri</i>	46
<i>APRISO</i>	53
<i>APTIOM</i>	30
<i>APTIVUS</i>	12
<i>ARALAST NP</i>	66
<i>aranelle</i>	46
<i>ARCALYST</i>	58
<i>aripiprazole odt</i>	35
<i>aripiprazole oral solution 1 mg/ml</i>	35
<i>aripiprazole tab</i>	36
<i>ARISTADA</i>	36
<i>ARISTADA INITIO</i>	36
<i>armodafinil</i>	41
<i>ARNUITY ELLIPTA</i>	67
<i>aspirin-dipyridamole</i>	57
<i>atazanavir sulfate</i>	12
<i>atenolol</i>	26

<i>atenolol & chlorthalidone</i>	26	<i>benzoyl peroxide-erythromycin</i>	67
<i>atomoxetine hcl</i>	39	<i>benztropine mesylate inj</i>	35
<i>atorvastatin calcium</i>	25	<i>benztropine mesylate tab 0.5mg</i>	35
<i>atovaquone</i>	10	<i>benztropine mesylate tab 1mg</i>	35
<i>atovaquone-proguanil hcl</i>	12	<i>benztropine mesylate tab 2mg</i>	35
ATRIPLA.....	13	BEPREVE	64
ATROVENT HFA.....	65	BERINERT	56
<i>aubra</i>	46	BESIVANCE	63
AURYXIA	51	<i>betamethasone dipropionate (topical)</i> 68	
AUSTEDO	40	<i>betamethasone dipropionate</i>	
AVASTIN	19	<i>augmented</i>	68
<i>aviane</i>	46	<i>betamethasone valerate</i>	68
<i>avita</i>	67	BETASERON	41
<i>azacitidine</i>	18	<i>betaxolol hcl (ophth)</i>	64
AZACTAM IN ISO-OSMOTIC DE	10	<i>bethanechol chloride</i>	55
AZACTAM/DEX INJ	10	BETOPTIC-S	64
AZASITE	63	BEVESPI AEROSPHERE.....	65
<i>azathioprine</i>	58	<i>bexarotene</i>	22
<i>azelastine drop 0.05%</i>	64	BEXSERO	59
<i>azelastine spr 0.1%</i>	65	<i>bicalutamide</i>	20
<i>azelastine spr 0.15%</i>	65	BICILLIN L-A	17
<i>azithromycin</i>	16	BIKTARVY	13
AZOPT	64	<i>bisoprolol & hydrochlorothiazide</i>	26
<i>aztreonam</i>	10	<i>bisoprolol fumarate</i>	26
<i>bacitracin (ophthalmic)</i>	63	BIVIGAM	58
<i>bacitracin-polymyxin b (ophth)</i>	63	<i>bleomycin sulfate</i>	18
<i>bacitracin-poly-neomycin-hc</i>	62	BLEPHAMIDE	62
<i>baclofen</i>	41	<i>blisovi fe 1.5/30</i>	46
<i>balsalazide disodium</i>	53	BOOSTRIX.....	59
BALVERSA.....	21	BORTEZOMIB.....	19
<i>balziva</i>	46	<i>bosentan</i>	29
BANZEL SUS 40MG/ML	30	BOSULIF	21
BANZEL TAB 200MG	30	BRAFTOVI	21
BANZEL TAB 400MG	30	BREO ELLIPTA	67
BARACLUDE	15	<i>briellyn</i>	46
BASAGLAR KWIKPEN	42	BRILINTA	57
BCG VACCINE.....	59	<i>brimonidine sol 0.15%</i>	64
BD ULTRAFINE INSULIN SYRINGE	42	<i>brimonidine sol 0.2%</i>	64
BD ULTRAFINE/NANO PEN NEEDLES ..	42	BRIVIACT INJ 50MG/5ML	30
<i>bekyree</i>	46	BRIVIACT SOL 10MG/ML	30
<i>benazepril & hydrochlorothiazide</i>	23	BRIVIACT TAB 100MG.....	30
<i>benazepril hcl</i>	24	BRIVIACT TAB 10MG	30
BENDEKA	18	BRIVIACT TAB 25MG	30
BENLYSTA.....	58	BRIVIACT TAB 50MG	30

BRIVIACT TAB 75MG	30
<i>bromfenac sodium (ophth)</i>	63
<i>bromocriptine mesylate</i>	35
BROMSITE.....	63
<i>budesonide (inhalation)</i>	67
<i>budesonide ec</i>	53
<i>bumetanide</i>	28
<i>buprenorphine hcl</i>	41
<i>buprenorphine hcl-naloxone hcl</i> <i>dihydrate 12-3mg</i>	42
<i>buprenorphine hcl-naloxone hcl</i> <i>dihydrate 2-0.5mg</i>	41
<i>buprenorphine hcl-naloxone hcl</i> <i>dihydrate 4-1mg</i>	41
<i>buprenorphine hcl-naloxone hcl</i> <i>dihydrate 8-2mg</i>	41
<i>buprenorphine hcl-naloxone hcl sl</i>	42
<i>bupropion hcl</i>	33
<i>bupropion hcl (smoking deterrent)</i>	42
<i>buspirone hcl</i>	30
<i>butorphanol tartrate</i>	7
BYDUREON BCISE	42
BYDUREON INJ	42
BYDUREON PEN	42
BYETTA.....	42
BYSTOLIC	26
<i>cabergoline</i>	51
CABOMETYX	21
<i>calcipotriene</i>	68
<i>calcitonin (salmon)</i>	51
<i>calcitrene</i>	68
<i>calcitriol</i>	62
<i>calcitriol inj</i>	62
<i>calcitriol oral soln 1 mcg/ml</i>	62
<i>calcium acetate (phosphate binder)</i> ...	51
CALQUENCE	21
<i>camila</i>	46
CAPRELSA	21
<i>captopril</i>	24
<i>captopril & hydrochlorothiazide</i>	23
CARBAGLU	49
<i>carbamazepine</i>	30
<i>carbidopa/levodopa/entacapone</i>	35
<i>carbidopa-levodopa</i>	35

<i>carboplatin</i>	23
CARIMUNE NANOFILTERED.....	58
<i>carteolol hcl (ophth)</i>	64
<i>cartia xt cap 120/24hr</i>	27
<i>cartia xt cap 180/24hr</i>	27
<i>cartia xt cap 240/24hr</i>	27
<i>cartia xt cap 300/24hr</i>	27
<i>carvedilol</i>	27
<i>caspofungin acetate</i>	11
CAYSTON	10
<i>caziant pak</i>	46
<i>cefaclor</i>	15
CEFACLOR MONOHYDRATE ER	15
<i>cefadroxil</i>	15
CEFAZOLIN IN DEXTROSE 2GM/100ML- 4%	15
<i>cefazolin inj</i>	15
<i>cefazolin sodium</i>	15
CEFAZOLIN SODIUM 1 GM/50ML.....	15
<i>cefdinir</i>	15
<i>cefepime hcl</i>	15
<i>cefixime cap 400mg</i>	15
<i>cefixime susr</i>	15
<i>cefotaxime sodium</i>	16
<i>cefoxitin sodium</i>	16
<i>cefpodoxime proxetil</i>	16
<i>cefprozil</i>	16
<i>ceftazidime</i>	16
CEFTAZIDIME/DEXTROSE.....	16
<i>ceftriaxone sodium</i>	16
<i>cefuroxime axetil</i>	16
<i>cefuroxime sodium</i>	16
<i>celecoxib</i>	7
CELONTIN	30
<i>cephalexin</i>	16
CERDELGA	49
CEREZYME	49
<i>cetirizine syrup</i>	65
<i>cevimeline hcl</i>	70
CHANTIX.....	42
CHANTIX CONTINUING MONTH.....	42
CHANTIX STARTER PACK	42
CHEMET	45
<i>chlorhexidine gluconate (mouth-throat)</i>	

.....	70	<i>clonidine hcl</i>	28
<i>chloroquine phosphate</i>	12	<i>clonidine hcl ptwk</i>	29
<i>chlorothiazide tabs</i>	28	<i>clopidogrel tab 75mg</i>	57
<i>chlorpromazine hcl</i>	36	<i>clorazepate dipotassium</i>	30
CHLORPROMAZINE INJ	36	<i>clotrimazole</i>	70
<i>chlorthalidone</i>	28	<i>clotrimazole (topical)</i>	68
<i>cholestyramine</i>	26	<i>clotrimazole w/ betamethasone</i>	68
<i>cholestyramine light</i>	26	<i>clozapine odt</i>	36
<i>ciclopirox</i>	68	<i>clozapine tab 100mg</i>	36
<i>ciclopirox shampoo 1%</i>	68	<i>clozapine tab 200mg</i>	36
<i>cilostazol</i>	56	<i>clozapine tab 25mg</i>	36
CILOXAN	63	<i>clozapine tab 50mg</i>	36
CIMDUO	14	COARTEM	12
<i>cinacalcet hcl</i>	45	<i>colchicine w/ probenecid</i>	7
CIPRODEX	70	COLCRYS	7
<i>ciprofloxacin</i>	16	<i>colesevelam hcl</i>	26
<i>ciprofloxacin hcl (ophth)</i>	63	<i>colestipol hcl gran</i>	26
<i>ciprofloxacin hcl tab</i>	16	<i>colestipol hcl pack</i>	26
<i>ciprofloxacin in d5w</i>	16	<i>colestipol hcl tabs</i>	26
<i>cisplatin</i>	23	<i>colistimethate sodium</i>	10
<i>citalopram hydrobromide</i>	33	<i>colocort enema 100mg</i>	53
<i>claravis</i>	67	COMBIGAN	64
<i>clarithromycin</i>	16	COMBIVENT RESPIMAT	65
<i>clarithromycin er</i>	16	COMETRIQ	21
<i>clarithromycin for susp</i>	16	COMPLERA	14
<i>clindacin-p</i>	67	<i>compro</i>	52
<i>clindamycin cap 300mg</i>	10	<i>constulose</i>	53
<i>clindamycin cap 75mg</i>	10	COPIKTRA	21
<i>clindamycin hcl cap 150 mg</i>	10	CORLANOR	29
<i>clindamycin phosphate (topical)</i>	67	<i>cortisone acetate</i>	50
<i>clindamycin phosphate in d5w</i>	10	COTELLIC	21
CLINDAMYCIN PHOSPHATE IN NACL ..	10	COUMADIN	55
<i>clindamycin phosphate inj</i>	10	CREON	54
<i>clindamycin phosphate vaginal</i>	55	CRIXIVAN	12
<i>clindamycin soln 75mg/5ml</i>	10	<i>cromolyn sodium (mastocytosis)</i>	54
CLINIMIX 4.25%/DEXTROSE 25%	60	<i>cromolyn sodium (ophth)</i>	64
CLINIMIX 4.25%/DEXTROSE 5%	60	<i>cromolyn sodium nebu</i>	66
CLINIMIX 5%/DEXTROSE 15%	60	<i>cryselle-28</i>	46
CLINIMIX 5%/DEXTROSE 20%	60	<i>cyclafem 1/35</i>	46
CLINIMIX 5%/DEXTROSE 25%	60	<i>cyclafem 7/7/7</i>	46
CLINIMIX INJ 4.25/D10	61	<i>cyclobenzaprine hcl</i>	41
<i>clobazam</i>	30	<i>cyclophosphamide</i>	18
<i>clomipramine hcl</i>	33	<i>cycloserine</i>	14
<i>clonazepam</i>	30	<i>cyclosporine</i>	58

<i>cyclosporine modified (for microemulsion)</i>	58
<i>cyproheptadine hcl</i>	65
<i>cyred tab</i>	46
CYSTADANE	49
CYSTAGON	49
CYSTARAN	64
<i>cytarabine</i>	18
<i>dacarbazine</i>	18
<i>dalfampridine</i>	41
DALIRESP	66
<i>danazol</i>	49
<i>dantrolene sodium</i>	41
<i>dapsone</i>	10
DAPTACEL	59
<i>daptomycin</i>	10
DAPTOMYCIN	10
<i>dasetta 1/35</i>	46
<i>dasetta 7/7/7</i>	46
DAURISMO	19
<i>deblitane</i>	46
DELESTROGEN	49
DELSTRIGO	14
<i>delyla</i>	46
DELZICOL	53
DEMSEER	29
DEPEN TITRATABS	45
DEPO-PROVERA INJ 400/ML	20
DESCOVY	14
<i>desipramine hcl</i>	33
<i>desmopressin acetate spray</i>	52
<i>desmopressin acetate spray refrigerated</i>	52
<i>desmopressin acetate tabs</i>	52
<i>desmopressin inj 4mcg/ml</i>	52
<i>desogestrel & ethinyl estradiol</i>	46
<i>desogestrel-ethinyl estradiol (biphasic)</i>	46
<i>desvenlafaxine succinate</i>	33
<i>dexamethasone</i>	50
DEXAMETHASONE	50
<i>dexamethasone sodium phosphate</i>	50
<i>dexamethasone sodium phosphate (ophth)</i>	63

DEXILANT	54
<i>dexmethylphenidate hcl</i>	39
<i>dexrazoxane hcl</i>	23
<i>dextrose 10% flex contain</i>	61
DEXTROSE 10%/NACL 0.2%	61
<i>dextrose 10%/nacl 0.45%</i>	61
<i>dextrose 2.5%/nacl 0.45%</i>	61
<i>dextrose 5%</i>	61
DEXTROSE 5% /ELECTROLYTE	61
<i>dextrose 5%/nacl 0.2%</i>	61
<i>dextrose 5%/nacl 0.225%</i>	61
DEXTROSE 5%/NACL 0.3%	61
<i>dextrose 5%/nacl 0.33%</i>	61
<i>dextrose 5%/nacl 0.45%</i>	61
<i>dextrose 5%/nacl 0.9%</i>	61
<i>dextrose 5%/potassium chl</i>	61
<i>dextrose 50%</i>	61
<i>dextrose in lactated ringers</i>	61
<i>dextrose inj 70%</i>	61
DIASTAT ACUDIAL	30
DIASTAT PEDIATRIC	30
<i>diazepam</i>	31
<i>diazepam gel</i>	31
<i>diazepam inj</i>	31
<i>diazepam intensol</i>	31
<i>diazepam oral soln 1 mg/ml</i>	31
<i>diclofenac potassium</i>	7
<i>diclofenac sodium</i>	7
<i>diclofenac sodium (ophth)</i>	63
<i>diclofenac sodium (topical) 1% gel</i>	69
<i>dicloxacillin sodium</i>	17
<i>dicyclomine hcl cap 10mg</i>	53
<i>dicyclomine hcl soln 10mg/5ml</i>	53
<i>dicyclomine hcl tab 20mg</i>	53
<i>didanosine</i>	12
DIFICID	16
<i>diflunisal</i>	7
<i>digitek</i>	28
<i>digox</i>	28
<i>digoxin</i>	28
<i>digoxin inj</i>	28
<i>digoxin sol 50mcg/ml</i>	28
<i>dihydroergotamine mesylate inj 1 mg/ml</i>	40

<i>dihydroergotamine mesylate nasal</i>	40	<i>e.e.s 400</i>	16
DILANTIN CAP 100MG	31	EDURANT	12
DILANTIN CAP 30MG	31	<i>efavirenz</i>	12
DILANTIN CHEW TAB 50MG	31	<i>eletriptan hydrobromide</i>	40
DILANTIN-125 SUSP	31	ELIQUIS	55
<i>diltiazem cap 180mg cd</i>	27	ELIQUIS STARTER PACK	56
<i>diltiazem cap 240mg cd</i>	27	ELLA	46
<i>diltiazem cap 360mg cd</i>	27	EMCYT	18
<i>diltiazem cap er/12hr</i>	27	EMEND	52
<i>diltiazem hcl</i>	27	EMGALITY	40
<i>diltiazem hcl cap sr 24hr</i>	27	<i>emoquette</i>	46
<i>diltiazem hcl coated beads cap sr 24hr</i>	27	EMSAM	34
<i>diltiazem hcl extended release beads</i> <i>cap sr</i>	27	EMTRIVA	12
<i>diltiazem inj</i>	27	EMVERM	10
<i>dilt-xr cap</i>	27	<i>enalapril maleate</i>	24
<i>diphenhydramine hcl inj 50mg/ml</i>	65	<i>enalapril maleate & hydrochlorothiazide</i>	23
<i>diphenoxylate w/ atropine</i>	54	ENDARI	56
DIPHThERIA/TETANUS TOXOID	59	<i>endocet 10-325mg</i>	8
<i>disopyramide phosphate</i>	25	<i>endocet 2.5-325mg</i>	8
<i>disulfiram</i>	42	<i>endocet 5-325mg</i>	8
<i>divalproex sodium</i>	31	<i>endocet 7.5-325mg</i>	8
<i>docetaxel</i>	18, 19	ENGERIX-B	59
DOCETAXEL	19	<i>enoxaparin sodium</i>	56
<i>dofetilide</i>	25	<i>enpresse-28</i>	46
<i>donepezil hydrochloride</i>	33	<i>enskyce</i>	46
<i>dorzolamide hcl</i>	64	ENSTILAR	68
<i>dorzolamide hcl-timolol maleate</i>	64	<i>entacapone</i>	35
DOVATO	14	<i>entecavir</i>	15
<i>doxazosin mesylate</i>	24	ENTRESTO	25
<i>doxepin hcl</i>	33	<i>enulose</i>	53
<i>doxorubicin hcl</i>	18	EPCLUSA	15
<i>doxorubicin hcl liposomal</i>	18	EPIDIOLEX	31
<i>doxy 100</i>	17	<i>epinephrine (anaphylaxis)</i>	66
<i>doxycycline (monohydrate)</i>	17	<i>epirubicin hcl</i>	18
<i>doxycycline hyclate</i>	17	<i>epitol</i>	31
<i>dronabinol</i>	52	EPIVIR HBV	15
<i>drospirenone-ethinyl estradiol</i>	46	<i>eplerenone</i>	24
DROXIA	56	<i>ergotamine w/ caffeine</i>	40
<i>duloxetine hcl</i>	33, 34	ERIVEDGE	19
DUREZOL	63	ERLEADA	20
<i>dutasteride</i>	55	<i>erlotinib hcl</i>	21
<i>dutasteride-tamsulosin hcl</i>	55	<i>errin</i>	46
		<i>ertapenem sodium</i>	10

<i>ery pad 2%</i>	67	<i>fentanyl citrate</i>	8
<i>ery-tab</i>	16	<i>fentanyl patch 100 mcg/hr</i>	8
ERYTHROCIN LACTOBIONATE	16	<i>fentanyl patch 12 mcg/hr</i>	8
<i>erythrocine stearate</i>	16	<i>fentanyl patch 25 mcg/hr</i>	8
<i>erythromycin (acne aid)</i>	67	<i>fentanyl patch 50 mcg/hr</i>	8
<i>erythromycin (ophth)</i>	63	<i>fentanyl patch 75 mcg/hr</i>	8
<i>erythromycin base</i>	16	FENTORA	8
<i>erythromycin cap 250mg ec</i>	16	FETZIMA	34
<i>erythromycin ethylsuccinate</i>	16	FETZIMA TITRATION PACK	34
ESBRIET	66	FIASP	42
<i>escitalopram oxalate</i>	34	FIASP FLEXTOUCH	42
<i>esomeprazole magnesium</i>	54	<i>finasteride</i>	55
<i>esomeprazole sodium inj</i>	55	FIRAZYR	56
<i>estarylla tab 0.25-35</i>	46	<i>flac</i>	70
<i>estradiol</i>	49	FLEBOGAMMA DIF	58
<i>estradiol vaginal cream</i>	49	<i>flecainide acetate</i>	25
<i>estradiol vaginal tab</i>	49	FLOVENT DISKUS	67
<i>estradiol valerate</i>	50	FLOVENT HFA	67
<i>ethambutol hcl</i>	14	<i>fluconazole</i>	11
<i>ethosuximide</i>	31	<i>fluconazole in dextrose</i>	11
<i>ethynodiol diacet & eth estrad</i>	46	<i>fluconazole inj nacl 200</i>	11
<i>ethynodiol tab 1-50</i>	46	<i>fluconazole inj nacl 400</i>	11
<i>etodolac</i>	7	<i>flucytosine</i>	11
<i>etodolac er</i>	7	<i>fludrocortisone acetate</i>	50
<i>etoposide</i>	23	<i>flunisolide (nasal)</i>	66
EVOTAZ	14	<i>fluocinolone acetonide</i>	68
<i>exemestane</i>	20	<i>fluocinolone acetonide (otic)</i>	70
<i>ezetimibe</i>	26	<i>fluocinolone acetonide oil body</i>	68
FABRAZYME	49	<i>fluocinonide</i>	68
<i>falmina</i>	46	<i>fluocinonide emulsified base</i>	69
<i>famciclovir</i>	15	<i>fluorometholone</i>	63
<i>famotidine</i>	53	<i>fluorouracil</i>	18
<i>famotidine in nacl</i>	53	<i>fluorouracil (topical)</i>	69
<i>famotidine inj</i>	53	<i>fluoxetine cap 10mg</i>	34
FANAPT	36	<i>fluoxetine cap 20mg</i>	34
FANAPT TITRATION PACK	36	<i>fluoxetine cap 40mg</i>	34
FARXIGA	43	<i>fluoxetine hcl</i>	34
FARYDAK	19	<i>fluphenazine decanoate</i>	36
FASLODEX	20	<i>fluphenazine hcl</i>	36
<i>felbamate</i>	31	<i>flurbiprofen</i>	7
<i>felodipine</i>	27	<i>flurbiprofen sodium</i>	63
<i>femynor</i>	46	<i>flutamide</i>	20
<i>fenofibrate</i>	26	<i>fluticasone propionate</i>	69
<i>fenofibrate micronized</i>	26	<i>fluticasone propionate (nasal)</i>	66

<i>fluvoxamine maleate</i>	30	<i>gentamicin sulfate soln (ophth)</i>	63
<i>fondaparinux sodium</i>	56	GENVOYA	14
FORTEO	51	GEODON	36
<i>fosamprenavir tab 700 mg</i>	12	<i>gianvi</i>	46
<i>fosinopril sodium</i>	24	GILENYA CAP 0.5MG	41
<i>fosinopril sodium & hydrochlorothiazide</i>	23	GILOTRIF TAB 20MG	21
FREAMINE HBC 6.9%	61	GILOTRIF TAB 30MG	21
FREAMINE III	61	GILOTRIF TAB 40MG	21
<i>fulvestrant</i>	20	<i>glatiramer acetate 20mg/ml</i>	41
<i>furosemide</i>	28	<i>glatiramer acetate 40mg/ml</i>	41
<i>furosemide inj</i>	28	<i>glatopa</i>	41
FUZEON	12	GLEOSTINE	18
<i>fyavolv</i>	50	<i>glimepiride</i>	43
FYCOMPA	31	<i>glip/metform tab 2.5-250mg</i>	43
<i>gabapentin</i>	31	<i>glip/metform tab 2.5-500mg</i>	43
<i>galantamine hydrobromide</i>	33	<i>glip/metform tab 5-500mg</i>	43
<i>galantamine hydrobromide er</i>	33	<i>glipizide</i>	43, 44
GAMASTAN S/D	58	<i>glipizide xl</i>	44
GAMMAGARD LIQUID	58	GLUCAGEN HYPOKIT	50
GAMMAGARD S/D	58	GLUCAGON EMERGENCY KIT	50
GAMMAKED	58	<i>glycopyrrolate tab 1mg</i>	53
GAMMAPLEX	58	<i>glycopyrrolate tab 2mg</i>	53
GAMMAPLEX 10GM/100ML	58	<i>glydo</i>	69
GAMUNEX-C	58	GOLYTELY	54
<i>ganciclovir sodium</i>	15	<i>granisetron hcl</i>	52
GARDASIL 9	59	GRANIX	56
<i>gatifloxacin (ophth)</i>	63	<i>griseofulvin microsize</i>	12
GATTEX	54	<i>griseofulvin ultramicrosize</i>	12
GAUZE PADS 2	42	<i>guanfacine er (adhd)</i>	39
<i>gavilyte-c</i>	54	HAEGARDA	56
<i>gavilyte-g</i>	54	<i>halobetasol propionate</i>	69
<i>gavilyte-n/flavor pack</i>	54	<i>haloperidol</i>	36
<i>gemcitabine inj soln</i>	18	<i>haloperidol conc 2mg/ml</i>	36
<i>gemcitabine inj solr</i>	18	<i>haloperidol decanoate</i>	36
<i>gemfibrozil</i>	26	<i>haloperidol lactate inj 5mg/ml</i>	36
<i>generlac</i>	54	HARVONI	15
<i>gengraf</i>	58	HAVRIX	59
GENOTROPIN	51	<i>heather</i>	46
GENOTROPIN MINIQUICK	51	<i>heparin sod (porcine) in d5w</i>	56
<i>gentak</i>	63	<i>heparin sod inj 1000/ml</i>	56
<i>gentamicin in saline</i>	10	<i>heparin sod inj 10000/ml</i>	56
<i>gentamicin sulfate</i>	10	<i>heparin sod inj 20000/ml</i>	56
<i>gentamicin sulfate (topical)</i>	67	<i>heparin sod inj 5000/ml</i>	56
		HEPARIN SODIUM/NACL 0.45%	56

<i>hepatamine</i>	61	<i>ibuprofen</i>	7
HERCEPTIN	19	ICLUSIG.....	21
HERCEPTIN HYLECTA.....	19	IDHIFA	19
HETLIOZ	39	IFEX INJ 3GM	18
HIBERIX.....	59	<i>ifosfamide inj 1gm/20ml</i>	18
HUMIRA	57	IFOSFAMIDE INJ 3GM	18
HUMIRA INJ 10MG/0.2ML.....	57	<i>ifosfamide inj 3gm/60ml</i>	18
HUMIRA KIT 20MG/0.4ML.....	57	ILEVRO	63
HUMIRA KIT 40MG/0.8ML.....	57	<i>imatinib mesylate</i>	21
HUMIRA PEDIATRIC CROHNS DISEASE		IMBRUVICA	21
.....	57	<i>imipenem-cilastatin</i>	10
HUMIRA PEN.....	57	<i>imipramine hcl</i>	34
HUMIRA PEN CD/UC/HS STARTER	57	<i>imiquimod</i>	69
HUMIRA PEN INJ CD/UC/HS STARTER	57	IMOVAX RABIES (H.D.C.V.)	59
HUMIRA PEN INJ PS/UV STARTER.....	57	<i>incassia</i>	46
HUMIRA PEN-PS/UV STARTER.....	57	INCRELEX	51
HUMULIN R INJ U-500	42	INCRUSE ELLIPTA	65
HUMULIN R U-500 KWIKPEN	42	<i>indapamide</i>	28
<i>hydralazine hcl</i>	29	INFANRIX.....	59
<i>hydrochlorothiazide</i>	28	INLYTA	21, 22
<i>hydroco/apap tab 10-325mg</i>	8	INSULIN PEN NEEDLE	43
<i>hydroco/apap tab 5-325mg</i>	8	INSULIN SAFETY NEEDLES	43
<i>hydroco/apap tab 7.5-325</i>	8	INSULIN SYRINGE	43
<i>hydrocodone-acetaminophen 7.5-325</i>		INTELENCE.....	12
<i>mg/15ml</i>	8	INTRALIPID 30%.....	61
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>		<i>intralipid inj 20%</i>	61
.....	8	INTRON-A INJ 10MU	58
<i>hydrocortisone</i>	50	INTRON-A INJ 18MU.....	58
<i>hydrocortisone (enema)</i>	53	INTRON-A INJ 25MU.....	58
<i>hydrocortisone (topical)</i>	69	INTRON-A INJ 50MU.....	58
<i>hydrocortisone butyrate cream 0.1%</i>	69	<i>introvale</i>	46
<i>hydrocortisone butyrate oint 0.1%</i>	69	INVEGA SUST INJ 117 MG/0.75 ML ...	36
<i>hydrocortisone valerate</i>	69	INVEGA SUST INJ 156MG/ML.....	36
<i>hydromorphone hcl</i>	8	INVEGA SUST INJ 234 MG/1.5 ML	36
<i>hydroxychloroquine sulfate</i>	57	INVEGA SUST INJ 39 MG/0.25 ML	36
<i>hydroxyurea</i>	23	INVEGA SUST INJ 78 MG/0.5 ML.....	36
<i>hydroxyzine hcl</i>	65	INVEGA TRINZA.....	36
<i>hydroxyzine hcl inj</i>	65	INVIRASE.....	12
<i>hydroxyzine pamoate</i>	65	IONOSOL-MB/DEXTROSE 5%	61
HYSINGLA ER	8	IPOL INACTIVATED IPV.....	59
<i>ibandronate sodium</i>	45	<i>ipratropium bromide</i>	65
IBRANCE.....	19	<i>ipratropium bromide (nasal)</i>	65
<i>ibu tab 600mg</i>	7	<i>ipratropium-albuterol nebu</i>	65
<i>ibu tab 800mg</i>	7	<i>irbesartan</i>	25

<i>irbesartan-hydrochlorothiazide</i>	25	KALETRA TAB 100-25MG.....	14
IRESSA.....	22	KALETRA TAB 200-50MG.....	14
<i>irinotecan hcl</i>	23	KALYDECO	66
ISENTRESS	12	<i>kariva</i>	47
ISENTRESS HD	12	<i>kcl 0.075%/d5w/nacl 0.45%</i>	61
<i>isibloom</i>	47	KCL 0.15%/D5W/NACL 0.225%	61
ISOLYTE P.....	61	<i>kcl 0.15%/d5w/nacl 0.9%</i>	61
ISOLYTE S.....	61	<i>kcl 0.3%/d5w/nacl 0.45%</i>	61
<i>isoniazid</i>	14	KCL 0.3%/D5W/NACL 0.9%	61
<i>isoniazid syp 50mg/5ml</i>	14	<i>kcl/d5w inj 0.3%</i>	62
<i>isosorb mononitrate tab</i>	29	<i>kcl/d5w/nacl inj .15/.33%</i>	62
<i>isosorbide dinitrate</i>	29	<i>kcl/d5w/nacl inj .15/.45%</i>	62
<i>isosorbide dinitrate er</i>	29	<i>kcl/d5w/nacl inj 0.22%/0.45%</i>	62
<i>isosorbide mononitrate er</i>	29	<i>kcl/nacl inj 0.15%-0.9%</i>	62
<i>isotretinoin</i>	67	<i>kcl/nacl inj 0.3-0.9</i>	62
<i>isradipine</i>	27	<i>kcl0.15%/d5w/nacl0.2%</i>	61
<i>itraconazole</i>	12	<i>kelnor 1/35</i>	47
<i>ivermectin</i>	10	<i>kelnor 1/50</i>	47
IXIARO	59	<i>ketoconazole</i>	12
JADENU	45	<i>ketoconazole cream</i>	68
JADENU SPRINKLE	45	<i>ketoconazole shampoo</i>	68
JAKAFI.....	22	<i>ketorolac tromethamine (ophth)</i>	63
<i>jantoven</i>	56	KEYTRUDA	19
JANUMET	44	KINRIX	59
JANUMET XR TAB 100-1000.....	44	<i>kionex sus 15gm/60ml</i>	45
JANUMET XR TAB 50-1000	44	KISQALI.....	19
JANUMET XR TAB 50-500MG.....	44	KISQALI FEMARA 200 DOSE	19
JANUVIA	44	KISQALI FEMARA 400 DOSE	19
JARDIANCE	44	KISQALI FEMARA 600 DOSE	19
<i>jasmiel</i>	47	<i>klor-con 10</i>	60
JENTADUETO	44	<i>klor-con 8</i>	60
JENTADUETO TAB XR 2.5-1000 MG ...	44	<i>klor-con m10</i>	60
JENTADUETO TAB XR 5-1000 MG	44	<i>klor-con m15</i>	60
<i>jinteli</i>	50	<i>klor-con m20</i>	60
<i>jolessa tab 0.15-0.03 mg</i>	47	<i>klor-con pak 20meq</i>	60
<i>jolivette</i>	47	<i>klor-con spr cap 10meq</i>	60
<i>juleber</i>	47	<i>klor-con spr cap 8meq</i>	60
JULUCA.....	14	KORLYM.....	51
<i>junel 1.5/30</i>	47	<i>kurvelo</i>	47
<i>junel 1/20</i>	47	KUVAN.....	49
<i>junel fe 1.5/30</i>	47	KYNAMRO	26
<i>junel fe 1/20</i>	47	<i>labetalol hcl</i>	27
JUXTAPID.....	26	<i>lactated ringer's</i>	62
KADCYLA	19	<i>lactulose</i>	54

<i>lactulose (encephalopathy)</i>	54	<i>levofloxacin inj 25mg/ml</i>	16
<i>lamivudine</i>	13	<i>levofloxacin oral soln 25 mg/ml</i>	17
<i>lamivudine (hbv)</i>	15	<i>levonest</i>	47
<i>lamivudine-zidovudine</i>	14	<i>levonor/ethi tab</i>	47
<i>lamotrigine</i>	31	<i>levonorgestrel & eth estradiol</i>	47
<i>lansoprazole</i>	55	<i>levonorgestrel-ethinyl estradiol (91-day)</i>	47
<i>larin 1.5/30</i>	47	<i>levora 0.15/30-28</i>	47
<i>larin 1/20</i>	47	<i>levo-t</i>	52
<i>larin fe 1.5/30</i>	47	<i>levothyroxine sodium</i>	52
<i>larin fe 1/20</i>	47	<i>levoxyl</i>	52
<i>larissia tab</i>	47	<i>LEXIVA</i>	13
<i>LASTACAF</i>	64	<i>lidocaine</i>	69
<i>latanoprost</i>	64	<i>lidocaine hcl</i>	69
<i>LATUDA</i>	36, 37	<i>lidocaine hcl (local anesth.)</i>	9
<i>leena</i>	47	<i>lidocaine hcl (mouth-throat)</i>	70
<i>leflunomide</i>	57	<i>lidocaine inj 0.5%</i>	9
<i>LENVIMA 10 MG DAILY DOSE</i>	22	<i>lidocaine inj 1%</i>	9
<i>LENVIMA 12MG DAILY DOSE</i>	22	<i>lidocaine inj 1.5% preservative free (pf)</i>	9
<i>LENVIMA 14 MG DAILY DOSE</i>	22	<i>lidocaine oint 5%</i>	69
<i>LENVIMA 18 MG DAILY DOSE</i>	22	<i>lidocaine-prilocaine</i>	69
<i>LENVIMA 20 MG DAILY DOSE</i>	22	<i>linezolid in sodium chloride</i>	10
<i>LENVIMA 24 MG DAILY DOSE</i>	22	<i>linezolid inj</i>	10
<i>LENVIMA 4 MG DAILY DOSE</i>	22	<i>linezolid susp</i>	10
<i>LENVIMA 8 MG DAILY DOSE</i>	22	<i>linezolid tab 600mg</i>	10
<i>lessina</i>	47	<i>LINZESS</i>	54
<i>letrozole</i>	20	<i>liothyronine sodium</i>	52
<i>leucovorin calcium</i>	23	<i>lisinopril</i>	24
<i>leucovorin calcium solr</i>	23	<i>lisinopril & hydrochlorothiazide</i>	24
<i>LEUKERAN</i>	18	<i>lithium carbonate</i>	40
<i>leuprolide inj 1mg/0.2</i>	20	<i>lithium carbonate er</i>	40
<i>levalbuterol hcl</i>	66	<i>LITHIUM SOLN 8MEQ/5ML</i>	40
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml</i>	66	<i>LONSURF</i>	23
<i>levalbuterol tartrate hfa</i>	66	<i>loperamide hcl</i>	54
<i>LEVEMIR</i>	43	<i>lopinavir-ritonavir</i>	14
<i>LEVEMIR FLEXTOUCH</i>	43	<i>lorazepam</i>	30
<i>levetiracetam</i>	31	<i>lorazepam intensol</i>	30
<i>levetiracetam in sodium chloride</i>	31	<i>LORBRENA</i>	22
<i>levetiracetam oral soln 100 mg/ml</i> ...	32	<i>lorcet hd tab 10-325mg</i>	8
<i>levobunolol hcl</i>	64	<i>lorcet plus tab 7.5-325</i>	8
<i>levocarnitine (metabolic modifiers)</i> ...	49	<i>lorcet tab 5-325mg</i>	8
<i>levocetirizine dihydrochloride</i>	65	<i>loryna</i>	47
<i>levofloxacin</i>	16	<i>losartan potassium</i>	25
<i>levofloxacin in d5w</i>	16		

<i>losartan-hydrochlorothiazide</i>	25	<i>meloxicam</i>	7
LOTEMAX	63	<i>memantine hcl cp24</i>	33
<i>loteprednol etabonate</i>	63	<i>memantine soln</i>	33
<i>lovastatin</i>	25	<i>memantine tabs</i>	33
<i>low-ogestrel</i>	47	MENACTRA.....	59
<i>loxapine succinate</i>	37	MENVEO	59
LUMIGAN	64	<i>mercaptapurine</i>	18
LUMIZYME.....	49	<i>meropenem</i>	10
LUPRON DEPOT (1-MONTH).....	20	<i>mesalamine</i>	53
LUPRON DEPOT INJ 11.25MG (3- MONTH).....	20	<i>mesalamine w/ cleanser</i>	53
LUPRON DEPOT-PED (1-MONTH	51	MESNEX.....	23
LUPRON DEPOT-PED (3-MONTH	51	<i>metadate er tab 20mg</i>	39
LUPRON DEP-PED INJ 11.25MG (3- MONTH).....	51	<i>metformin er</i>	44
LUPRON DEP-PED INJ 7.5MG	51	<i>metformin hcl</i>	44
<i>lutea</i>	47	<i>methadone hcl</i>	8
LYNPARZA.....	19	<i>methadone hcl 10mg</i>	8
LYRICA	32	<i>methadone hcl 5mg</i>	8
LYRICA CR	40	<i>methadone hcl intensol</i>	9
LYSODREN	20	<i>methazolamide</i>	28
<i>lyza</i>	47	<i>methenamine hippurate</i>	11
<i>magnesium sulfate</i>	60	<i>methimazole</i>	52
MAGNESIUM SULFATE	60	<i>methotrexate sodium inj</i>	18
MAGNESIUM SULFATE IN D5W.....	60	<i>methotrexate sodium tabs</i>	57
<i>magnesium sulfate in dextrose</i>	60	<i>methyclothiazide</i>	28
<i>magnesium sulfate inj 50%</i>	60	<i>methylphenidate hcl</i>	39
<i>malathion</i>	70	<i>methylphenidate hcl oral soln</i>	39
<i>maprotiline hcl</i>	34	<i>methylphenidate tab 10mg er</i>	39
<i>marlissa</i>	47	<i>methylphenidate tab 20mg er</i>	39
MARPLAN TAB 10MG.....	34	<i>methylpr ss inj</i>	50
MATULANE	23	<i>methylpred pak 4mg</i>	50
MAVYRET	15	<i>methylpred tab 16mg</i>	50
<i>meclizine hcl</i>	52	<i>methylpred tab 32mg</i>	50
<i>medroxyprogesterone acetate</i> (contraceptive)	47	<i>methylpred tab 4mg</i>	50
<i>medroxyprogesterone acetate tab</i>	51	<i>methylpred tab 8mg</i>	50
<i>mefloquine hcl</i>	12	<i>methylprednisolone acetate</i>	50
<i>megestrol ac sus 40mg/ml</i>	20	<i>metoclopramide hcl</i>	52
<i>megestrol ac tab 20mg</i>	20	<i>metoclopramide hcl inj</i>	52
<i>megestrol ac tab 40mg</i>	20	<i>metolazone</i>	28
<i>megestrol sus 625mg/5ml</i>	20	<i>metoprolol & hctz tab 100-25mg</i>	26
MEKINIST	22	<i>metoprolol & hctz tab 100-50mg</i>	26
MEKTOVI.....	22	<i>metoprolol & hctz tab 50-25mg</i>	26
		<i>metoprolol succinate</i>	27
		<i>metoprolol tartrate</i>	27
		<i>metronidazole</i>	11

<i>metronidazole (topical)</i>	69	<i>mupirocin</i>	67
<i>metronidazole gel 0.75%</i>	69	MYCAMINE	12
<i>metronidazole in nacl</i>	11	<i>mycophenolate mofetil</i>	58
<i>metronidazole vaginal</i>	55	<i>mycophenolate sodium tbec</i>	58
<i>mexiletine hcl</i>	25	MYLOTARG	19
<i>microgestin 1.5/30</i>	47	<i>myorisan</i>	67
<i>microgestin 1/20</i>	47	MYRBETRIQ	55
<i>microgestin fe 1.5/30</i>	47	<i>myzilra</i>	47
<i>microgestin fe 1/20</i>	47	<i>nabumetone</i>	7
<i>midodrine hcl</i>	29	<i>nadolol</i>	27
<i>miglustat</i>	49	<i>nafcillin sodium</i>	17
<i>mili</i>	47	NAFCILLIN SODIUM FOR INJ 10GM....	17
<i>minitran</i>	29	NAGLAZYME	49
<i>minocycline hcl</i>	17	<i>nalbuphine hcl</i>	7
<i>minoxidil</i>	29	<i>naloxone inj 0.4mg/ml</i>	42
<i>mirtazapine</i>	34	<i>naloxone inj 1mg/ml</i>	42
<i>misoprostol</i>	54	<i>naltrexone hcl</i>	42
MITIGARE	7	NAMZARIC	33
<i>mitomycin</i>	18	<i>naproxen</i>	7
M-M-R II	59	<i>naproxen dr</i>	7
M-NATAL PLUS	62	<i>naproxen sodium</i>	7
<i>moexipril hcl</i>	24	<i>naratriptan hcl</i>	40
<i>moexipril-hydrochlorothiazide</i>	24	NARCAN	42
<i>molindone hcl</i>	37	NATACYN	63
<i>mometasone furoate</i>	69	<i>nateglinide</i>	44
<i>mondoxyne nl cap 100mg</i>	18	NATPARA	51
<i>mono-lynyah tab 0.25-35</i>	47	NEBUPENT	11
<i>mononessa</i>	47	<i>necon 0.5/35-28</i>	48
<i>montelukast sodium</i>	66	<i>necon 7/7/7</i>	48
<i>morgidox cap 1x50mg</i>	18	<i>nefazodone hcl</i>	34
<i>morphine ext-rel tab</i>	9	<i>neomycin sulfate</i>	10
<i>morphine sul inj 10mg/ml</i>	9	<i>neomycin-bacitracin zn-polymyxin</i>	63
<i>morphine sul inj 1mg/ml</i>	9	<i>neomycin-polymy-dexameth</i>	62
MORPHINE SUL INJ 4MG/ML	9	<i>neomycin-polymyxin-gramicidin</i>	63
<i>morphine sulfate</i>	9	<i>neomycin-polymyxin-hc (ophth)</i>	62
MORPHINE SULFATE	9	<i>neomycin-polymyxin-hc (otic)</i>	70
<i>morphine sulfate oral soln 100mg/5ml</i> ..	9	NEPHRAMINE	61
<i>morphine sulfate oral soln 10mg/5ml</i> ..	9	NERLYNX	22
<i>morphine sulfate oral soln 20mg/5ml</i> ..	9	NEUPOGEN	56
MOVANTIK	54	NEUPRO	35
MOVIPREP	54	<i>nevirapine susp 50 mg/5ml</i>	13
MOXEZA	63	<i>nevirapine tab 100mg er</i>	13
<i>moxifloxacin hcl (ophth)</i>	63	<i>nevirapine tab 200mg</i>	13
MULTAQ	25	<i>nevirapine tab 400mg er</i>	13

NEXAVAR	22
<i>niacin er (antihyperlipidemic)</i>	26
<i>niacor</i>	26
<i>nicardipine hcl</i>	27
NICOTROL INHALER	42
NICOTROL NS.....	42
<i>nifedipine</i>	27
<i>nifedipine er</i>	27
<i>nikki</i>	48
<i>nilutamide</i>	20
<i>nimodipine</i>	27
NINLARO.....	19
NITRO-BID	29
NITRO-DUR DIS 0.3MG/HR.....	29
NITRO-DUR DIS 0.8MG/HR.....	29
<i>nitrofurantoin macrocrystal</i>	11
<i>nitrofurantoin monohyd macro</i>	11
<i>nitroglycerin</i>	29
<i>nitroglycerin td patch</i>	29
NITYR	49
<i>nora-be tab</i>	48
<i>norethindrone (contraceptive)</i>	48
<i>norethindrone acet & eth estra</i>	48
<i>norethindrone acetate</i>	52
<i>norethindrone acetate-ethinyl estradiol</i>	50
<i>norgest/ethi tab 0.25/35</i>	48
<i>norgestimate-ethinyl estradiol</i> (triphasic) 0.18-25/0.215-25/0.25-25 mg-mcg	48
<i>norgestimate-ethinyl estradiol</i> (triphasic) 0.18-35/0.215-35/0.25-35 mg-mcg	48
<i>norlyroc</i>	48
NORMOSOL-M IN D5W.....	62
NORMOSOL-R.....	62
NORMOSOL-R IN D5W	62
NORPACE CR	25
NORTHERA	29
<i>nortrel 0.5/35 (28)</i>	48
<i>nortrel 1/35</i>	48
<i>nortrel 7/7/7</i>	48
<i>nortriptyline hcl</i>	34
NORVIR PACK.....	13

NORVIR SOLN.....	13
NOVOLIN 70/30	43
NOVOLIN 70/30 FLEXPEN.....	43
NOVOLIN N	43
NOVOLIN R	43
NOVOLOG	43
NOVOLOG 70/30 FLEXPEN.....	43
NOVOLOG FLEXPEN	43
NOVOLOG MIX 70/30.....	43
NOVOLOG PENFILL.....	43
NOXAFIL	12
NUCYNTA ER	9
NUEDEXTA	40
NULOJIX	58
NULYTELY/FLAVOR PACKS.....	54
NUPLAZID CAPS.....	37
NUPLAZID TABS 10MG.....	37
NUPLAZID TABS 17MG.....	37
<i>nutrilipid inj 20%</i>	61
NUVARING	48
<i>nyamyc</i>	68
NYMALIZE	27
<i>nystatin</i>	12
<i>nystatin (mouth-throat)</i>	70
<i>nystatin (topical)</i>	68
<i>nystatin pow 100000</i>	68
<i>nystop</i>	68
<i>ocella tab 3-0.03mg</i>	48
OCTAGAM	58
<i>octreotide acetate</i>	51
ODEFSEY	14
ODOMZO.....	19
OFEV	66
<i>ofloxacin (ophth)</i>	63
<i>ofloxacin (otic)</i>	70
<i>olanzapine</i>	37
<i>olmesartan medoxomil</i>	25
<i>olmesartan medoxomil-amlodipine-</i> <i>hydrochlorothiazide</i>	25
<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide</i>	25
<i>olopatadine hcl 0.2%</i>	64
<i>omeprazole cap 10mg</i>	55
<i>omeprazole cap 20mg</i>	55

<i>omeprazole cap 40mg</i>	55	PASER D/R	14
<i>ondansetron hcl</i>	52	PAXIL	34
<i>ondansetron hcl inj</i>	52	PAZEO	64
<i>ondansetron hcl oral soln</i>	52	PEDIARIX.....	59
<i>ondansetron odt</i>	52	PEDVAX HIB.....	59
OPSUMIT	29	<i>peg 3350/electrolytes</i>	54
ORFADIN.....	49	<i>peg 3350-kcl-sod bicarb-sod chloride-</i>	
ORKAMBI	66	<i>sod sulfate</i>	54
<i>orsythia</i>	48	<i>peg 3350-potassium chloride-sod</i>	
<i>oseltamivir phosphate</i>	15	<i>bicarbonate-sod chloride</i>	54
<i>oxacillin sodium</i>	17	PEGANONE.....	32
<i>oxaliplatin inj 100mg</i>	23	PEGASYS.....	15
<i>oxaliplatin inj 100mg/20ml</i>	23	PEGASYS PROCLICK	15
<i>oxaliplatin inj 50mg</i>	23	PENICILLIN G POT IN DEXTROSE 2MU	
<i>oxaliplatin inj 50mg/10ml</i>	23		17
<i>oxandrolone</i>	42	PENICILLIN G POT IN DEXTROSE 3MU	
<i>oxcarbazepine</i>	32		17
<i>oxybutynin chloride</i>	55	PENICILLIN G PROCAINE.....	17
<i>oxycodone hcl</i>	9	<i>penicillin g sodium</i>	17
<i>oxycodone w/ acetaminophen 10-</i>		<i>penicillin v potassium</i>	17
<i>325mg</i>	9	<i>penicilln gk inj 20mu</i>	17
<i>oxycodone w/ acetaminophen 2.5-</i>		<i>penicilln gk inj 5mu</i>	17
<i>325mg</i>	9	PENTACEL	59
<i>oxycodone w/ acetaminophen 5-325mg</i>		PENTAM 300.....	11
.....	9	<i>pentamidine isethionate</i>	11
<i>oxycodone w/ acetaminophen 7.5-</i>		<i>pentoxifylline</i>	56
<i>325mg</i>	9	<i>perindopril erbumine</i>	24
OZEMPIC INJ 0.25 OR 0.5MG/DOSE ..	43	<i>periogard</i>	70
OZEMPIC INJ 1MG/DOSE.....	43	<i>permethrin cre 5%</i>	70
<i>pacerone</i>	25	<i>perphenazine</i>	37
<i>paclitaxel</i>	19	PERSERIS	37
<i>paliperidone</i>	37	<i>pfizerpen-g inj 20mu</i>	17
<i>pamidronate disodium</i>	45	<i>pfizerpen-g inj 5mu</i>	17
PAMIDRONATE DISODIUM.....	45	<i>phenelzine sulfate</i>	34
<i>pamidronate inj 30mg</i>	45	<i>phenobarbital</i>	32
<i>pamidronate inj 90mg</i>	45	<i>phenobarbital sodium</i>	32
PANRETIN	69	PHENOBARBITAL SODIUM	32
<i>pantoprazole sodium</i>	55	PHENYTEK.....	32
<i>pantoprazole sodium tbec</i>	55	<i>phenytoin</i>	32
PANZYGA	58	<i>phenytoin sodium extended</i>	32
<i>paricalcitol</i>	62	<i>phenytoin sodium inj 50mg/ml</i>	32
<i>paroex sol 0.12%</i>	70	<i>philith</i>	48
<i>paromomycin sulfate</i>	10	PHOSPHOLINE IODIDE.....	64
<i>paroxetine hcl tabs</i>	34	PICATO	69

PIFELTRO	13	<i>prednisolone acetate (ophth)</i>	63
<i>pilocarpine hcl</i>	64	<i>prednisolone sodium phosphate</i>	50
<i>pilocarpine hcl (oral)</i>	70	PREDNISOLONE SODIUM PHOSPHATE	
<i>pimozide</i>	37	(OPHTH)	64
<i>pimtrea</i>	48	<i>prednisolone sol 15mg/5ml</i>	50
<i>pindolol</i>	27	<i>prednisolone sol 25mg/5ml</i>	50
<i>pioglitazone hcl</i>	44	PREDNISON CON 5MG/ML	50
PIPER/TAZوبا INJ 12-1.5GM	17	<i>prednisone pak 10mg</i>	50
<i>piper/tazoba inj 2-0.25gm</i>	17	<i>prednisone pak 5mg</i>	50
<i>piper/tazoba inj 3-0.375gm</i>	17	<i>prednisone sol 5mg/5ml</i>	50
<i>piper/tazoba inj 36-4.5gm</i>	17	<i>prednisone tab 10mg</i>	50
<i>piper/tazoba inj 4-0.5gm</i>	17	<i>prednisone tab 1mg</i>	50
<i>pirmella 1/35</i>	48	<i>prednisone tab 2.5mg</i>	50
<i>piroxicam</i>	7	<i>prednisone tab 20mg</i>	50
PLASMA-LYTE A	62	<i>prednisone tab 50mg</i>	50
PLASMA-LYTE-148	62	<i>prednisone tab 5mg</i>	50
PNV FOLIC ACID + IRON MUL	62	PREMASOL SOL 10%	61
<i>podofilox</i>	69	<i>premasol sol 6%</i>	61
<i>polymyxin b-trimethoprim</i>	63	PRENATAL	62
POMALYST CAP 1MG	20	PRENATAL PLUS	62
POMALYST CAP 2MG	20	PRENATAL PLUS LOW IRON	62
POMALYST CAP 3MG	20	<i>prevalite</i>	26
POMALYST CAP 4MG	20	<i>previfem</i>	48
<i>portia-28</i>	48	PREZCOBIX	14
<i>pot chloride inj 2meq/ml</i>	62	PREZISTA	13
<i>potassium chloride</i>	60, 62	PRIFTIN	14
<i>potassium chloride in nacl</i>	62	<i>primaquine phosphate</i>	12
<i>potassium chloride microencapsulated</i>		PRIMAQUINE PHOSPHATE	12
<i>crystals er</i>	60	<i>primidone</i>	32
<i>potassium chloride tab cr 10 meq</i>	60	PRIVIGEN	58
<i>potassium citrate (alkalinizer) er tabs</i>	55	<i>probenecid</i>	7
PRADAXA	56	PROCALAMINE	61
PRALUENT	26	<i>prochlorperazine inj</i>	52
<i>pramipexole tab 0.125mg</i>	35	<i>prochlorperazine maleate</i>	52
<i>pramipexole tab 0.25mg</i>	35	<i>prochlorperazine supp</i>	52
<i>pramipexole tab 0.5mg</i>	35	PROCRIT	56
<i>pramipexole tab 0.75mg</i>	35	<i>procto-med hc</i>	69
<i>pramipexole tab 1.5mg</i>	35	<i>procto-pak</i>	69
<i>pramipexole tab 1mg</i>	35	<i>proctosol hc cre 2.5%</i>	70
<i>prasugrel hcl</i>	57	<i>proctozone-hc</i>	70
<i>pravastatin sodium</i>	25	PROGLYCEM SUS 50MG/ML	50
<i>praziquantel</i>	11	PROGRAF	58
<i>prazosin hcl</i>	24	PROLASTIN-C	66
<i>pred sod pho sol 5mg/5ml</i>	50	PROLENSA	64

PROLIA	51	RELISTOR	54
PROMACTA	56, 57	REMICADE.....	57
<i>promethazine hcl</i>	52	REMODULIN	29
<i>promethazine hcl inj</i>	53	<i>repaglinide</i>	44
<i>propafenone hcl</i>	25	RESCRIPTOR	13
<i>propafenone hcl 12hr</i>	25	RESTASIS	64
<i>proparacaine hcl</i>	64	RESTASIS MULTIDOSE.....	64
<i>propranolol & hydrochlorothiazide</i>	26	REVLIMID.....	20
<i>propranolol cap er</i>	27	REXULTI	37
<i>propranolol hcl</i>	27	REYATAZ.....	13
<i>propranolol oral sol</i>	27	RHOPRESSA	64
<i>propylthiouracil</i>	52	<i>ribasphere</i>	15
PROQUAD	59	<i>ribavirin 200mg</i>	15
PROSOL	61	<i>rifabutin</i>	14
<i>protriptyline hcl</i>	34	<i>rifampin</i>	14
PULMICORT FLEXHALER	67	RIFATER.....	14
PULMOZYME	66	<i>riluzole</i>	40
PURIXAN.....	18	<i>rimantadine hydrochloride</i>	15
<i>pyrazinamide</i>	14	RISPERDAL INJ 12.5MG	37
<i>pyridostigmine tab 60mg</i>	40	RISPERDAL INJ 25MG	37
QUADRACEL	59	RISPERDAL INJ 37.5MG	37
<i>quasense</i>	48	RISPERDAL INJ 50MG	37
<i>quetiapine fumarate</i>	37	<i>risperidone</i>	37, 38
<i>quinapril hcl</i>	24	<i>ritonavir</i>	13
<i>quinapril-hydrochlorothiazide</i>	24	RITUXAN.....	19
<i>quinidine gluconate</i>	25	RITUXAN HYCELA.....	19
<i>quinidine sulfate</i>	25	<i>rivastigmine tartrate</i>	33
<i>quinine sulfate</i>	12	<i>rivastigmine td patch 24hr 13.3</i> <i>mg/24hr</i>	33
RABAVERT.....	59	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	33
<i>raloxifene hcl</i>	51	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	33
<i>ramipril</i>	24	<i>rizatriptan benzoate</i>	40
<i>ranitidine hcl</i>	53	<i>rizatriptan benzoate odt</i>	40
<i>ranitidine hcl inj</i>	53	<i>ropinirole tab 0.25mg</i>	35
<i>ranitidine inj</i>	53	<i>ropinirole tab 0.5mg</i>	35
<i>ranitidine syrup</i>	53	<i>ropinirole tab 1mg</i>	35
<i>ranolazine</i>	29	<i>ropinirole tab 2mg</i>	35
RAPAMUNE	58	<i>ropinirole tab 3mg</i>	35
<i>rasagiline mesylate</i>	35	<i>ropinirole tab 4mg</i>	35
RAYALDEE.....	62	<i>ropinirole tab 5mg</i>	35
REBETOL SOLN	15	<i>rosadan</i>	70
<i>reclipsen</i>	48	<i>rosuvastatin calcium</i>	25
RECOMBIVAX HB.....	59		
REGRANEX	70		
RELENZA DISKHALER	15		

ROTARIX.....	59	SOMAVERT.....	51
ROTATEQ.....	59	<i>sorine</i>	25
<i>roweepra</i>	32	<i>sotalol hcl</i>	25
<i>roweepra xr</i>	32	<i>sotalol hcl (afib/afl)</i>	25
RUBRACA.....	19	<i>spironolactone</i>	24
RYDAPT.....	22	<i>spironolactone & hydrochlorothiazide</i>	28
SANDIMMUNE.....	58	<i>sprintec 28</i>	48
SANTYL.....	70	SPRITAM.....	32
SAPHRIS.....	38	SPRYCEL.....	22
<i>scopolamine patch</i>	53	<i>sps susp 15gm/60ml</i>	46
<i>selegiline hcl</i>	35	<i>sronyx</i>	48
<i>selenium sulfide</i>	68	<i>ssd</i>	68
SELZENTRY.....	13	<i>stavudine</i>	13
SENSIPAR.....	45	STIMATE.....	52
SEREVENT DISKUS.....	66	STIVARGA.....	22
<i>sertraline hcl</i>	34	<i>streptomycin sulfate</i>	10
<i>setlakin tab</i>	48	STRIBILD.....	14
<i>sevelamer carbonate</i>	51	<i>subvenite tab</i>	32
<i>sharobel</i>	48	<i>sucralfate</i>	54
SHINGRIX.....	59	<i>sulfacetamide sodium (acne)</i>	67
SIGNIFOR.....	51	<i>sulfacetamide sodium (ophth)</i>	63
<i>sildenafil citrate tab 20 mg (pulmonary hypertension)</i>	29	<i>sulfacetamide sod-prednisolone</i>	62
SILENOR.....	39	SULFADIAZINE.....	10
<i>silver sulfadiazine</i>	68	<i>sulfamethoxazole-trimethop ds</i>	11
SIMBRINZA.....	64	<i>sulfamethoxazole-trimethoprim inj</i>	11
<i>simvastatin</i>	26	<i>sulfamethoxazole-trimethoprim susp</i>	11
<i>sirolimus</i>	58	<i>sulfamethoxazole-trimethoprim tab</i>	11
SIRTURO.....	14	<i>400-80mg</i>	11
SIVEXTRO.....	11	SULFAMYLON.....	68
<i>sodium chlor sol 0.9% irr</i>	70	<i>sulfasalazine</i>	53
<i>sodium chloride</i>	60, 62	<i>sulfasalazine ec</i>	53
<i>sodium chloride 0.45%</i>	62	<i>sulindac</i>	7
<i>sodium chloride inj 0.9%</i>	62	<i>sumatriptan</i>	40
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	60	<i>sumatriptan inj 4mg/0.5ml</i>	40
<i>sodium phenylbutyrate</i>	49	<i>sumatriptan inj 6mg/0.5ml</i>	40
<i>sodium polystyrene sulfonate powder</i>	45	<i>sumatriptan succinate</i>	40
<i>sodium polystyrene sulfonate susp</i>	45	SUPRAX.....	16
<i>solifenacin succinate</i>	55	SUPREP BOWEL PREP KIT.....	54
SOLQUA 100/33.....	43	SUTENT.....	22
SOLTAMOX.....	20	<i>syeda</i>	48
SOLU-CORTEF.....	50	SYLATRON KIT 200MCG.....	23
SOMATULINE DEPOT.....	51	SYLATRON KIT 300MCG.....	23
		SYLATRON KIT 600MCG.....	23
		SYMBICORT.....	67

SYMDEKO.....	66	<i>terazosin hcl</i>	24
SYMFI.....	14	<i>terbinafine hcl</i>	12
SYMFI LO.....	14	<i>terbutaline sulfate</i>	66
SYMPAZAN.....	32	<i>terconazole vaginal</i>	55
SYMPROIC.....	54	<i>testosterone</i>	42
SYMTUZA.....	14	<i>testosterone cypionate</i>	42
SYNAREL.....	49	<i>testosterone enanthate</i>	42
SYNERCID.....	11	<i>tetrabenazine</i>	41
SYNJARDY TAB 12.5-1000MG.....	45	<i>tetracycline hcl</i>	18
SYNJARDY TAB 12.5-500MG.....	45	TEXACORT SOLN 2.5%.....	69
SYNJARDY TAB 5-1000MG.....	45	THALOMID.....	21
SYNJARDY TAB 5-500MG.....	44	THEO-24.....	66
SYNJARDY XR TAB 10-1000MG.....	45	<i>theophylline</i>	66
SYNJARDY XR TAB 12.5-1000MG.....	45	<i>thioridazine hcl</i>	38
SYNJARDY XR TAB 25-1000MG.....	45	<i>thiothixene</i>	38
SYNJARDY XR TAB 5-1000MG.....	45	<i>tiagabine hcl</i>	32
SYNRIBO.....	23	TIBSOVO.....	19
SYNTHROID.....	52	<i>tigecycline</i>	11
TABLOID.....	18	<i>tilia fe</i>	48
<i>tacrolimus</i>	58	<i>timolol maleate</i>	27
<i>tacrolimus (topical)</i>	70	<i>timolol maleate (ophth) soln</i>	64
TAFINLAR.....	22	<i>timolol maleate gel</i>	64
TAGRISSE.....	22	<i>timolol maleate ophth soln 0.5% (once-daily)</i>	64
TALZENNA.....	19	TIVICAY.....	13
<i>tamoxifen citrate</i>	20	<i>tizanidine hcl</i>	41
<i>tamsulosin hcl</i>	55	TOBRADEX.....	62
TARCEVA.....	22	TOBRADEX ST.....	63
TARGRETIN.....	70	<i>tobramycin</i>	10
<i>tarina fe 1/20</i>	48	<i>tobramycin (ophth)</i>	63
TASIGNA.....	22	<i>tobramycin inj 1.2 gm/30ml</i>	10
TAXOTERE.....	19	<i>tobramycin inj 1.2gm</i>	10
<i>tazarotene</i>	68	<i>tobramycin inj 10mg/ml</i>	10
<i>tazicef</i>	16	<i>tobramycin inj 40mg/ml</i>	10
TAZORAC.....	68	<i>tobramycin inj 80mg/2ml</i>	10
<i>taztia xt</i>	27	<i>tobramycin-dexamethasone</i>	63
TDVAX.....	59	<i>tolterodine tartrate cap er</i>	55
TECENTRIQ.....	19	<i>tolterodine tartrate tabs</i>	55
TEFLARO.....	16	<i>topiramate</i>	32
TEKTURNA.....	28	<i>toposar</i>	23
TEKTURNA HCT.....	28	<i>topotecan hcl</i>	23
<i>telmisartan</i>	25	TOPOTECAN INJ 4MG/4ML.....	23
<i>temazepam</i>	39	<i>toremifene citrate</i>	20
TENIVAC.....	59	<i>torse mide tabs</i>	28
<i>tenofovir disoproxil fumarate</i>	13		

TOVIAZ.....	55	<i>trinessa lo</i>	49
<i>tpn electrolytes</i>	60	TRINTELLIX	34
TRACLEER	29	<i>tri-previfem</i>	48
TRADJENTA	45	<i>tri-sprintec</i>	49
<i>tramadol hcl tab 50 mg</i>	7	TRIUMEQ	14
<i>tramadol-acetaminophen</i>	7	<i>trivora-28</i>	49
<i>trandolapril</i>	24	<i>tri-vylibra</i>	49
<i>tranexamic acid</i>	57	<i>tri-vylibra lo</i>	49
TRANSDERM-SCOP	53	TROGARZO.....	13
<i>tranylcypromine sulfate</i>	34	TROPHAMINE INJ 10%.....	61
TRAVASOL.....	61	<i>trospium chloride</i>	55
TRAVATAN Z.....	64	TRULICITY.....	43
<i>trazodone hcl</i>	34	TRUMENBA.....	59
TRECTOR	14	TRUVADA TAB 100-150.....	14
TRELEGY ELLIPTA.....	65	TRUVADA TAB 133-200.....	14
TRELSTAR DEP INJ 3.75MG	20	TRUVADA TAB 167-250.....	14
TRELSTAR LA INJ 11.25MG.....	20	TRUVADA TAB 200-300.....	14
<i>treprostinil</i>	29	<i>tulana</i>	49
TRESIBA FLEXTOUCH.....	43	TWINRIX INJ	59
TRESIBA INJ.....	43	TYBOST	13
<i>tretinoin</i>	67	TYKERB.....	22
<i>tretinoin (chemotherapy)</i>	23	TYMLOS	51
<i>triamcinolone acetonide (mouth)</i>	70	TYPHIM VI	59
<i>triamcinolone acetonide (topical)</i>	69	ULORIC.....	7
<i>triamterene & hydrochlorothiazide cap</i> <i>37.5-25 mg</i>	28	<i>unithroid</i>	52
<i>triamterene & hydrochlorothiazide tabs</i>	28	<i>ursodiol</i>	54
TRICARE	62	<i>valacyclovir hcl</i>	15
<i>trientine hcl</i>	46	VALCHLOR	70
<i>tri-estarylla</i>	48	<i>valganciclovir hcl</i>	15
<i>trifluoperazine hcl</i>	38	<i>valproate sodium</i>	32
<i>trifluridine</i>	63	<i>valproic acid</i>	32
<i>trihexyphenidyl hcl</i>	35	<i>valsartan</i>	25
<i>tri-legest fe</i>	48	<i>valsartan-hydrochlorothiazide</i>	25
<i>tri-linyah</i>	48	<i>vancomycin hcl</i>	11
<i>tri-lo marzia</i>	48	VANCOMYCIN IN NACL.....	11
<i>tri-lo-estarylla</i>	48	<i>vandazole</i>	55
<i>tri-lo-sprintec</i>	48	VAQTA.....	59
<i>trilyte</i>	54	VARIVAX	59
<i>trimethoprim</i>	11	VASCEPA.....	26
<i>tri-mili</i>	48	VELCADE.....	19
<i>trimipramine maleate</i>	34	<i>velivet</i>	49
<i>trinessa</i>	49	VEMLIDY	15
		VENCLEXTA	20
		VENCLEXTA STARTING PACK	20

<i>venlafaxine hcl</i>	34	XELJANZ	57
VENTAVIS	29	XELJANZ XR	57
VENTOLIN HFA.....	66	XGEVA	51
<i>verapamil cap er</i>	27	XIFAXAN	54
<i>verapamil hcl</i>	27, 28	XIGDUO XR TAB 10-1000MG	45
<i>verapamil hcl tab er</i>	28	XIGDUO XR TAB 10-500MG	45
VERSACLOZ.....	38	XIGDUO XR TAB 2.5-1000MG	45
VERZENIO	20	XIGDUO XR TAB 5-1000MG	45
VICTOZA.....	43	XIGDUO XR TAB 5-500MG	45
VIDEX EC	13	XOLAIR.....	66
VIDEX PEDIATRIC	13	XOSPATA	22
<i>vienna</i>	49	XTANDI.....	20
<i>vigabatrin powd pack 500mg</i>	32	<i>xulane</i>	49
<i>vigabatrin tab 500mg</i>	32	XULTOPHY 100/3.6.....	43
<i>vigadrone</i>	32	XYREM.....	41
VIIBRYD STARTER PACK	34	YF-VAX	59
VIIBRYD TAB	35	<i>yuvafem vaginal tablet 10 mcg</i>	50
VIMPAT.....	32	<i>zafirlukast</i>	66
VIMPAT INJ 200MG/20ML.....	32	<i>zarah</i>	49
VIMPAT SOL 10MG/ML	33	ZEJULA	20
<i>vinblastine sulfate</i>	19	ZELBORAF.....	22
<i>vincasar pfs</i>	19	ZEMAIRA.....	66
<i>vincristine sulfate</i>	19	<i>zenatane</i>	67
<i>vinorelbine tartrate</i>	19	ZENPEP.....	54
<i>viorele</i>	49	ZEPATIER.....	15
VIRACEPT.....	13	<i>zidovudine cap 100mg</i>	13
VIRAMUNE	13	<i>zidovudine syp 50mg/5ml</i>	13
VIREAD.....	13	<i>zidovudine tab 300mg</i>	13
VITRAKVI	22	<i>ziprasidone hcl</i>	38
VIVITROL	42	ZIRGAN	63
VIZIMPRO	22	<i>zoledronic acid inj 5mg/100ml</i>	45
<i>voriconazole</i>	12	<i>zoledronic inj 4mg/5ml</i>	45
VOSEVI.....	15	ZOLINZA.....	20
VOTRIENT	22	<i>zolmitriptan</i>	40
VRAYLAR.....	38	<i>zolmitriptan odt</i>	40
VRAYLAR THERAPY PACK.....	38	<i>zolpidem tartrate</i>	39
<i>vyfemla</i>	49	<i>zonisamide</i>	33
<i>vylibra</i>	49	ZONTIVITY	57
<i>warfarin sodium</i>	56	ZORTRESS TAB 0.25MG	58
<i>water for irrigation, sterile</i>	70	ZORTRESS TAB 0.5MG.....	58
XALKORI.....	22	ZORTRESS TAB 0.75MG	59
XARELTO.....	56	ZORTRESS TAB 1MG.....	59
XARELTO STARTER PACK	56	ZOSTAVAX	60
XATMEP	57	<i>zovia 1/35e</i>	49

ZYDELIG	22
ZYKADIA.....	22
ZYLET	63

ZYPREXA RELPREVV	38
ZYPREXA RELPREVV INJ 210MG	38
ZYTIGA	20

Multi-Language & 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 **Customer Care at 1-844-280-5555 (toll-free)**.

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: Director of Compliance and Legal Services, 210 Park Avenue, Ste 2800, Oklahoma City, OK 73102-5621, Fax: (405) 280-5894, or E-mail: compliance@globalhealth.com. You can file a grievance in person or by mail, fax, or email. 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)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-280-5555 (TTY: 711)번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-280-5555 (TTY: 711).

والبكم الصم هاتف 711). اتصل بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا: ملحوظة 1-844-280-5555 (برقم)

သတိပဉ်ရန်။ ။ ခဉ်းဘာ ဗမာစကား ဝေဟတတ္ထိဉ်း ဘာသာစကား လုဝိအပ္ပ; အကူအညီမသားကုဝိ အခဲး/ ။
ဆေးဉ်းကုဝေးဝေးပါသည့်။ ဖုန်းနံပါတ် 1-844-280-5555 (TTY: 711) ကုဝိ ဝေဒုးဉ်းပါသည့်။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-280-5555 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-280-5555 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-280-5555 (ATS: 711).

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ແຈ້ງຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-844-280-5555 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-280-5555 (TTY: 711).

1-844-280-5555 (TTY: 711) کریں کال - ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ہیں، بولتے اردو آپ اگر: خبردار 711).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-844-280-5555 (TTY: 711).

شما برای رایگان بصورت زبانی تسهیلات کنید، می گفتگو فارسی زبان به اگر: توجه

بگیرید تماس با .باشد می فراهم 1-844-280-5555 (TTY: 711)

This formulary was updated on 08/01/2019

For more recent information or other questions, please contact GlobalHealth Customer Care at 1-866-494-3927 or, for TTY users, 711 24 hours a day, seven days a week or visit www.GlobalHealth.com/medicare.



This formulary was updated on 08/01/2019
For more recent information or other questions, please
contact GlobalHealth Customer Care
at 1-866-494-3927 or, for TTY users, 711
24 hours a day, seven days a week
or visit www.GlobalHealth.com/medicare