



GlobalHealth

GlobalHealth

2020 Formulary

(List of
Covered Drugs)

For Generations
Classic (HMO) and
Generations Select
(HMO)



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

This formulary was updated
on 09/01/2020. 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: 00020327
Version 15

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

**Generations Classic (HMO) and
Generations Select (HMO)
2020 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 00020327, Version Number 15.

This formulary was updated on 09/01/2020. For more recent information or other questions, please contact 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.

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_SELECT_2020_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) or Generations Select (HMO).

This document includes list of the drugs (formulary) for our plan which is current as of 09/01/2020. 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, 2020, and from time to time during the year.

What is the Generations Classic (HMO) and Generations Select (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?

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

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Generations Classic (HMO) and Generations Select (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, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Generations Classic (HMO) and Generations Select (HMO) Formulary?”

Changes that will not affect you if you are currently taking the drug. 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 2020 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year.

The enclosed formulary is current as of 09/01/2020. 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. In the event of any CMS-approved, mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 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 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 70. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that we 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. 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) and Generations Select (HMO) formulary?" on page 4 for information about how to request an exception.

What if my drug is not on the Formulary?

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

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

- You can ask Customer Care for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask our plan 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) and Generations Select (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 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. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

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

For more information

For more detailed information about your Generations Classic (HMO) and Generations Select (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) and Generations Select (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 70.

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.

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

- LA – Limited Access drugs are designated with the abbreviation LA. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Care at 1-866-494-3927, 24 hours a day, seven days a week. TTY users should call 711.
- 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.
- QL – Quantity Limit drugs are designated with the abbreviation QL and the limit is designated for each drug.
- PA – Prior Authorization drugs are designated with the abbreviation PA.
- 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.

Copayments and coinsurance amounts are shown in the Evidence of Coverage booklet in Chapter 6, Sections 5.2 and 5.4.

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

ANALGESICS

GOUT

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

NSAIDS

<i>celecoxib CAPS 50mg</i>	3	QL (240 caps / 30 days)
<i>celecoxib CAPS 100mg</i>	3	QL (120 caps / 30 days)
<i>celecoxib CAPS 200mg</i>	3	QL (60 caps / 30 days)
<i>celecoxib CAPS 400mg</i>	3	QL (30 caps / 30 days)
<i>diclofenac potassium</i>	3	QL (120 tabs / 30 days)
<i>diclofenac sodium TB24</i>	3	
<i>diclofenac sodium TBEC</i>	2	
<i>diflunisal TABS</i>	3	
<i>ec-naproxen</i>	2	
<i>etodolac</i>	3	
<i>flurbiprofen TABS 100mg</i>	2	
<i>ibu tab 600mg</i>	1	GC
<i>ibu tab 800mg</i>	1	GC
<i>ibuprofen SUSP</i>	3	
<i>ibuprofen TABS 400mg, 600mg, 800mg</i>	1	GC
<i>meloxicam TABS</i>	1	GC
<i>nabumetone TABS</i>	2	
<i>naproxen TABS 250mg, 375mg, 500mg</i>	1	GC
<i>naproxen dr</i>	2	
<i>naproxen sodium TABS 275mg, 550mg</i>	3	
<i>piroxicam CAPS</i>	3	
<i>sulindac TABS</i>	2	

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>	3	QL (240 tabs / 30 days)

OPIOID ANALGESICS, CII

<i>endocet 2.5-325mg</i>	3	QL (360 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>endocet 5-325mg</i>	3	QL (360 tabs / 30 days)
<i>endocet 7.5-325mg</i>	3	QL (240 tabs / 30 days)
<i>endocet 10-325mg</i>	3	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP	5	QL (120 lozenges / 30 days), PA
<i>fentanyl patch 12 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 25 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 50 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 75 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>fentanyl patch 100 mcg/hr</i>	4	QL (10 patches / 30 days), PA
<i>hydroco/apap tab 5-325mg</i>	3	QL (240 tabs / 30 days)
<i>hydroco/apap tab 7.5-325</i>	3	QL (180 tabs / 30 days)
<i>hydroco/apap tab 10-325mg</i>	3	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen 7.5-325 mg/15ml</i>	4	QL (2700 mL / 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	3	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD	4	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> SOLN 10mg/ml, 50mg/5ml, 500mg/50ml	4	B/D
<i>hydromorphone hcl</i> TABS	3	QL (180 tabs / 30 days)
HYSINGLA ER	3	QL (30 tabs / 30 days), PA
<i>lorcet hd tab 10-325mg</i>	3	QL (180 tabs / 30 days)
<i>lorcet plus tab 7.5-325</i>	3	QL (180 tabs / 30 days)
<i>lorcet tab 5-325mg</i>	3	QL (240 tabs / 30 days)
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	3	QL (450 mL / 30 days), PA
<i>methadone hcl 5mg</i>	3	QL (90 tabs / 30 days), PA
<i>methadone hcl 10mg</i>	3	QL (90 tabs / 30 days), PA
<i>methadone hcl intensol</i>	3	QL (90 mL / 30 days), PA
<i>morphine ext-rel tab</i>	3	QL (90 tabs / 30 days), PA
<i>morphine sul inj 1mg/ml</i>	4	B/D
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	4	B/D
<i>morphine sulfate</i> SOLN 4mg/ml, 8mg/ml, 10mg/ml	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
<i>morphine sulfate</i> TABS	3	QL (180 tabs / 30 days)
<i>morphine sulfate oral soln 10mg/5ml</i>	3	QL (900 mL / 30 days)
<i>morphine sulfate oral soln 20mg/5ml</i>	3	QL (900 mL / 30 days)
<i>morphine sulfate oral soln 100mg/5ml</i>	3	QL (180 mL / 30 days)
NUCYNTA ER	3	QL (60 tabs / 30 days), PA
<i>oxycodone hcl</i> CAPS	4	QL (180 caps / 30 days)
<i>oxycodone hcl</i> CONC	4	QL (180 mL / 30 days)
<i>oxycodone hcl</i> SOLN	4	QL (900 mL / 30 days)
<i>oxycodone hcl</i> TABS	3	QL (180 tabs / 30 days)
<i>oxycodone w/ acetaminophen 2.5-325mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen 5-325mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen 7.5-325mg</i>	3	QL (240 tabs / 30 days)
<i>oxycodone w/ acetaminophen 10-325mg</i>	3	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</i> SOLN	4	
<i>gentamicin in saline</i>	2	
<i>gentamicin sulfate</i> SOLN	2	
<i>neomycin sulfate</i> TABS	2	
<i>paramomycin sulfate</i> CAPS	4	
<i>streptomycin sulfate</i> SOLR	5	
SULFADIAZINE TABS	4	
<i>tobramycin</i> NEBU	5	NM, PA
<i>tobramycin inj 1.2 gm/30ml</i>	3	
<i>tobramycin inj 1.2gm</i>	5	
<i>tobramycin inj 10mg/ml</i>	3	
<i>tobramycin inj 80mg/2ml</i>	3	
<i>tobramycin sulfate</i> SOLN	3	

ANTI-INFECTIVES - MISCELLANEOUS

<i>albendazole</i> TABS	5	
ALINIA	5	
<i>atovaquone</i> SUSP	5	
<i>aztreonam</i>	4	
CAYSTON	5	NM, LA, PA
<i>clindamycin cap 75mg</i>	1	GC

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

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin cap 300 mg</i>	1	GC
<i>clindamycin hcl cap 150 mg</i>	1	GC
<i>clindamycin phosphate in d5w</i>	4	
CLINDAMYCIN PHOSPHATE IN NAACL	4	
<i>clindamycin phosphate inj</i>	3	
<i>clindamycin soln 75mg/5ml</i>	4	
<i>colistimethate sodium SOLR</i>	4	
<i>dapsone TABS</i>	3	
<i>daptomycin</i>	5	
EMVERM	5	QL (12 tabs / 365 days)
<i>ertapenem sodium</i>	4	
<i>imipenem-cilastatin</i>	3	
<i>ivermectin TABS</i>	3	
<i>linezolid in sodium chloride</i>	4	
<i>linezolid inj</i>	4	
<i>linezolid susp</i>	5	
<i>linezolid tab 600mg</i>	4	
<i>meropenem</i>	4	
<i>methenamine hippurate</i>	3	
<i>metronidazole TABS</i>	2	
<i>metronidazole in nacl</i>	2	
<i>nitrofurantoin macrocrystal 50mg, 100mg</i>	3	
<i>nitrofurantoin monohyd macro</i>	3	
<i>pentamidine isethionate inh</i>	4	B/D
<i>pentamidine isethionate inj</i>	4	
<i>praziquantel TABS</i>	3	
SIVEXTRO	5	
<i>sulfamethoxazole-trimethop ds</i>	1	GC
<i>sulfamethoxazole-trimethoprim inj</i>	4	
<i>sulfamethoxazole-trimethoprim susp</i>	3	
<i>sulfamethoxazole-trimethoprim tab 400-80mg</i>	1	GC
SYNERCID	5	
<i>tigecycline</i>	5	
<i>trimethoprim TABS</i>	2	
<i>vancomycin hcl CAPS 125mg</i>	4	QL (120 caps / 30 days)
<i>vancomycin hcl CAPS 250mg</i>	5	QL (240 caps / 30 days)
<i>vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg</i>	4	
VANCOMYCIN IN NAACL	4	
ANTIFUNGALS		
ABELCET	5	B/D
AMBISOME	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
<i>amphotericin b</i> SOLR	4	B/D
<i>caspofungin acetate</i>	5	
<i>fluconazole</i> SUSR	3	
<i>fluconazole</i> TABS 50mg, 100mg, 200mg	3	
<i>fluconazole</i> TABS 150mg	1	GC
<i>fluconazole inj nacl 200</i>	3	
<i>fluconazole inj nacl 400</i>	3	
<i>flucytosine</i> CAPS	5	
<i>griseofulvin microsize</i>	4	
<i>griseofulvin ultramicrosize</i>	4	
<i>itraconazole</i> CAPS	4	PA
<i>ketoconazole</i> TABS	3	PA
<i>micafungin sodium</i>	5	
MYCAMINE	5	
NOXAFIL SUSP	5	QL (630 mL / 30 days)
<i>nystatin</i> TABS	3	
<i>posaconazole</i>	5	QL (93 tabs / 30 days)
<i>terbinafine hcl</i> TABS	1	GC, QL (90 tabs / year)
<i>voriconazole</i> SOLR	5	PA
<i>voriconazole</i> SUSR	5	PA
<i>voriconazole</i> TABS 50mg	4	
<i>voriconazole</i> TABS 200mg	5	
ANTIMALARIALS		
<i>atovaquone-proguanil hcl</i>	4	
<i>chloroquine phosphate</i> TABS	3	
COARTEM	4	
<i>mefloquine hcl</i>	3	
<i>primaquine phosphate</i> 26.3mg	3	
PRIMAQUINE PHOSPHATE 26.3mg	3	
<i>quinine sulfate</i> CAPS	4	PA
ANTIRETROVIRAL AGENTS		
<i>abacavir sulfate</i> SOLN	4	
<i>abacavir sulfate</i> TABS	3	
APTIVUS	5	
<i>atazanavir sulfate</i>	4	
CRIXIVAN	4	
<i>didanosine</i>	4	
EDURANT	5	
<i>efavirenz</i> CAPS 50mg	4	
<i>efavirenz</i> CAPS 200mg	5	
<i>efavirenz</i> TABS	5	
EMTRIVA	3	
<i>fosamprenavir tab 700 mg</i>	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
FUZEON	5	NM
INTELENCE 25mg	4	
INTELENCE 100mg, 200mg	5	
INVIRASE	5	
ISENTRESS CHEW 25mg	3	
ISENTRESS CHEW 100mg	5	
ISENTRESS PACK	3	
ISENTRESS TABS	5	
ISENTRESS HD	5	
<i>lamivudine</i>	3	
LEXIVA SUSP	4	
<i>nevirapine susp 50 mg/5ml</i>	4	
<i>nevirapine tab 100mg er</i>	4	
<i>nevirapine tab 200mg</i>	3	
<i>nevirapine tab 400mg er</i>	4	
NORVIR PACK	4	
NORVIR SOLN	4	
PIFELTRO	5	
PREZISTA SUSP	5	QL (400 mL / 30 days)
PREZISTA TABS 75mg	4	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)
REYATAZ PACK	5	
<i>ritonavir</i>	3	
SELZENTRY SOLN	5	
SELZENTRY TABS 25mg	4	
SELZENTRY TABS 75mg, 150mg, 300mg	5	
<i>stavudine</i>	3	
<i>tenofovir disoproxil fumarate</i>	3	
TIVICAY 10mg	3	
TIVICAY 25mg, 50mg	5	
TIVICAY PD	3	
TROGARZO	5	NM, LA
TYBOST	4	
VIRACEPT	5	
VIREAD POWD	5	
VIREAD TABS 150mg, 200mg, 250mg	5	
<i>zidovudine cap 100mg</i>	4	
<i>zidovudine syp 50mg/5ml</i>	4	
<i>zidovudine tab 300mg</i>	3	
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>abacavir sulfate-lamivudine-zidovudine</i>	5	
ATRIPLA	5	
BIKTARVY	5	
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>	4	
<i>lopinavir-ritonavir</i>	4	
ODEFSEY	5	
PREZCOBIX	5	
STRIBILD	5	
SYMFI	5	
SYMFI LO	5	
SYMTUZA	5	
TEMIXYS	5	
TRIUMEQ	5	
TRUVADA TAB 100-150	5	QL (30 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	3	
<i>isoniazid</i> TABS	1	GC
<i>isoniazid syp 50mg/5ml</i>	4	
PASER D/R	4	
PRIFTIN	4	
<i>pyrazinamide</i> TABS	4	
<i>rifabutin</i>	4	
<i>rifampin</i> CAPS	3	
<i>rifampin</i> SOLR	4	
SIRTURO 100mg	5	LA, PA
TRECTOR	4	
ANTIVIRALS		
<i>acyclovir</i> CAPS; TABS	2	
<i>acyclovir</i> SUSP	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>acyclovir sodium</i>	4	B/D
<i>adefovir dipivoxil</i>	5	
BARACLUDE SOLN	5	
<i>entecavir</i>	4	
EPCLUSA	5	NM, PA
EPIVIR HBV SOLN	4	
<i>famciclovir TABS</i>	3	
<i>ganciclovir sodium</i>	4	B/D
HARVONI	5	NM, PA
<i>lamivudine (hbv)</i>	4	
MAVYRET	5	NM, PA
<i>oseltamivir phosphate CAPS 30mg</i>	3	QL (168 caps / year)
<i>oseltamivir phosphate CAPS 45mg, 75mg</i>	3	QL (84 caps / year)
<i>oseltamivir phosphate SUSR</i>	3	QL (1080 mL / year)
PEGASYS	5	NM, PA
PEGASYS PROCLICK	5	NM, PA
RELENZA DISKHALER	3	QL (6 inhalers / year)
<i>ribavirin cap 200mg</i>	3	NM
<i>ribavirin tab 200mg</i>	4	NM
<i>rimantadine hydrochloride</i>	3	
<i>valacyclovir hcl TABS</i>	3	
<i>valganciclovir hcl</i>	5	
VEMLIDY	5	
VOSEVI	5	NM, PA
CEPHALOSPORINS		
<i>cefaclor CAPS</i>	3	
<i>cefaclor SUSR</i>	4	
CEFACLOR ER TAB 500MG	4	
<i>cefadroxil CAPS</i>	2	
<i>cefadroxil SUSR</i>	3	
<i>cefadroxil TABS</i>	4	
CEFAZOLIN IN DEXTROSE 2GM/100ML-4%	3	
<i>cefazolin inj</i>	3	
<i>cefazolin sodium SOLR 1gm</i>	3	
CEFAZOLIN SODIUM 1 GM/50ML	3	
<i>cefdinir CAPS</i>	2	
<i>cefdinir SUSR</i>	4	
<i>cefepime for inj</i>	4	
<i>cefixime SUSR</i>	4	
<i>cefoxitin for inj</i>	4	
<i>cefpodoxime proxetil SUSR</i>	4	
<i>cefpodoxime proxetil TABS</i>	3	
<i>cefprozil</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>ceftazidime</i> SOLR	3	
CEFTAZIDIME/DEXTROSE	4	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	3	
<i>cefuroxime axetil</i>	3	
<i>cefuroxime sodium</i>	3	
<i>cephalexin</i> CAPS 250mg, 500mg	1	GC
<i>cephalexin</i> SUSR	3	
<i>tazicef</i> SOLR	3	
TEFLARO	5	

ERYTHROMYCINS/MACROLIDES

<i>azithromycin</i> PACK; SOLR; SUSR	3	
<i>azithromycin</i> TABS	1	GC
<i>clarithromycin</i> TABS	3	
<i>clarithromycin er</i>	3	
<i>clarithromycin for susp</i>	4	
DIFICID	5	
<i>ery-tab</i>	4	
ERYTHROCIN LACTOBIONATE	4	
<i>erythrocin stearate</i>	4	
<i>erythromycin base</i>	4	
<i>erythromycin cap 250mg ec</i>	4	
<i>erythromycin ethylsuccinate</i> TABS	4	
<i>erythromycin tab ec</i>	4	

FLUOROQUINOLONES

CIPRO SUSR 500mg/5ml	4	
<i>ciprofloxacin hcl tab</i> 100mg	4	
<i>ciprofloxacin hcl tab</i> 250mg, 500mg, 750mg	1	GC
<i>ciprofloxacin in d5w</i>	3	
<i>levofloxacin</i> TABS	1	GC
<i>levofloxacin in d5w</i>	3	
<i>levofloxacin inj 25mg/ml</i>	4	
<i>levofloxacin oral soln 25 mg/ml</i>	4	

PENICILLINS

<i>amoxicillin</i> CAPS; SUSR; TABS	1	GC
<i>amoxicillin</i> CHEW	2	
<i>amoxicillin & pot clavulanate 200-28.5 chw tabs</i>	4	
<i>amoxicillin & pot clavulanate 200/5ml susr</i>	3	
<i>amoxicillin & pot clavulanate 250-125 tabs</i>	4	
<i>amoxicillin & pot clavulanate 250/5ml susr</i>	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>amoxicillin & pot clavulanate 400-57 chw tabs</i>	4	
<i>amoxicillin & pot clavulanate 400/5ml susr</i>	3	
<i>amoxicillin & pot clavulanate 500-125 tabs</i>	2	
<i>amoxicillin & pot clavulanate 600/5ml susr</i>	3	
<i>amoxicillin & pot clavulanate 875-125 tabs</i>	2	
<i>amoxicillin & pot clavulanate er 12hr 1000-62.5 tabs</i>	4	
<i>ampicillin & sulbactam sodium</i>	4	
<i>ampicillin cap 500mg</i>	2	
<i>ampicillin inj</i>	4	
<i>ampicillin sodium</i>	4	
BICILLIN L-A	4	
<i>dicloxacillin sodium</i>	3	
<i>nafcillin sodium for inj 1gm, 2gm</i>	4	
<i>nafcillin sodium for inj 10gm</i>	5	
NAFCILLIN SODIUM FOR INJ 10GM	4	
<i>oxacillin sodium SOLR 1gm, 2gm</i>	4	
<i>oxacillin sodium SOLR 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>	4	
<i>penicillin v potassium SOLR</i>	2	
<i>penicillin v potassium TABS</i>	1	GC
<i>penicillin gk inj 5mu</i>	4	
<i>penicillin gk inj 20mu</i>	4	
<i>pfizerpen-g inj 5mu</i>	4	
<i>pfizerpen-g inj 20mu</i>	4	
<i>piper/tazoba inj 2-0.25gm</i>	4	
<i>piper/tazoba inj 3-0.375gm</i>	4	
<i>piper/tazoba inj 4-0.5gm</i>	4	
<i>piper/tazoba inj 12-1.5gm</i>	4	
<i>piper/tazoba inj 36-4.5gm</i>	4	
TETRACYCLINES		
<i>doxy 100</i>	4	
<i>doxycycline (monohydrate) CAPS 50mg, 100mg</i>	2	
<i>doxycycline (monohydrate) TABS 50mg, 75mg, 100mg</i>	3	
<i>doxycycline hyclate CAPS</i>	3	
<i>doxycycline hyclate SOLR</i>	4	
<i>doxycycline hyclate 20 mg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>doxycycline hyclate 100 mg</i>	3	
<i>minocycline hcl CAPS</i>	2	
<i>mondoxylene nl cap 100mg</i>	2	
<i>tetracycline hcl CAPS</i>	4	

ANTINEOPLASTIC AGENTS

ALKYLATING AGENTS

BENDEKA	5	B/D, NM
<i>cyclophosphamide CAPS</i>	3	B/D
<i>cyclophosphamide SOLR</i>	5	B/D
EMCYT	4	
GLEOSTINE 10mg	4	
GLEOSTINE 40mg, 100mg	5	
LEUKERAN	5	

ANTHRACYCLINES

<i>adriamycin SOLN</i>	4	B/D
<i>doxorubicin hcl</i>	4	B/D
<i>doxorubicin hcl liposomal</i>	5	B/D
<i>epirubicin hcl</i>	4	B/D

ANTIMETABOLITES

<i>adrucil inj</i>	3	B/D
ALIMTA	5	B/D
<i>azacitidine</i>	5	B/D
<i>cytarabine 20mg/ml</i>	3	B/D
<i>fluorouracil SOLN</i>	3	B/D
<i>gemcitabine inj soln</i>	4	B/D
<i>gemcitabine inj solr</i>	4	B/D
<i>mercaptopurine TABS</i>	3	
<i>methotrexate sodium inj soln</i>	2	B/D
<i>methotrexate sodium inj solr</i>	2	B/D
PURIXAN	5	NM
TABLOID	5	

ANTIMITOTIC, TAXOIDS

ABRAXANE	5	B/D
<i>docetaxel CONC 20mg/ml, 80mg/4ml, 160mg/8ml</i>	5	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml, 200mg/10ml	5	B/D
<i>docetaxel SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml</i>	5	B/D
DOCETAXEL SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
<i>paclitaxel</i>	4	B/D
TAXOTERE	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
ANTIMITOTIC, VINCA ALKALOIDS		
<i>vincristine sulfate</i>	2	B/D
<i>vinorelbine tartrate</i>	3	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
HERZUMA	5	NM, PA
IBRANCE CAPS	5	QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS	5	QL (21 tabs / 28 days), NM, LA, PA
IDHIFA	5	QL (30 tabs / 30 days), NM, LA, PA
KADCYLA	5	B/D
KANJINTI	5	NM, PA
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
MVASI	5	NM, LA, PA
NINLARO	5	NM, PA
ODOMZO	5	NM, LA, PA
OGIVRI	5	NM, PA
ONTRUZANT	5	NM, PA
RITUXAN	5	LA, PA
RITUXAN HYCELA	5	NM, LA, PA
RUBRACA	5	NM, LA, PA
RUXIENCE	5	NM, PA
TALZENNA	5	NM, LA, PA
TECENTRIQ	5	NM, LA, PA
TIBSOVO	5	NM, LA, PA
TRAZIMERA	5	NM, PA
TRUXIMA	5	NM, PA
VELCADE	5	PA
VENCLEXTA 10mg	4	NM, LA, PA
VENCLEXTA 50mg, 100mg	5	NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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 STARTING PACK	5	NM, LA, PA
VERZENIO	5	NM, LA, PA
ZEJULA	5	NM, LA, PA
ZIRABEV	5	PA
ZOLINZA	5	NM, PA

HORMONAL ANTINEOPLASTIC AGENTS

<i>abiraterone acetate</i>	5	NM, PA
<i>anastrozole</i> TABS	1	GC
<i>bicalutamide</i>	2	
DEPO-PROVERA INJ 400/ML	4	B/D
ERLEADA	5	NM, LA, PA
<i>exemestane</i>	4	
<i>flutamide</i>	3	
<i>fulvestrant</i>	5	B/D
<i>letrozole</i> TABS	1	GC
<i>leuprolide inj 1mg/0.2</i>	3	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>	3	
<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	
NUBEQA	5	NM, LA, PA
SOLTAMOX	5	
<i>tamoxifen citrate</i> TABS	1	GC
<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 1mg, 2mg	5	QL (21 caps / 21 days), NM, LA, PA
POMALYST 3mg, 4mg	5	QL (21 caps / 28 days), NM, LA, PA
REVLIMID	5	QL (28 caps / 28 days), NM, LA, PA
THALOMID 50mg, 100mg	5	QL (28 caps / 28 days), NM, PA
THALOMID 150mg, 200mg	5	QL (56 caps / 28 days), NM, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
KINASE INHIBITORS		
AFINITOR 10mg	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
AYVAKIT	5	QL (30 tabs / 30 days), NM, LA, PA
BALVERSA	5	NM, LA, PA
BOSULIF	5	NM, PA
BRAFTOVI	5	NM, LA, PA
BRUKINSA	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
<i>everolimus</i>	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
INLYTA 5mg	5	QL (120 tabs / 30 days), NM, LA, PA
INREBIC	5	NM, LA, PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
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
PEMAZYRE	5	NM, LA, PA
PIQRAY 200MG DAILY DOSE	5	NM, PA
PIQRAY 250MG DAILY DOSE	5	NM, PA
PIQRAY 300MG DAILY DOSE	5	NM, PA
QINLOCK	5	NM, LA, PA
RETEVMO	5	NM, LA, PA
ROZLYTREK	5	NM, LA, PA
RYDAPT	5	NM, PA
SPRYCEL	5	NM, PA
STIVARGA	5	NM, LA, PA
SUTENT	5	QL (30 caps / 30 days), NM, PA
TABRECTA	5	NM, PA
TAFINLAR	5	NM, LA, PA
TAGRISSO	5	QL (30 tabs / 30 days), NM, LA, PA
TASIGNA	5	NM, PA
TUKYSA	5	NM, LA, PA
TURALIO	5	NM, LA, 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

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
ZYKADIA	5	NM, LA, PA
MISCELLANEOUS		
<i>bexarotene</i>	5	NM, PA
<i>hydroxyurea</i> CAPS	2	
LONSURF	5	NM, PA
MATULANE	5	LA
SYLATRON	5	PA
SYNRIBO	5	NM, PA
TAZVERIK	5	NM, LA, PA
<i>tretinoin (chemotherapy)</i>	5	
XPOVIO 40 MG ONCE WEEKLY	5	NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY	5	NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY	5	NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY	5	NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY	5	NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY	5	NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY	5	NM, LA, PA
PLATINUM-BASED AGENTS		
<i>carboplatin</i>	3	B/D
<i>cisplatin</i> SOLN	3	B/D
<i>oxaliplatin inj 50mg</i>	5	B/D
<i>oxaliplatin inj 50mg/10ml</i>	4	B/D
<i>oxaliplatin inj 100mg</i>	5	B/D
<i>oxaliplatin inj 100mg/20ml</i>	4	B/D
PROTECTIVE AGENTS		
<i>leucovorin calcium</i> SOLN 500mg/50ml	4	B/D
<i>leucovorin calcium</i> SOLR	4	B/D
<i>leucovorin calcium</i> TABS 5mg, 10mg	3	
<i>leucovorin calcium</i> TABS 15mg, 25mg	4	
MESNEX TABS	5	
TOPOISOMERASE INHIBITORS		
<i>etoposide</i> SOLN	3	B/D
<i>irinotecan hcl</i>	4	B/D
<i>toposar</i>	3	B/D
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	GC
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	GC
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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 besylate-benazepril hcl cap 5-40 mg</i>	1	GC
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	GC
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	GC
<i>benazepril & hydrochlorothiazide</i>	1	GC
<i>captopril & hydrochlorothiazide</i>	1	GC
<i>enalapril maleate & hydrochlorothiazide</i>	1	GC
<i>fosinopril sodium & hydrochlorothiazide</i>	1	GC
<i>lisinopril & hydrochlorothiazide</i>	1	GC
<i>quinapril-hydrochlorothiazide</i>	1	GC
ACE INHIBITORS		
<i>benazepril hcl TABS</i>	1	GC
<i>captopril TABS</i>	1	GC
<i>enalapril maleate TABS</i>	1	GC
<i>fosinopril sodium</i>	1	GC
<i>lisinopril TABS</i>	1	GC
<i>moexipril hcl</i>	1	GC
<i>perindopril erbumine</i>	1	GC
<i>quinapril hcl</i>	1	GC
<i>ramipril</i>	1	GC
<i>trandolapril</i>	1	GC
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i>	3	
<i>spironolactone TABS</i>	1	GC
ALPHA BLOCKERS		
<i>doxazosin mesylate TABS</i>	2	
<i>prazosin hcl</i>	3	
<i>terazosin hcl 1mg, 2mg, 5mg</i>	1	GC
<i>terazosin hcl 10mg</i>	2	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-olmesartan medoxomil</i>	1	GC
<i>amlodipine besylate-valsartan tab</i>	1	GC
<i>amlodipine-valsartan-hydrochlorothiazide tab</i>	1	GC
ENTRESTO	3	
<i>irbesartan-hydrochlorothiazide</i>	1	GC
<i>losartan-hydrochlorothiazide</i>	1	GC
<i>olmesartan medoxomil-amlodipine-hydrochlorothiazide</i>	1	GC
<i>olmesartan medoxomil-hydrochlorothiazide</i>	1	GC
<i>valsartan-hydrochlorothiazide</i>	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>irbesartan</i>	1	GC
<i>losartan potassium</i> TABS	1	GC
<i>olmesartan medoxomil</i> TABS	1	GC
<i>telmisartan</i>	1	GC
<i>valsartan</i>	1	GC
ANTIARRHYTHMICS		
<i>amiodarone hcl soln</i>	2	
<i>amiodarone tab 100mg</i>	4	
<i>amiodarone tab 200mg</i>	1	GC
<i>amiodarone tab 400mg</i>	4	
<i>disopyramide phosphate</i>	4	
<i>dofetilide</i>	4	
<i>flecainide acetate</i>	3	
MULTAQ	4	
NORPACE CR	4	
<i>pacerone 100mg, 400mg</i>	4	
<i>pacerone 200mg</i>	1	GC
<i>propafenone hcl</i>	2	
<i>propafenone hcl 12hr</i>	4	
<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	1	GC
<i>lovastatin</i>	1	GC
<i>pravastatin sodium</i>	1	GC
<i>rosuvastatin calcium</i>	1	GC, QL (30 tabs / 30 days)
<i>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>simvastatin</i> TABS 80mg	1	GC, QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
<i>cholestyramine</i>	3	
<i>cholestyramine light pack</i>	4	
<i>cholestyramine light powd</i>	3	
<i>colesevelam hcl</i>	4	
<i>colestipol hcl gran</i>	4	
<i>colestipol hcl pack</i>	4	
<i>colestipol hcl tabs</i>	3	
<i>ezetimibe</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>fenofibrate</i> TABS 48mg, 54mg, 145mg, 160mg	3	
<i>fenofibrate micronized</i> 67mg, 134mg, 200mg	3	
<i>gemfibrozil</i> TABS	1	GC
JUXTAPID	5	NM, LA, PA
<i>niacin (antihyperlipidemic)</i>	4	
<i>niacin er (antihyperlipidemic)</i> 500mg	4	QL (60 tabs / 30 days)
<i>niacin er (antihyperlipidemic)</i> 750mg, 1000mg	4	
<i>niacor</i>	4	
PRALUENT	3	NM, PA
<i>prevalite</i> PACK	4	
<i>prevalite</i> POWD	3	
VASCEPA	4	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol & chlorthalidone</i>	2	
<i>bisoprolol & hydrochlorothiazide</i>	1	GC
<i>metoprolol & hydrochlorothiazide</i>	3	
<i>propranolol & hydrochlorothiazide</i>	3	
BETA-BLOCKERS		
<i>acebutolol hcl</i> CAPS	2	
<i>atenolol</i> TABS	1	GC
<i>bisoprolol fumarate</i>	2	
BYSTOLIC 2.5mg, 5mg, 10mg	4	QL (30 tabs / 30 days)
BYSTOLIC 20mg	4	QL (60 tabs / 30 days)
<i>carvedilol</i>	1	GC
<i>labetalol hcl</i> TABS	3	
<i>metoprolol succinate</i>	2	
<i>metoprolol tartrate</i> SOCT	3	
<i>metoprolol tartrate</i> SOLN	3	
<i>metoprolol tartrate</i> TABS 25mg, 50mg, 100mg	1	GC
<i>nadolol</i> TABS	3	
<i>pindolol</i>	3	
<i>propranolol cap er</i>	3	
<i>propranolol hcl</i> TABS	2	
<i>propranolol oral sol</i>	3	
<i>timolol maleate</i> TABS	3	
CALCIUM CHANNEL BLOCKERS		
<i>amlodipine besylate</i> TABS	1	GC
<i>cartia xt</i>	2	
<i>dilt-xr cap</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>diltiazem cap 240mg cd</i>	2	
<i>diltiazem cap 360mg cd</i>	4	
<i>diltiazem cap er/12hr</i>	4	
<i>diltiazem hcl TABS</i>	2	
<i>diltiazem hcl coated beads CP24</i>	4	
<i>diltiazem hcl coated beads cap sr 24hr</i>	2	
<i>diltiazem hcl extended release beads cap sr</i>	2	
<i>diltiazem inj</i>	2	
<i>felodipine</i>	2	
<i>isradipine</i>	3	
<i>nicardipine hcl CAPS</i>	4	
<i>nifedipine TB24</i>	2	
<i>nifedipine er</i>	2	
<i>nimodipine CAPS</i>	5	
NYMALIZE	5	
<i>taztia xt</i>	2	
<i>tiadyt er</i>	2	
<i>verapamil cap er 100mg, 200mg, 300mg, 360mg</i>	4	
<i>verapamil cap er 120mg, 180mg, 240mg</i>	3	
<i>verapamil hcl SOLN</i>	4	
<i>verapamil hcl TABS</i>	1	GC
<i>verapamil hcl TBCR</i>	2	
<i>verapamil tab er</i>	2	
<i>DIGITALIS GLYCOSIDES</i>		
<i>digitek .25mg</i>	2	PA; PA if 70 years and older
<i>digitek .125mg</i>	2	QL (30 tabs / 30 days)
<i>digox 125mcg</i>	2	QL (30 tabs / 30 days)
<i>digox 250mcg</i>	2	PA; PA if 70 years and older
<i>digoxin TABS 125mcg</i>	2	QL (30 tabs / 30 days)
<i>digoxin TABS 250mcg</i>	2	PA; PA if 70 years and older
<i>digoxin inj</i>	4	
<i>digoxin sol 50mcg/ml</i>	4	PA; PA if 70 years and older
<i>DIURETICS</i>		
<i>acetazolamide CP12</i>	4	
<i>acetazolamide TABS</i>	3	
<i>amiloride & hydrochlorothiazide</i>	2	
<i>amiloride hcl 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>bumetanide inj 0.25/ml</i>	3	
<i>bumetanide tab</i>	3	
<i>chlorothiazide TABS</i>	3	
<i>chlorthalidone</i>	2	
<i>furosemide SOLN</i>	2	
<i>furosemide TABS</i>	1	GC
<i>furosemide inj</i>	2	
<i>hydrochlorothiazide CAPS; TABS</i>	1	GC
<i>indapamide</i>	2	
<i>methazolamide TABS</i>	4	
<i>metolazone</i>	3	
<i>spironolactone & hydrochlorothiazide</i>	3	
<i>torseamide tabs</i>	2	
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	GC
<i>triamterene & hydrochlorothiazide tabs</i>	1	GC
MISCELLANEOUS		
<i>aliskiren fumarate</i>	4	
<i>clonidine hcl TABS</i>	1	GC
<i>clonidine hcl ptwk</i>	4	
CORLANOR	4	
DEMSER	5	PA
<i>hydralazine hcl SOLN</i>	4	
<i>hydralazine hcl TABS</i>	2	
<i>midodrine hcl</i>	3	
<i>minoxidil TABS</i>	2	
NORTHERA 100mg	5	QL (90 caps / 30 days), NM, LA, PA
NORTHERA 200mg, 300mg	5	QL (180 caps / 30 days), NM, LA, PA
<i>ranolazine</i>	4	
NITRATES		
<i>isosorb mononitrate tab</i>	2	
<i>isosorbide dinitrate 5mg, 10mg, 20mg, 30mg</i>	3	
<i>isosorbide mononitrate er</i>	1	GC
<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>	3	
<i>nitroglycerin td patch</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
<u>PULMONARY ARTERIAL HYPERTENSION</u>		
ADEMPAS	5	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i>	5	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan</i> 62.5mg	5	QL (120 tabs / 30 days), NM, LA, PA
<i>bosentan</i> 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT	5	QL (30 tabs / 30 days), NM, LA, PA
<i>sildenafil citrate tab 20 mg (pulmonary hypertension)</i>	3	QL (90 tabs / 30 days), NM, PA
<i>treprostinil</i>	5	NM, LA, PA
VENTAVIS	5	NM, PA

CENTRAL NERVOUS SYSTEM

ANTI-ANXIETY

<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 2 mg</i>	2	QL (150 tabs / 30 days)
<i>bupirone hcl</i> TABS 5mg, 10mg, 15mg	1	GC
<i>bupirone hcl</i> TABS 7.5mg, 30mg	3	
<i>fluvoxamine maleate</i> TABS	2	
<i>lorazepam</i> SOLN	2	
<i>lorazepam</i> TABS	2	QL (150 tabs / 30 days)
<i>lorazepam intensol</i>	3	QL (150 mL / 30 days)

ANTICONVULSANTS

APTIOM	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</i> CHEW; TABS	3	
<i>carbamazepine</i> CP12; SUSP; TB12	4	
CELONTIN	4	
<i>clobazam</i>	4	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>clonazepam</i> TABS 2mg	2	QL (300 tabs / 30 days)
<i>clonazepam</i> TABS .5mg, 1mg	2	QL (90 tabs / 30 days)
<i>clonazepam</i> TBDP 2mg	3	QL (300 tabs / 30 days)
<i>clonazepam</i> TBDP .125mg, .25mg, .5mg, 1mg	3	QL (90 tabs / 30 days)
<i>clorazepate dipotassium</i>	4	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIASTAT ACUDIAL	4	
DIASTAT PEDIATRIC	4	
<i>diazepam</i> TABS	2	QL (120 tabs / 30 days), PA; PA if 65 years and older
<i>diazepam gel</i>	4	
<i>diazepam inj</i>	3	
<i>diazepam intensol</i>	3	QL (240 mL / 30 days), PA; PA if 65 years and older
<i>diazepam oral soln 1 mg/ml</i>	3	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	4	
<i>divalproex sodium</i> TB24; TBEC	3	
EPIDIOLEX	5	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i>	3	
<i>ethosuximide</i> CAPS; SOLN	4	
<i>felbamate</i> SUSP	5	
<i>felbamate</i> TABS	4	
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	2	QL (1080 caps / 30 days)
<i>gabapentin</i> CAPS 300mg	2	QL (360 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>gabapentin</i> CAPS 400mg	2	QL (270 caps / 30 days)
<i>gabapentin</i> SOLN	3	QL (2160 mL / 30 days)
<i>gabapentin</i> TABS 600mg	3	QL (180 tabs / 30 days)
<i>gabapentin</i> TABS 800mg	3	QL (120 tabs / 30 days)
<i>lamotrigine</i> CHEW	3	
<i>lamotrigine</i> TABS	1	GC
<i>lamotrigine</i> TB24	4	
<i>levetiracetam</i> SOLN	4	
<i>levetiracetam</i> TABS	2	
<i>levetiracetam</i> TB24	3	
<i>levetiracetam in sodium chloride</i>	4	
<i>levetiracetam oral soln 100 mg/ml</i>	3	
NAYZILAM	4	
<i>oxcarbazepine</i> SUSP	4	
<i>oxcarbazepine</i> TABS	3	
PEGANONE	4	
<i>phenobarbital</i> ELIX	4	PA; PA if 70 years and older
<i>phenobarbital</i> TABS	3	PA; PA if 70 years and older
<i>phenobarbital sodium</i> SOLN	4	PA; PA if 70 years and older
PHENYTEK	3	
<i>phenytoin</i> CHEW; SUSP	3	
<i>phenytoin sodium extended</i>	3	
<i>phenytoin sodium inj 50mg/ml</i>	3	
<i>pregabalin</i> CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days), PA
<i>pregabalin</i> CAPS 200mg	3	QL (90 caps / 30 days), PA
<i>pregabalin</i> CAPS 225mg, 300mg	3	QL (60 caps / 30 days), PA
<i>pregabalin</i> SOLN	4	QL (900 mL / 30 days), PA
<i>primidone</i> TABS	2	
<i>roweepra</i>	2	
<i>roweepra xr</i>	3	
SPRITAM	4	
<i>subvenite tab</i>	1	GC
SYMPAZAN 5mg	4	PA
SYMPAZAN 10mg, 20mg	5	PA
<i>tiagabine hcl</i>	4	
<i>topiramate</i> CPSP	3	
<i>topiramate</i> TABS	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>valproate sodium SOLN</i>	3	
<i>valproate sodium oral soln</i>	3	
<i>valproic acid CAPS</i>	3	
VALTOCO	4	
<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	
VIMPAT SOL 10MG/ML	5	QL (1200 mL / 30 days)
XCOPRI MAINTENANCE PAK 150-200MG	5	QL (56 tabs / 28 days)
XCOPRI PAK 12.5-25MG	4	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	5	QL (28 tabs / 28 days)
XCOPRI PAK 50-200MG	5	QL (56 tabs / 28 days)
XCOPRI TABS 50mg	5	QL (90 tabs / 30 days)
XCOPRI TABS 100mg, 150mg, 200mg	5	QL (60 tabs / 30 days)
XCOPRI TITRATION PAK 150-200MG	5	QL (28 tabs / 28 days)
<i>zonisamide CAPS</i>	2	

ANTIDEMENTIA

<i>donepezil hydrochloride TABS 5mg</i>	2	QL (30 tabs / 30 days)
<i>donepezil hydrochloride TABS 10mg</i>	2	
<i>donepezil hydrochloride TBDP 5mg</i>	2	QL (30 tabs / 30 days)
<i>donepezil hydrochloride TBDP 10mg</i>	2	
<i>galantamine hydrobromide SOLN</i>	4	
<i>galantamine hydrobromide TABS</i>	3	QL (60 tabs / 30 days)
<i>galantamine hydrobromide er</i>	3	QL (30 caps / 30 days)
<i>memantine hcl cp24</i>	4	PA; PA if < 30 yrs
<i>memantine soln</i>	4	PA; PA if < 30 yrs
<i>memantine tabs</i>	3	PA; PA if < 30 yrs
NAMZARIC	4	
<i>rivastigmine tartrate 1.5mg, 3mg</i>	4	QL (90 caps / 30 days)
<i>rivastigmine tartrate 4.5mg, 6mg</i>	4	QL (60 caps / 30 days)
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	4	QL (30 patches / 30 days)
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	4	QL (30 patches / 30 days)
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	4	QL (30 patches / 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
ANTIDEPRESSANTS		
<i>amitriptyline hcl</i> TABS	3	
<i>amoxapine</i>	3	
<i>bupropion hcl</i> TABS	3	
<i>bupropion hcl</i> TB12	2	
<i>bupropion hcl</i> TB24 150mg, 300mg	3	
<i>citalopram hydrobromide</i> SOLN	3	
<i>citalopram hydrobromide</i> TABS	1	GC
<i>clomipramine hcl</i> CAPS	4	PA
<i>desipramine hcl</i> TABS	4	
<i>desvenlafaxine succinate</i>	4	QL (30 tabs / 30 days), PA
<i>doxepin hcl</i> CAPS; CONC	3	
DRIZALMA SPRINKLE 20mg, 30mg, 60mg	4	QL (60 caps / 30 days), PA
DRIZALMA SPRINKLE 40mg	4	QL (90 caps / 30 days), PA
<i>duloxetine hcl</i> CPEP 20mg, 30mg, 60mg	3	QL (60 caps / 30 days)
EMSAM	5	QL (30 patches / 30 days), PA
<i>escitalopram oxalate</i> SOLN	4	
<i>escitalopram oxalate</i> TABS	1	GC
FETZIMA 20mg, 40mg	4	QL (60 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	GC
<i>fluoxetine cap 20mg</i>	1	GC
<i>fluoxetine cap 40mg</i>	2	
<i>fluoxetine hcl</i> SOLN	2	
<i>imipramine hcl</i> TABS	2	
<i>maprotiline hcl</i>	3	
MARPLAN TAB 10MG	4	QL (180 tabs / 30 days)
<i>mirtazapine</i> TABS 7.5mg	3	
<i>mirtazapine</i> TABS 15mg, 30mg, 45mg	1	GC
<i>mirtazapine</i> TBDP	3	
<i>nefazodone hcl</i>	4	
<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	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
<i>protriptyline hcl</i>	4	
<i>sertraline hcl</i> CONC	4	
<i>sertraline hcl</i> TABS	1	GC
<i>tranylcypromine sulfate</i>	4	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	GC
<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; TABS	2	
VIIBRYD STARTER PACK	4	
VIIBRYD TAB	4	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
<i>amantadine hcl</i> CAPS	3	QL (120 caps / 30 days)
<i>amantadine hcl</i> SYRP	2	
<i>amantadine hcl</i> TABS	3	
APOKYN	5	QL (20 cartridges / 30 days), NM, LA, PA
<i>benztropine mesylate inj</i>	4	
<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	4	
<i>carbidopa-levodopa</i> TABS	2	
<i>carbidopa-levodopa</i> TBCR	3	
<i>carbidopa-levodopa</i> TBDP	4	
<i>carbidopa/levodopa/entacapone</i>	4	
<i>entacapone</i>	4	
NEUPRO	4	
<i>pramipexole tab 0.5mg</i>	1	GC
<i>pramipexole tab 0.25mg</i>	1	GC
<i>pramipexole tab 0.75mg</i>	1	GC
<i>pramipexole tab 0.125mg</i>	1	GC
<i>pramipexole tab 1.5mg</i>	1	GC
<i>pramipexole tab 1mg</i>	1	GC
<i>rasagiline mesylate</i> TABS	4	
<i>ropinirole tab 0.5mg</i>	2	
<i>ropinirole tab 0.25mg</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>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 CAPS; TABS</i>	3	
<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)
<i>aripiprazole tab</i>	4	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	
CAPLYTA	4	QL (30 caps / 30 days)
<i>chlorpromazine hcl TABS</i>	4	
CHLORPROMAZINE INJ	4	
<i>clozapine odt 12.5mg, 25mg</i>	4	PA
<i>clozapine odt 100mg</i>	4	QL (270 tabs / 30 days), PA
<i>clozapine odt 150mg</i>	4	QL (180 tabs / 30 days), PA
<i>clozapine odt 200mg</i>	4	QL (135 tabs / 30 days), PA
<i>clozapine tab 25mg</i>	3	
<i>clozapine tab 50mg</i>	3	
<i>clozapine tab 100mg</i>	4	QL (270 tabs / 30 days)
<i>clozapine tab 200mg</i>	4	QL (135 tabs / 30 days)
FANAPT	4	QL (60 tabs / 30 days), PA
FANAPT TITRATION PACK	4	PA
<i>fluphenazine decanoate SOLN</i>	4	
<i>fluphenazine hcl</i>	4	
GEODON SOLR	4	QL (6 mL / 3 days)
<i>haloperidol TABS</i>	3	
<i>haloperidol conc 2mg/ml</i>	2	
<i>haloperidol decanoate SOLN</i>	3	
<i>haloperidol lactate inj 5mg/ml</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
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, 40mg, 60mg, 120mg	4	QL (30 tabs / 30 days)
LATUDA 80mg	4	QL (60 tabs / 30 days)
<i>loxapine succinate</i>	3	
<i>molindone hcl</i>	4	
NUPLAZID CAPS	5	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10MG	5	QL (30 tabs / 30 days), NM, LA, PA
<i>olanzapine SOLR</i>	4	QL (3 vials / 1 day)
<i>olanzapine TABS 2.5mg, 5mg, 10mg</i>	2	QL (60 tabs / 30 days)
<i>olanzapine TABS 7.5mg, 15mg, 20mg</i>	2	QL (30 tabs / 30 days)
<i>olanzapine TBDP 5mg, 15mg, 20mg</i>	4	QL (30 tabs / 30 days)
<i>olanzapine TBDP 10mg</i>	4	QL (60 tabs / 30 days)
<i>paliperidone 1.5mg, 3mg, 9mg</i>	4	QL (30 tabs / 30 days)
<i>paliperidone 6mg</i>	4	QL (60 tabs / 30 days)
<i>perphenazine TABS</i>	3	
PERSERIS	5	QL (1 injection / 30 days)
<i>pimozide</i>	4	
<i>quetiapine fumarate TABS</i>	2	
<i>quetiapine fumarate TB24 50mg, 300mg, 400mg</i>	4	QL (60 tabs / 30 days), PA
<i>quetiapine fumarate TB24 150mg, 200mg</i>	4	QL (30 tabs / 30 days), PA
REXULTI 3mg, 4mg	5	QL (30 tabs / 30 days)
REXULTI .25mg, .5mg, 1mg, 2mg	5	QL (60 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)

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
RISPERDAL INJ 50MG	5	QL (2 injections / 28 days)
<i>risperidone</i> SOLN	3	QL (240 mL / 30 days)
<i>risperidone</i> TABS	2	
<i>risperidone</i> TBDP 1mg, 2mg, 3mg, 4mg	4	QL (60 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, .5mg	4	QL (90 tabs / 30 days)
SAPHRIS	4	QL (60 tabs / 30 days)
SECUADO	4	QL (30 patches / 30 days)
<i>thioridazine hcl</i> TABS	3	
<i>thiothixene</i>	4	
<i>trifluoperazine hcl</i>	3	
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>	4	QL (60 caps / 30 days)
<i>ziprasidone mesylate</i>	4	QL (6 injections / 3 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 24hr 5 mg</i>	4	QL (90 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 10 mg</i>	4	QL (90 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 15 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 20 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 25 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine cap sr 24hr 30 mg</i>	4	QL (30 caps / 30 days)
<i>amphetamine-dextroamphetamine tab 5 mg</i>	3	QL (120 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	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
<i>amphetamine-dextroamphetamine tab 10 mg</i>	3	QL (120 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	3	QL (120 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 15 mg</i>	3	QL (90 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 20 mg</i>	3	QL (90 tabs / 30 days)
<i>amphetamine-dextroamphetamine tab 30 mg</i>	3	QL (60 tabs / 30 days)
<i>atomoxetine hcl 10mg, 18mg, 25mg</i>	4	QL (120 caps / 30 days)
<i>atomoxetine hcl 40mg</i>	4	QL (60 caps / 30 days)
<i>atomoxetine hcl 60mg, 80mg, 100mg</i>	4	QL (30 caps / 30 days)
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i>	3	QL (120 tabs / 30 days)
<i>dexmethylphenidate hcl TABS 10mg</i>	3	QL (60 tabs / 30 days)
<i>guanfacine er (adhd)</i>	3	PA; PA if 70 years and older
<i>metadate er tab 20mg</i>	4	QL (90 tabs / 30 days)
<i>methylphenidate hcl TABS 5mg, 10mg</i>	3	QL (180 tabs / 30 days)
<i>methylphenidate hcl TABS 20mg</i>	3	QL (90 tabs / 30 days)
<i>methylphenidate hcl oral soln 5mg/5ml</i>	4	QL (1800 mL / 30 days)
<i>methylphenidate hcl oral soln 10mg/5ml</i>	4	QL (900 mL / 30 days)
<i>methylphenidate hcl tbc 10 mg</i>	4	QL (90 tabs / 30 days)
<i>methylphenidate hcl tbc 20mg</i>	4	QL (90 tabs / 30 days)

HYPNOTICS

<i>BELSOMRA</i>	4	QL (30 tabs / 30 days)
<i>doxepin hcl (sleep)</i>	3	QL (30 tabs / 30 days)
<i>HETLIOZ</i>	5	NM, LA, PA
<i>temazepam 7.5mg</i>	4	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>	4	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), NM, PA
<i>dihydroergotamine mesylate inj 1 mg/ml</i>	5	
<i>dihydroergotamine mesylate nasal spr 4 mg/ml</i>	5	QL (8 mL / 30 days), PA
<i>eletriptan hydrobromide</i>	4	QL (12 tabs / 30 days)
EMGALITY SOAJ	3	QL (2 pens / 30 days), NM, PA
EMGALITY SOSY 120mg/ml	3	QL (2 syringes / 30 days), NM, PA
<i>ergotamine w/ caffeine TABS</i>	4	
<i>naratriptan hcl</i>	3	QL (12 tabs / 30 days)
<i>rizatriptan benzoate</i>	3	QL (18 tabs / 30 days)
<i>rizatriptan benzoate odt</i>	3	QL (18 tabs / 30 days)
<i>sumatriptan SOLN 5mg/act</i>	4	QL (24 inhalers / 30 days)
<i>sumatriptan SOLN 20mg/act</i>	4	QL (12 inhalers / 30 days)
<i>sumatriptan inj 4mg/0.5ml</i>	4	QL (18 injections / 30 days)
<i>sumatriptan inj 6mg/0.5ml</i>	4	QL (12 injections / 30 days)
<i>sumatriptan succinate TABS</i>	2	QL (12 tabs / 30 days)
<i>zolmitriptan TABS</i>	4	QL (12 tabs / 30 days)
<i>zolmitriptan odt</i>	4	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO 6mg	5	QL (60 tabs / 30 days), NM, PA
AUSTEDO 9mg, 12mg	5	QL (120 tabs / 30 days), NM, PA
INGREZZA CAPS	5	QL (30 caps / 30 days), NM, PA
INGREZZA CPPK	5	QL (28 caps / 28 days), NM, PA
<i>lithium carbonate CAPS</i>	1	GC
<i>lithium carbonate TABS</i>	2	
<i>lithium carbonate er</i>	2	
LITHIUM SOLN 8MEQ/5ML	4	
LYRICA CR	3	QL (60 tabs / 30 days), PA
NUEDEXTA	4	QL (60 caps / 30 days), PA
<i>pyridostigmine tab 60mg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>riluzole</i>	3	
<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> TB12	5	NM, PA
GILENYA	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	3	
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	3	PA; PA if 70 years and older
<i>dantrolene sodium</i> CAPS	4	
<i>tizanidine hcl</i> TABS	2	
NARCOLEPSY/CATAPLEXY		
<i>armodafinil</i> 50mg	3	QL (90 tabs / 30 days), PA
<i>armodafinil</i> 150mg, 200mg, 250mg	3	QL (30 tabs / 30 days), PA
XYREM	5	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
<i>acamprosate calcium</i>	4	
<i>buprenorphine hcl</i> SUBL	3	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 2-0.5mg	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 4-1mg	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 8-2mg	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl dihydrate</i> 12-3mg	4	QL (60 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 sl</i>	2	QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent)</i>	3	
CHANTIX	4	PA
CHANTIX CONTINUING MONTH	4	PA
CHANTIX STARTER PACK	4	PA
<i>disulfiram</i> TABS	3	
<i>naloxone inj 0.4mg/ml</i>	2	
<i>naloxone inj 1mg/ml</i>	2	
<i>naltrexone hcl</i> TABS	3	
NARCAN	3	
NICOTROL INHALER	4	
NICOTROL NS	4	
VIVITROL	5	NM

ENDOCRINE AND METABOLIC

ANDROGENS

ANADROL-50	5	PA
ANDRODERM	4	QL (30 patches / 30 days), PA
<i>oxandrolone tab 2.5mg</i>	3	PA
<i>oxandrolone tab 10mg</i>	4	PA
<i>testosterone</i> GEL 1%, 25mg/2.5gm, 50mg/5gm	4	QL (300 grams / 30 days), PA
<i>testosterone cypionate</i> SOLN	3	PA
<i>testosterone enanthate</i> SOLN	3	PA

ANTIDIABETICS, INJECTABLE

BASAGLAR KWIKPEN	3	
BD ALCOHOL SWABS	3	
BD ULTRAFINE INSULIN SYRINGE	3	
BD ULTRAFINE/NANO PEN NEEDLES	3	
BYDUREON BCISE	3	QL (4 pens / 28 days)
BYDUREON PEN	3	QL (4 pens / 28 days)
BYETTA	4	QL (1 pen / 30 days)
FIASP	3	
FIASP FLEXTOUCH	3	
FIASP PENFILL	3	
GAUZE PADS 2" X 2"	3	
HUMULIN R INJ U-500	5	B/D
HUMULIN R U-500 KWIKPEN	5	
INSULIN PEN NEEDLE	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGE	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	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
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 N FLEXPEN	3	(brand RELION not covered)
NOVOLIN R	3	(brand RELION not covered)
NOVOLIN R FLEXPEN	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	3	GC
FARXIGA	3	GC, QL (30 tabs / 30 days)
<i>glimepiride</i> 1mg, 2mg	2	QL (90 tabs / 30 days)
<i>glimepiride</i> 4mg	2	QL (60 tabs / 30 days)
<i>glip/metform tab 2.5-250mg</i>	1	GC, QL (240 tabs / 30 days)
<i>glip/metform tab 2.5-500mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glip/metform tab 5-500mg</i>	1	GC, QL (120 tabs / 30 days)
<i>glipizide</i> TABS 5mg	1	GC, QL (240 tabs / 30 days)
<i>glipizide</i> TABS 10mg	1	GC, QL (120 tabs / 30 days)
<i>glipizide</i> TB24 2.5mg, 5mg	1	GC, QL (90 tabs / 30 days)

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> TB24 10mg	1	GC, QL (60 tabs / 30 days)
<i>glipizide xl</i> 2.5mg, 5mg	1	GC, QL (90 tabs / 30 days)
<i>glipizide xl</i> 10mg	1	GC, QL (60 tabs / 30 days)
GLYXAMBI	3	GC, QL (30 tabs / 30 days)
JANUMET	3	GC, QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	GC, QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	3	GC, QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	GC, QL (30 tabs / 30 days)
JANUVIA	3	GC, QL (30 tabs / 30 days)
JARDIANCE 10mg	3	GC, QL (60 tabs / 30 days)
JARDIANCE 25mg	3	GC, QL (30 tabs / 30 days)
JENTADUETO	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000 MG	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000 MG	3	GC, QL (30 tabs / 30 days)
<i>metformin er</i> 500mg	1	GC, QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin er</i> 750mg	1	GC, QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl</i> TABS 500mg	1	GC, QL (150 tabs / 30 days)
<i>metformin hcl</i> TABS 850mg	1	GC, QL (90 tabs / 30 days)
<i>metformin hcl</i> TABS 1000mg	1	GC, QL (75 tabs / 30 days)
<i>nateglinide</i>	1	GC, QL (90 tabs / 30 days)
<i>pioglitazone hcl</i>	1	GC, QL (30 tabs / 30 days)
<i>repaglinide</i> 2mg	1	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>repaglinide</i> .5mg, 1mg	1	GC, QL (120 tabs / 30 days)
RYBELSUS	3	GC, QL (30 tabs / 30 days)
SYNJARDY TAB 5-500MG	3	GC, QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000MG	3	GC, QL (30 tabs / 30 days)
TRADJENTA	3	GC, QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	3	GC, QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 10-5-1000 MG	3	GC, QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	3	GC, QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000 MG	3	GC, QL (30 tabs / 30 days)
XIGDUO XR TAB 2.5-1000MG	3	GC, QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	GC, QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	GC, QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	GC, QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000MG	3	GC, QL (30 tabs / 30 days)
BISPHOSPHONATES		
<i>alendronate sodium tab 5 mg</i>	1	GC
<i>alendronate sodium tab 10 mg</i>	1	GC
<i>alendronate sodium tab 35 mg</i>	1	GC
<i>alendronate sodium tab 40 mg</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>alendronate sodium tab 70 mg</i>	1	GC
<i>ibandronate sodium tabs</i>	3	B/D
PAMIDRONATE DISODIUM 6mg/ml	3	B/D
<i>pamidronate disodium 30mg/10ml, 90mg/10ml</i>	3	B/D
<i>pamidronate inj 30mg</i>	3	B/D
<i>pamidronate inj 90mg</i>	3	B/D
<i>zoledronic acid inj 4mg/100ml</i>	4	B/D, NM
<i>zoledronic acid inj 5mg/100ml</i>	4	B/D, NM
<i>zoledronic inj 4mg/5ml</i>	4	B/D, NM

CHELATING AGENTS

CHEMET	4	
<i>clovique</i>	5	PA
<i>deferasirox tab</i>	5	NM, PA
JADENU 180mg	5	NM, LA, PA
JADENU SPRINKLE	5	NM, LA, PA
<i>kionex sus 15gm/60ml</i>	3	
LOKELMA	3	
<i>penicillamine TABS</i>	5	
<i>sodium polystyrene sulfonate powder</i>	3	
<i>sodium polystyrene sulfonate susp</i>	3	
<i>sps susp 15gm/60ml</i>	3	
<i>trientine hcl</i>	5	PA
VELTASSA	4	LA, PA

CONTRACEPTIVES

<i>altavera tab</i>	2	
<i>alyacen 1/35</i>	2	
<i>apri</i>	2	
<i>aranelle</i>	3	
<i>aubra</i>	2	
<i>aviane</i>	2	
<i>balziva</i>	3	
<i>bekyree</i>	3	
<i>blisovi fe 1.5/30</i>	2	
<i>briellyn</i>	3	
<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	

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>deblitane</i>	2	
<i>desogestrel & ethinyl estradiol</i>	2	
<i>desogestrel-ethinyl estradiol (biphasic)</i>	3	
<i>drospirenone-ethinyl estradiol</i>	3	
<i>ELLA</i>	3	
<i>eluryng</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>	3	
<i>etonogestrel-ethinyl estradiol</i>	4	
<i>falmina</i>	2	
<i>femynor</i>	2	
<i>gianvi tab 3-0.02mg</i>	3	
<i>heather</i>	2	
<i>incassia</i>	2	
<i>introvale</i>	3	
<i>isibloom</i>	2	
<i>jasmiel</i>	3	
<i>jolessa tab 0.15-0.03 mg</i>	3	
<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>	3	
<i>kelnor 1/35</i>	2	
<i>kelnor 1/50</i>	3	
<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 tab</i>	3	
<i>lessina</i>	2	
<i>levonest</i>	2	
<i>levonor/ethi tab</i>	2	
<i>levonorgestrel & eth estradiol</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>levonorgestrel-ethinyl estradiol (91-day)</i>	3	
<i>levora 0.15/30-28</i>	2	
<i>loryna</i>	3	
<i>low-ogestrel</i>	2	
<i>lutera</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>necon 0.5/35-28</i>	3	
<i>nikki</i>	3	
<i>nora-be tab 0.35mg</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>	3	
<i>norgestimate-ethinyl estradiol (triphasic) 0.18-35/0.215-35/0.25-35 mg-mcg</i>	2	
<i>nortrel 0.5/35 (28)</i>	3	
<i>nortrel 1/35</i>	2	
<i>nortrel 7/7/7</i>	2	
<i>ocella tab 3-0.03mg</i>	3	
<i>orsythia</i>	2	
<i>philith</i>	3	
<i>pimtrea</i>	3	
<i>pirmella 1/35</i>	2	
<i>portia-28</i>	2	
<i>previfem</i>	2	
<i>reclipsen</i>	2	
<i>setlakin tab</i>	3	
<i>sharobel</i>	2	
<i>sprintec 28</i>	2	
<i>sronyx</i>	2	
<i>syeda</i>	3	
<i>tarina fe 1/20</i>	2	
<i>tilia fe</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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-estarylla</i>	2	
<i>tri-legest fe</i>	3	
<i>tri-linyah</i>	2	
<i>tri-lo marzia</i>	3	
<i>tri-lo-estarylla</i>	3	
<i>tri-lo-sprintec</i>	3	
<i>tri-mili</i>	2	
<i>tri-previfem</i>	2	
<i>tri-sprintec</i>	2	
<i>tri-vylibra</i>	2	
<i>tri-vylibra lo</i>	3	
<i>trivora-28</i>	2	
<i>tulana</i>	2	
<i>velivet</i>	2	
<i>vienva</i>	2	
<i>viorele</i>	3	
<i>vyfemla</i>	3	
<i>vylibra</i>	2	
<i>xulane dis 150-35</i>	4	
<i>zarah</i>	3	
<i>zovia 1/35e</i>	2	
ENDOMETRIOSIS		
<i>danazol CAPS</i>	4	
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>	4	B/D
LUMIZYME	5	NM, LA, PA
<i>miglustat</i>	5	NM, PA
NAGLAZYME	5	NM, LA, PA
<i>nitisinone</i>	5	NM, PA
NITYR	5	NM, LA, PA
ORFADIN	5	NM, LA, PA
<i>sodium phenylbutyrate</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
ESTROGENS		
DELESTROGEN 10mg/ml	4	
<i>estradiol</i> PTWK	3	
<i>estradiol</i> TABS	2	
<i>estradiol vaginal cream</i>	3	
<i>estradiol vaginal tab</i>	4	
<i>estradiol valerate inj</i>	4	
<i>fyavolv</i>	3	
<i>jinteli</i>	3	
<i>norethindrone acetate-ethinyl estradiol</i>	3	
<i>yuvafem vaginal tablet 10mcg</i>	4	
GLUCOCORTICOIDS		
<i>cortisone acetate</i> TABS	4	
DEXAMETHASONE CONC	4	
<i>dexamethasone</i> ELIX; SOLN	3	
<i>dexamethasone</i> TABS	2	
<i>dexamethasone sodium phosphate</i>	2	
<i>fludrocortisone acetate</i> TABS	2	
<i>hydrocortisone</i> TABS	3	
<i>methylpr ss inj</i>	3	B/D
<i>methylpred pak 4mg</i>	2	
<i>methylpred tab 4mg</i>	3	B/D
<i>methylpred tab 8mg</i>	3	B/D
<i>methylpred tab 16mg</i>	3	B/D
<i>methylpred tab 32mg</i>	3	B/D
<i>methylprednisolone acetate</i>	2	B/D
<i>pred sod pho sol 5mg/5ml</i>	4	B/D
<i>prednisolone sodium phosphate</i> SOLN 15mg/5ml	2	B/D
<i>prednisolone sol 15mg/5ml</i>	2	B/D
<i>prednisolone sol 25mg/5ml</i>	4	B/D
PREDNISON CON 5MG/ML	4	B/D
<i>prednisone pak 5mg</i>	3	
<i>prednisone pak 10mg</i>	3	
<i>prednisone sol 5mg/5ml</i>	4	B/D
<i>prednisone tab 1mg</i>	1	GC, B/D
<i>prednisone tab 2.5mg</i>	1	GC, B/D
<i>prednisone tab 5mg</i>	1	GC, B/D
<i>prednisone tab 10mg</i>	1	GC, B/D
<i>prednisone tab 20mg</i>	1	GC, B/D
<i>prednisone tab 50mg</i>	1	GC, B/D
SOLU-CORTEF	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
GLUCOSE ELEVATING AGENTS		
<i>diazoxide</i> SUSP	4	
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
GVOKE HYPOPEN 2-PACK	3	
GVOKE PFS	3	
PROGLYCEM SUS 50MG/ML	4	
MISCELLANEOUS		
<i>cabergoline</i>	3	
<i>calcitonin (salmon)</i>	3	B/D
<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
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	4	NM, PA
<i>octreotide acetate</i> 500mcg/ml, 1000mcg/ml	5	NM, PA
OSPHENA	3	PA
PROLIA	4	QL (1 injection / 180 days), NM
<i>raloxifene tab</i> 60mg	3	
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

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>calcium acetate (phosphate binder)</i> CAPS	3	QL (360 caps / 30 days)
<i>calcium acetate (phosphate binder)</i> TABS	3	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	4	QL (540 tabs / 30 days)

PROGESTINS

<i>medroxyprogesterone acetate tab</i>	1	GC
<i>norethindrone acetate</i> TABS	3	

THYROID AGENTS

<i>euthyrox</i>	2	
<i>levo-t</i>	2	
<i>levothyroxine sodium</i> TABS	2	
<i>levoxyl</i>	2	
<i>liothyronine sodium</i> TABS	3	
<i>methimazole</i> TABS	1	GC
<i>propylthiouracil</i> TABS	3	
SYNTHROID	4	
<i>unithroid</i>	2	

VASOPRESSINS

<i>desmopressin acetate spray</i>	4	
<i>desmopressin acetate spray refrigerated</i>	4	
<i>desmopressin acetate tabs</i>	3	
<i>desmopressin inj 4mcg/ml</i>	4	
STIMATE	5	NM

GASTROINTESTINAL

ANTIEMETICS

<i>aprepitant</i>	4	B/D
<i>aprepitant pak 80mg & 125mg</i>	4	B/D
<i>compro supp</i>	4	
<i>dronabinol</i>	4	B/D, QL (60 caps / 30 days)
EMEND SUSR	4	B/D
<i>granisetron hcl</i> SOLN	3	
<i>granisetron hcl</i> TABS	4	B/D
<i>meclizine hcl</i> TABS	2	
<i>metoclopramide hcl</i> SOLN	2	
<i>metoclopramide hcl</i> TABS	1	GC
<i>metoclopramide hcl inj</i>	2	
<i>ondansetron hcl</i> TABS	3	B/D
<i>ondansetron hcl inj</i>	2	
<i>ondansetron hcl oral soln</i>	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
<i>ondansetron odt</i>	2	B/D
<i>prochlorperazine inj</i>	4	
<i>prochlorperazine maleate TABS</i>	2	
<i>prochlorperazine supp</i>	4	
<i>promethazine hcl SYRP; TABS</i>	2	PA; PA if 70 years and older
<i>promethazine hcl inj</i>	4	PA; PA if 70 years and older
<i>scopolamine</i>	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>	3	
<i>glycopyrrolate tab 2mg</i>	3	

H2-RECEPTOR ANTAGONISTS

<i>famotidine SUSR</i>	4	
<i>famotidine TABS 20mg, 40mg</i>	1	GC
<i>famotidine in nacl</i>	2	
<i>famotidine inj</i>	2	
<i>nizatidine CAPS</i>	3	

INFLAMMATORY BOWEL DISEASE

<i>balsalazide disodium</i>	3	
<i>budesonide ec</i>	4	
<i>colocort</i>	4	
<i>hydrocortisone (enema)</i>	4	
<i>mesalamine CPDR</i>	4	
<i>mesalamine ENEM</i>	4	
<i>mesalamine SUPP</i>	5	
<i>mesalamine TBEC 1.2gm</i>	4	
<i>mesalamine w/ cleanser</i>	4	
<i>sulfasalazine TABS</i>	2	
<i>sulfasalazine ec</i>	3	

LAXATIVES

<i>constulose</i>	3	
<i>enulose</i>	3	
<i>gavilyte-c</i>	2	
<i>gavilyte-g</i>	2	
<i>gavilyte-n/flavor pack</i>	2	
<i>generlac</i>	3	
<i>GOLYTELY</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>lactulose</i> SOLN	3	
<i>lactulose (encephalopathy)</i>	3	
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	
PLENVU	4	
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</i> LIQD	4	
<i>diphenoxylate w/ atropine</i> TABS	3	
GATTEX	5	NM, LA, PA
LINZESS	4	QL (30 caps / 30 days)
<i>loperamide hcl</i> CAPS	3	
<i>misoprostol</i> TABS	3	
MOVANTIK 12.5mg	3	QL (60 tabs / 30 days)
MOVANTIK 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN	5	PA
<i>sucralfate</i> TABS	2	
<i>ursodiol</i> CAPS	3	
<i>ursodiol</i> TABS	4	
XIFAXAN 550mg	5	PA
PANCREATIC ENZYMES		
CREON	3	
ZENPEP	4	
PROTON PUMP INHIBITORS		
DEXILANT	4	QL (30 caps / 30 days)
<i>esomeprazole magnesium</i> CPDR	4	QL (30 caps / 30 days), ST
<i>lansoprazole</i> CPDR	3	QL (30 caps / 30 days)
<i>omeprazole cap 10mg</i>	1	GC
<i>omeprazole cap 20mg</i>	1	GC
<i>omeprazole cap 40mg</i>	1	GC
<i>pantoprazole sodium</i> SOLR	4	
<i>pantoprazole sodium tbec</i>	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
-----------	-----------	---------------------

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

<i>alfuzosin hcl</i>	2	QL (30 tabs / 30 days)
<i>dutasteride CAPS</i>	3	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl</i>	4	QL (30 caps / 30 days)
<i>finasteride TABS 5mg</i>	1	GC
<i>tamsulosin hcl</i>	2	

MISCELLANEOUS

<i>bethanechol chloride TABS</i>	3	
<i>potassium citrate (alkalinizer) er tabs</i>	4	

URINARY ANTISPASMODICS

MYRBETRIQ	4	QL (30 tabs / 30 days)
<i>oxybutynin chloride SYRP</i>	3	
<i>oxybutynin chloride TABS</i>	3	
<i>oxybutynin chloride TB24 5mg</i>	3	QL (30 tabs / 30 days)
<i>oxybutynin chloride TB24 10mg, 15mg</i>	3	QL (60 tabs / 30 days)
<i>tolterodine tartrate CP24</i>	4	QL (30 caps / 30 days), ST
<i>tolterodine tartrate TABS</i>	4	ST
TOVIAZ	3	QL (30 tabs / 30 days)
<i>tropium chloride TABS</i>	3	QL (60 tabs / 30 days)

VAGINAL ANTI-INFECTIVES

<i>clindamycin phosphate vaginal</i>	3	
<i>metronidazole vaginal</i>	4	
<i>terconazole vaginal</i>	3	
<i>vandazole</i>	4	

HEMATOLOGIC

ANTICOAGULANTS

COUMADIN	3	
ELIQUIS 2.5mg	3	QL (60 tabs / 30 days)
ELIQUIS 5mg	3	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK	3	QL (74 tabs / 30 days)
<i>enoxaparin sodium</i>	4	
<i>fondaparinux sodium 2.5mg/0.5ml</i>	4	
<i>fondaparinux sodium 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml</i>	5	
<i>heparin sod (porcine) in d5w</i>	3	
<i>heparin sod inj 1000/ml</i>	3	B/D
<i>heparin sod inj 5000/ml</i>	3	B/D
<i>heparin sod inj 10000/ml</i>	3	B/D
<i>heparin sod inj 20000/ml</i>	3	B/D
HEPARIN SODIUM/NAACL 0.45%	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
<i>jantoven</i>	1	GC
PRADAXA	4	QL (60 caps / 30 days)
<i>warfarin sodium</i>	1	GC
XARELTO 2.5mg	3	QL (60 tabs / 30 days)
XARELTO 10mg, 15mg, 20mg	3	QL (30 tabs / 30 days)
XARELTO STARTER PACK	3	QL (51 tabs / 30 days)

HEMATOPOIETIC GROWTH FACTORS

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

MISCELLANEOUS

<i>anagrelide hcl</i>	4	
BERINERT	5	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i>	2	
DROXIA	3	
ENDARI	5	NM, LA, PA
HAEGARDA 2000unit	5	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
<i>icatibant acetate</i>	5	QL (9 syringes / 30 days), NM, PA
<i>pentoxifylline</i> TBCR	2	
PROMACTA PACK 12.5mg	5	QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	5	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	5	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>tranexamic acid</i> SOLN	4	
<i>tranexamic acid</i> TABS	3	

PLATELET AGGREGATION INHIBITORS

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

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
------------------	------------------	----------------------------

IMMUNOLOGIC AGENTS

DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)

ENBREL SOLR	5	QL (16 vials / 28 days), NM, PA
ENBREL SOSY 25mg/0.5ml	5	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	5	QL (8 syringes / 28 days), NM, PA
ENBREL MINI	5	QL (8 injections / 28 days), NM, PA
ENBREL SURECLICK	5	QL (8 injections / 28 days), NM, PA
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>	3	
<i>leflunomide</i> TABS	3	QL (30 tabs / 30 days)
<i>methotrexate sodium tabs</i>	3	
REMICADE	5	NM, PA
RENFLEXIS	5	NM, LA, PA
RINVOQ	5	QL (30 tabs / 30 days), NM, PA
SKYRIZI	5	QL (7 kits / year), NM, PA
STELARA SOLN 45mg/0.5ml	5	QL (1 vial / 28 days), NM, LA, PA
STELARA SOSY	5	QL (1 syringe / 28 days), NM, PA
XATMEP	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
XELJANZ	5	QL (60 tabs / 30 days), NM, PA
XELJANZ XR	5	QL (30 tabs / 30 days), NM, PA

IMMUNOGLOBULINS

BIVIGAM	5	NM, PA
GAMASTAN	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	3	B/D
BENLYSTA	5	NM, PA
<i>cyclosporine</i> CAPS; SOLN	4	B/D
<i>cyclosporine modified (for microemulsion)</i>	4	B/D
<i>everolimus (immunosuppressant)</i> .5mg, .75mg	5	B/D
<i>everolimus (immunosuppressant)</i> .25mg	4	B/D
<i>gengraf</i>	4	B/D
<i>mycophenolate mofetil</i> CAPS; TABS	3	B/D
<i>mycophenolate mofetil</i> SUSR	5	B/D
<i>mycophenolate sodium tbec</i>	4	B/D
NULOJIX	5	B/D
PROGRAF PACK	4	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	4	B/D
<i>tacrolimus</i> CAPS	4	B/D
ZORTRESS TAB 0.5MG	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 0.25MG	5	B/D
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
ENGERIX-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	
ZOSTAVAX	3	QL (1 vial per lifetime)

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
-----------	-----------	---------------------

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

<i>klor-con 8</i>	2	
<i>klor-con 10</i>	2	
<i>klor-con m10</i>	2	
<i>klor-con m15</i>	2	
<i>klor-con m20</i>	2	
<i>klor-con pak 20meq</i>	4	
<i>klor-con spr cap 8meq</i>	3	
<i>klor-con spr cap 10meq</i>	3	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
<i>magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%</i>	3	
MAGNESIUM SULFATE IN D5W	3	
<i>magnesium sulfate in dextrose</i>	3	
<i>magnesium sulfate inj 50%</i>	3	
<i>potassium chloride</i> CPCR	3	
<i>potassium chloride</i> PACK	4	
<i>potassium chloride</i> SOLN 10%, 20%	4	
<i>potassium chloride</i> TBCR	2	
<i>potassium chloride microencapsulated crystals er</i>	2	
<i>sodium chloride</i> SOLN 2.5meq/ml	3	
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	2	
TPN ELECTROLYTES	4	B/D

IV NUTRITION

AMINOSYN II INJ 10%	4	B/D
AMINOSYN-PF 7%	4	B/D
CLINIMIX 4.25%/DEXTROSE 5%	4	B/D
CLINIMIX 5%/DEXTROSE 15%	4	B/D
CLINIMIX 5%/DEXTROSE 20%	4	B/D
CLINIMIX INJ 4.25/D10	4	B/D
<i>clinisol sf 15%</i>	4	B/D
CLINOLIPID	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
INTRALIPID INJ 20%	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
NEPHRAMINE	4	B/D
NUTRILIPID INJ 20%	4	B/D
<i>plenamine</i>	4	B/D
PREMASOL 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 0.45%</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% W/ SODIUM CHLORIDE 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	
ISOLYTE P	4	
ISOLYTE S	4	
<i>kcl0.15%/d5w/nacl0.2%</i>	3	
KCL 0.3%/D5W/NACL 0.9%	4	
<i>kcl 0.3%/d5w/nacl 0.45%</i>	3	
<i>kcl 0.15%/d5w/nacl 0.9%</i>	3	
KCL 0.15%/D5W/NACL 0.225%	4	
<i>kcl 0.075%/d5w/nacl 0.45%</i>	3	
<i>kcl/d5w/nacl inj 0.22%/0.45%</i>	3	
<i>kcl/d5w/nacl inj .15/.45%</i>	3	
<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	

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>pot chloride inj 2meq/ml</i>	2	
<i>potassium chloride SOLN 2meq/ml</i>	2	
POTASSIUM CHLORIDE SOLN .4meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 40meq/100ml	2	
<i>potassium chloride in nacl</i>	2	
<i>sodium chloride SOLN 3%, 5%</i>	3	
<i>sodium chloride 0.45%</i>	3	
<i>sodium chloride inj 0.9%</i>	3	

VITAMINS

<i>calcitriol CAPS</i>	2	B/D
<i>calcitriol inj</i>	4	B/D
<i>calcitriol oral soln 1 mcg/ml</i>	4	B/D
M-NATAL PLUS	3	
ONE VITE WOMENS PRENATAL	3	
<i>paricalcitol CAPS</i>	4	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>	3	
BLEPHAMIDE OINT	4	
<i>neomycin-polymy-dexameth</i>	2	
<i>neomycin-polymyxin-hc (ophth)</i>	4	
<i>sulfacetamide sod-prednisolone</i>	2	
TOBRADEX OINT	3	
TOBRADEX ST	3	
<i>tobramycin-dexamethasone</i>	4	
ZYLET	3	

ANTI-INFECTIVES

AZASITE	4	
<i>bacitracin (ophthalmic)</i>	3	
<i>bacitracin-polymyxin b (ophth)</i>	2	
BESIVANCE	3	
CILOXAN OINT	3	
<i>ciprofloxacin hcl (ophth)</i>	2	
<i>erythromycin (ophth)</i>	2	
<i>gatifloxacin (ophth)</i>	3	
<i>gentak</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 sulfate soln (ophth)</i>	2	
MOXEZA	3	
<i>moxifloxacin hcl (ophth)</i>	3	
NATACYN	4	
<i>neomycin-bacitracin zn-polymyxin</i>	3	
<i>neomycin-polymyxin-gramicidin</i>	3	
<i>ofloxacin (ophth)</i>	2	
<i>polymyxin b-trimethoprim</i>	2	
<i>sulfacetamide sodium (ophth)</i>	3	
<i>tobramycin (ophth)</i>	2	
<i>trifluridine</i>	3	
ZIRGAN	4	
ANTI-INFLAMMATORIES		
ALREX	3	
<i>bromfenac sodium (ophth)</i>	4	
BROMSITE	4	
<i>dexamethasone sodium phosphate (ophth)</i>	3	
<i>diclofenac sodium (ophth)</i>	3	
DUREZOL	3	
FLAREX	4	
<i>fluorometholone</i>	3	
<i>flurbiprofen sodium</i>	3	
ILEVRO	3	
<i>ketorolac tromethamine (ophth) .4%</i>	3	
<i>ketorolac tromethamine (ophth) .5%</i>	2	
LOTEMAX GEL; OINT	3	
<i>loteprednol etabonate</i>	3	
<i>prednisolone acetate (ophth)</i>	3	
PREDNISOLONE SODIUM PHOSPHATE (OPHTH)	3	
PROLENSA	3	
ANTIALLERGICS		
<i>azelastine drop 0.05%</i>	3	
BEPREVE	3	
<i>cromolyn sodium (ophth)</i>	1	GC
LASTACAFT	4	
<i>olopatadine hcl 0.2%</i>	4	
PAZEO	3	
ZERVIATE	4	
ANTIGLAUCOMA		
ALPHAGAN P SOL 0.1%	3	
AZOPT	3	
<i>betaxolol hcl (ophth)</i>	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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
BETOPTIC-S	3	
<i>brimonidine sol 0.2%</i>	1	GC
<i>brimonidine sol 0.15%</i>	4	
<i>carteolol hcl (ophth)</i>	2	
COMBIGAN	3	
<i>dorzolamide hcl</i>	2	
<i>dorzolamide hcl-timolol maleate</i>	2	
<i>latanoprost SOLN</i>	2	
<i>levobunolol hcl</i>	2	
LUMIGAN	3	
PHOSPHOLINE IODIDE	4	
<i>pilocarpine hcl SOLN</i>	3	
RHOPRESSA	3	
SIMBRINZA	3	
<i>timolol maleate (ophth) soln</i>	1	GC
<i>timolol maleate gel</i>	4	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	4	
<i>travoprost</i>	4	
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	3	
CYSTARAN	5	NM, LA, PA
<i>proparacaine hcl SOLN</i>	3	
RESTASIS	3	QL (60 single use vials / 30 days)
RESTASIS MULTIDOSE	3	QL (1 bottle / 30 days)
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>	3	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>	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
ANTI-HISTAMINES		
<i>azelastine spr 0.1%</i>	3	
<i>azelastine spr 0.15%</i>	3	
<i>cetirizine syrup</i>	2	
<i>cyproheptadine hcl</i> SYRP; TABS	3	PA; PA if 70 years and older
<i>diphenhydramine hcl inj 50mg/ml</i>	3	
<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> SOLN	4	
<i>levocetirizine dihydrochloride</i> TABS	2	
BETA AGONISTS		
<i>albuterol sulfate</i> AERS 108mcg/act	3	QL (2 inhalers / 30 days); (generic of Proair HFA)
<i>albuterol sulfate</i> AERS 108mcg/act	3	QL (2 inhalers / 30 days); (generic of Ventolin HFA)
<i>albuterol sulfate</i> NEBU .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	3	B/D
<i>albuterol sulfate</i> NEBU .083%	2	B/D
<i>albuterol sulfate</i> SYRP	2	
<i>albuterol sulfate</i> TABS	4	
<i>albuterol sulfate</i> TB12	3	
<i>levalbuterol hcl</i> NEBU 1.25mg/3ml	4	B/D
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml</i>	4	B/D
<i>levalbuterol tartrate hfa</i>	3	QL (2 inhalers / 30 days)
SEREVENT DISKUS	3	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS	4	
VENTOLIN HFA	3	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> CHEW	2	
<i>montelukast sodium</i> PACK	4	
<i>montelukast sodium</i> TABS	1	GC

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **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>zafirlukast</i>	3	
MAST CELL STABILIZERS		
<i>cromolyn sod neb 20mg/2ml</i>	3	B/D
MISCELLANEOUS		
<i>acetylcysteine SOLN 10%, 20%</i>	3	B/D
ARALAST NP	5	NM, LA, PA
DALIRESP	4	
<i>epinephrine (anaphylaxis) .15mg/0.3ml, .3mg/0.3ml</i>	3	(generic of EpiPen)
<i>epinephrine (anaphylaxis) .15mg/0.15ml, .3mg/0.3ml</i>	3	(generic of Adrenaclick)
ESBRIET	5	NM, PA
FASENRA	5	NM, LA, PA
FASENRA PEN	5	NM, LA, PA
KALYDECO	5	NM, PA
NUCALA	5	NM, LA, PA
OFEV	5	NM, PA
ORKAMBI	5	NM, PA
PROLASTIN-C	5	NM, LA, PA
PULMOZYME	5	NM, PA
SYMDEKO	5	NM, LA, PA
SYMJEPI	4	
THEO-24	4	
<i>theophylline</i>	4	
<i>theophylline tab er 12hr 300 mg</i>	4	
<i>theophylline tab er 12hr 450 mg</i>	4	
<i>theophylline tab sr 24hr</i>	3	
TRIKAFTA	5	NM, LA, PA
XOLAIR	5	NM, LA, PA
ZEMAIRA	5	NM, LA, PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i>	3	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i>	2	QL (1 bottle / 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA	3	QL (30 inhalations / 30 days)
<i>budesonide (inhalation) .25mg/2ml, .5mg/2ml</i>	4	B/D
FLOVENT DISKUS 50mcg/blist, 100mcg/blist	3	QL (120 inhalations / 30 days)
FLOVENT DISKUS 250mcg/blist	3	QL (240 inhalations / 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
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>	4	PA
<i>avita</i>	4	QL (45 grams / 30 days), PA
<i>benzoyl peroxide-erythromycin</i>	4	
<i>claravis</i>	4	PA
<i>clindamycin phosphate (topical) GEL</i>	4	QL (75 grams / 30 days)
<i>clindamycin phosphate (topical) LOTN</i>	3	
<i>clindamycin phosphate (topical) SOLN</i>	4	QL (60 mL / 30 days)
<i>ery pad 2%</i>	3	
<i>erythromycin (acne aid) GEL</i>	4	
<i>erythromycin (acne aid) SOLN</i>	3	
<i>isotretinoin CAPS</i>	4	PA
<i>myorisan</i>	4	PA
<i>sulfacetamide sodium (acne)</i>	4	
<i>tretinoin CREA</i>	4	QL (45 grams / 30 days), PA
<i>tretinoin GEL .01%, .025%</i>	4	QL (45 grams / 30 days), PA
<i>zenatane</i>	4	PA

DERMATOLOGY, ANTIBIOTICS

<i>gentamicin sulfate (topical) CREA</i>	4	
<i>gentamicin sulfate (topical) OINT</i>	3	
<i>mupirocin OINT</i>	2	QL (220 grams / 30 days)
<i>silver sulfadiazine CREA</i>	2	
<i>ssd</i>	2	
SULFAMYLON CREA	4	

DERMATOLOGY, ANTIFUNGALS

<i>ciclopirox CREA</i>	3	QL (90 grams / 30 days)
<i>ciclopirox SUSP</i>	3	QL (60 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>clotrimazole (topical)</i> CREA	3	
<i>clotrimazole (topical)</i> SOLN	3	QL (30 mL / 30 days)
<i>clotrimazole w/ betamethasone</i> CREA	3	
<i>ketoconazole cream</i>	3	QL (60 grams / 30 days)
<i>nyamyc</i>	3	QL (60 grams / 30 days)
<i>nystatin (topical)</i> CREA; OINT	3	
<i>nystatin (topical)</i> POWD	3	QL (60 grams / 30 days)
<i>nystop</i>	3	QL (60 grams / 30 days)

DERMATOLOGY, ANTIPSORIATICS

<i>acitretin</i>	4	PA
<i>calcipotriene</i> CREA; OINT	4	QL (120 grams / 30 days), PA
<i>calcipotriene</i> SOLN	4	QL (120 mL / 30 days), PA
<i>calcitrene</i>	4	QL (120 grams / 30 days), PA
<i>tazarotene</i> CREA	3	QL (60 grams / 30 days), PA
TAZORAC CREA .05%	4	QL (60 grams / 30 days), PA

DERMATOLOGY, ANTISEBORRHEICS

<i>ketoconazole shampoo</i>	2	
<i>selenium sulfide</i> LOTN	2	

DERMATOLOGY, CORTICOSTEROIDS

<i>ala-cort cre 1%</i>	1	GC
<i>ala-cort cre 2.5%</i>	2	
<i>alclometasone dipropionate</i> CREA	4	
<i>alclometasone dipropionate</i> OINT	3	
<i>betamethasone dipropionate (topical)</i> CREA; LOTN	3	
<i>betamethasone dipropionate (topical)</i> OINT	4	
<i>betamethasone dipropionate augmented</i> CREA	3	
<i>betamethasone dipropionate augmented</i> GEL; LOTN; OINT	4	
<i>betamethasone valerate</i> CREA; LOTN; OINT	3	
ENSTILAR	4	QL (120 grams / 30 days), PA
<i>fluocinolone acetonide</i> CREA; OINT	3	
<i>fluocinolone acetonide</i> OIL	4	
<i>fluocinolone acetonide</i> SOLN	4	QL (90 mL / 30 days)
<i>fluocinolone acetonide oil body</i>	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>fluocinonide</i> CREA .05%	4	QL (120 grams / 30 days)
<i>fluocinonide</i> GEL	4	QL (60 grams / 30 days)
<i>fluocinonide</i> OINT	4	QL (60 grams / 30 days)
<i>fluocinonide</i> SOLN	4	QL (60 mL / 30 days)
<i>fluocinonide emulsified base</i>	4	QL (120 grams / 30 days)
<i>fluticasone propionate</i> CREA; OINT	3	
<i>halobetasol propionate</i> CREA; OINT	4	QL (50 grams / 30 days)
<i>hydrocortisone (topical) cream 1%</i>	1	GC
<i>hydrocortisone (topical) cream 2.5%</i>	2	
<i>hydrocortisone (topical) lotion 2.5%</i>	3	
<i>hydrocortisone (topical) oint 2.5%</i>	2	
<i>hydrocortisone butyrate cream 0.1%</i>	4	QL (45 grams / 30 days)
<i>hydrocortisone butyrate oint 0.1%</i>	4	QL (45 grams / 30 days)
<i>mometasone furoate</i> CREA; OINT; SOLN	3	
TEXACORT SOLN 2.5%	4	
<i>triamcinolone acetonide (topical)</i> CREA .1%	2	QL (454 grams / 30 days)
<i>triamcinolone acetonide (topical)</i> CREA .025%, .5%	2	
<i>triamcinolone acetonide (topical)</i> LOTN	3	
<i>triamcinolone acetonide (topical)</i> OINT .025%, .1%, .5%	2	

DERMATOLOGY, LOCAL ANESTHETICS

<i>glydo</i>	3	QL (30 mL / 30 days), PA
<i>lidocaine</i> PTCH 5%	4	QL (3 patches / 1 day), PA
<i>lidocaine hcl</i> GEL	3	QL (30 mL / 30 days), PA
<i>lidocaine hcl</i> SOLN 4%	3	QL (50 mL / 30 days), PA
<i>lidocaine oint</i> 5%	4	QL (50 grams / 30 days), PA
<i>lidocaine-prilocaine</i>	3	QL (30 grams / 30 days), PA

DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE

<i>ammonium lactate</i> CREA	2	
<i>ammonium lactate</i> LOTN	3	
<i>diclofenac sodium (topical) 1% gel</i>	3	QL (1000 grams / 30 days), PA
<i>fluorouracil (topical)</i> CREA 5%	4	QL (40 grams / 30 days)
<i>fluorouracil (topical)</i> SOLN	3	QL (10 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>imiquimod</i> CREA 5%	3	QL (24 packets / 30 days)
<i>metronidazole (topical)</i> CREA; LOTN	4	
<i>metronidazole gel</i> 0.75%	4	
PANRETIN	5	QL (60 grams / 30 days)
PICATO .05%	4	QL (2 tubes / 30 days)
PICATO .015%	4	QL (3 tubes / 30 days)
<i>podofilox</i> SOLN	3	
<i>procto-med hc</i>	3	
<i>procto-pak</i>	3	
<i>proctosol hc cre</i> 2.5%	3	
<i>proctozone-hc</i>	3	
RECTIV	4	QL (30 grams / 30 days)
<i>rosadan cre</i> 0.75%	4	
<i>tacrolimus (topical)</i>	4	QL (100 grams / 30 days)
TARGRETIN GEL	5	QL (60 grams / 30 days), NM, PA
VALCHLOR	5	QL (60 grams / 30 days), NM, LA, PA

DERMATOLOGY, SCABICIDES AND PEDICULIDES

<i>malathion</i>	4	
<i>permethrin cre</i> 5%	3	

DERMATOLOGY, WOUND CARE AGENTS

<i>acetic acid</i> .25%	2	
REGRANEX	5	QL (30 grams / 30 days), PA
SANTYL	4	
<i>sodium chlor sol</i> 0.9% irr	2	
<i>water for irrigation, sterile</i>	2	

MOUTH/THROAT/DENTAL AGENTS

<i>cevimeline hcl</i>	4	
<i>chlorhexidine gluconate (mouth-throat)</i>	1	GC
<i>clotrimazole</i> TROC	4	
<i>lidocaine hcl (mouth-throat)</i>	2	
<i>nystatin (mouth-throat)</i>	3	
<i>paroex sol</i> 0.12%	1	GC
<i>perio gard</i>	1	GC
<i>pilocarpine hcl (oral)</i>	4	
<i>triamcinolone acetoneide (mouth)</i>	3	

OTIC

<i>acetic acid (otic)</i>	3	
CIPRODEX	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
<i>flac</i>	4	
<i>fluocinolone acetonide (otic)</i>	4	
<i>neomycin-polymyxin-hc (otic)</i>	3	
<i>ofloxacin (otic)</i>	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.

Index of Drugs

<i>abacavir sulfate</i>	11	<i>alendronate sodium tab 40 mg</i>	43
<i>abacavir sulfate-lamivudine</i>	12	<i>alendronate sodium tab 5 mg</i>	43
<i>abacavir sulfate-lamivudine-zidovudine</i>	13	<i>alendronate sodium tab 70 mg</i>	44
ABELCET	10	<i>alfuzosin hcl</i>	53
ABILIFY MAINTENA.....	34	ALIMTA.....	17
<i>abiraterone acetate</i>	19	ALINIA.....	9
ABRAXANE	17	<i>aliskiren fumarate</i>	27
<i>acamprosate calcium</i>	39	<i>allopurinol tab</i>	7
<i>acarbose</i>	41	<i>alose tron hcl</i>	52
<i>acebutolol hcl</i>	25	ALPHAGAN P SOL 0.1%.....	61
<i>acetaminophen w/ codeine 300-15mg</i> 7		<i>alprazolam tab 0.25mg</i>	28
<i>acetaminophen w/ codeine 300-30mg</i> 7		<i>alprazolam tab 0.5mg</i>	28
<i>acetaminophen w/ codeine 300-60mg</i> 7		<i>alprazolam tab 1mg</i>	28
<i>acetaminophen w/ codeine soln</i>	7	<i>alprazolam tab 2 mg</i>	28
<i>acetazolamide</i>	26	ALREX	61
<i>acetic acid</i>	68	<i>altavera tab</i>	44
<i>acetic acid (otic)</i>	68	ALUNBRIG.....	20
<i>acetylcysteine</i>	64	<i>alyacen 1/35</i>	44
<i>acitretin</i>	66	<i>amantadine hcl</i>	33
ACTHIB.....	57	AMBISOME	10
ACTIMMUNE	56	<i>ambrisentan</i>	28
<i>acyclovir</i>	13	<i>amikacin sulfate</i>	9
<i>acyclovir sodium</i>	14	<i>amiloride & hydrochlorothiazide</i>	26
ADACEL	57	<i>amiloride hcl</i>	26
<i>adefovir dipivoxil</i>	14	AMINOSYN II INJ 10%.....	58
ADEMPAS	28	AMINOSYN-PF 7%	58
<i>adriamycin</i>	17	<i>amiodarone hcl soln</i>	24
<i>adrucil inj</i>	17	<i>amiodarone tab 100mg</i>	24
ADVAIR DISKUS.....	65	<i>amiodarone tab 200mg</i>	24
ADVAIR HFA	65	<i>amiodarone tab 400mg</i>	24
AFINITOR.....	20	AMITIZA CAP 24MCG	52
AFINITOR DISPERZ	20	AMITIZA CAP 8MCG.....	52
AIMOVIG.....	38	<i>amitriptyline hcl</i>	32
<i>ala-cort cre 1%</i>	66	<i>amlodipine besylate</i>	25
<i>ala-cort cre 2.5%</i>	66	<i>amlodipine besylate-benazepril hcl cap</i> <i>10-20 mg</i>	23
<i>albendazole</i>	9	<i>amlodipine besylate-benazepril hcl cap</i> <i>10-40 mg</i>	23
<i>albuterol sulfate</i>	63	<i>amlodipine besylate-benazepril hcl cap</i> <i>2.5-10 mg</i>	22
<i>alclometasone dipropionate</i>	66	<i>amlodipine besylate-benazepril hcl cap</i> <i>5-10 mg</i>	22
ALDURAZYME	47	<i>amlodipine besylate-benazepril hcl cap</i> <i>5-10 mg</i>	22
ALECENSA.....	20	<i>amlodipine besylate-benazepril hcl cap</i> <i>5-10 mg</i>	22
<i>alendronate sodium tab 10 mg</i>	43	<i>amlodipine besylate-benazepril hcl cap</i> <i>5-10 mg</i>	22
<i>alendronate sodium tab 35 mg</i>	43	<i>amlodipine besylate-benazepril hcl cap</i> <i>5-10 mg</i>	22

5-20 mg.....	22	12.5 mg.....	37
amlodipine besylate-benazepril hcl cap		amphetamine-dextroamphetamine tab	
5-40 mg.....	23	15 mg.....	37
amlodipine besylate-olmesartan		amphetamine-dextroamphetamine tab	
medoxomil	23	20 mg.....	37
amlodipine besylate-valsartan tab	23	amphetamine-dextroamphetamine tab	
amlodipine-valsartan-		30 mg.....	37
hydrochlorothiazide tab.....	23	amphetamine-dextroamphetamine tab	
ammonium lactate	67	5 mg	36
amnesteem	65	amphetamine-dextroamphetamine tab	
amoxapine	32	7.5 mg.....	36
amoxicillin.....	15	amphotericin b.....	11
amoxicillin & pot clavulanate 200/5ml		ampicillin & sulbactam sodium	16
susr.....	15	ampicillin cap 500mg.....	16
amoxicillin & pot clavulanate 200-28.5		ampicillin inj.....	16
chw tabs	15	ampicillin sodium	16
amoxicillin & pot clavulanate 250/5ml		ANADROL-50	40
susr.....	15	anagrelide hcl	54
amoxicillin & pot clavulanate 250-125		anastrozole	19
tabs.....	15	ANDRODERM	40
amoxicillin & pot clavulanate 400/5ml		ANORO ELLIPTA	62
susr.....	16	APOKYN	33
amoxicillin & pot clavulanate 400-57		aprepitant	50
chw tabs	16	aprepitant pak 80mg & 125mg.....	50
amoxicillin & pot clavulanate 500-125		apri	44
tabs.....	16	APTIOM.....	28
amoxicillin & pot clavulanate 600/5ml		APTIVUS	11
susr.....	16	ARALAST NP	64
amoxicillin & pot clavulanate 875-125		aranelle	44
tabs.....	16	ARCALYST	56
amoxicillin & pot clavulanate er 12hr		aripiprazole odt.....	34
1000-62.5 tabs.....	16	aripiprazole oral solution 1 mg/ml	34
amphetamine-dextroamphetamine cap		aripiprazole tab.....	34
sr 24hr 10 mg.....	36	ARISTADA	34
amphetamine-dextroamphetamine cap		ARISTADA INITIO.....	34
sr 24hr 15 mg.....	36	armodafinil.....	39
amphetamine-dextroamphetamine cap		ARNUITY ELLIPTA.....	64
sr 24hr 20 mg.....	36	aspirin-dipyridamole	54
amphetamine-dextroamphetamine cap		atazanavir sulfate.....	11
sr 24hr 25 mg.....	36	atenolol	25
amphetamine-dextroamphetamine cap		atenolol & chlorthalidone.....	25
sr 24hr 30 mg.....	36	atomoxetine hcl	37
amphetamine-dextroamphetamine cap		atorvastatin calcium	24
sr 24hr 5 mg	36	atovaquone	9
amphetamine-dextroamphetamine tab		atovaquone-proguanil hcl.....	11
10 mg.....	37	ATRIPLA.....	13
amphetamine-dextroamphetamine tab		ATROPINE SULFATE.....	62

ATROVENT HFA.....	62	<i>betamethasone dipropionate (topical)</i>	66
<i>aubra</i>	44	<i>betamethasone dipropionate</i>	
AURYXIA.....	49	<i>augmented</i>	66
AUSTEDO.....	38	<i>betamethasone valerate</i>	66
AVASTIN.....	18	BETASERON.....	39
<i>aviane</i>	44	<i>betaxolol hcl (ophth)</i>	61
<i>avita</i>	65	<i>bethanechol chloride</i>	53
AYVAKIT.....	20	BETOPTIC-S.....	62
<i>azacitidine</i>	17	BEVESPI AEROSPHERE.....	62
AZASITE.....	60	<i>bexarotene</i>	22
<i>azathioprine</i>	56	BEXSERO.....	57
<i>azelastine drop 0.05%</i>	61	<i>bicalutamide</i>	19
<i>azelastine spr 0.1%</i>	63	BICILLIN L-A.....	16
<i>azelastine spr 0.15%</i>	63	BIKTARVY.....	13
<i>azithromycin</i>	15	<i>bisoprolol & hydrochlorothiazide</i>	25
AZOPT.....	61	<i>bisoprolol fumarate</i>	25
<i>aztreonam</i>	9	BIVIGAM.....	56
<i>bacitracin (ophthalmic)</i>	60	BLEPHAMIDE.....	60
<i>bacitracin-polymyxin b (ophth)</i>	60	<i>blisovi fe 1.5/30</i>	44
<i>bacitracin-poly-neomycin-hc</i>	60	BOOSTRIX.....	57
<i>baclofen</i>	39	BORTEZOMIB.....	18
<i>balsalazide disodium</i>	51	<i>bosentan</i>	28
BALVERSA.....	20	BOSULIF.....	20
<i>balziva</i>	44	BRAFTOVI.....	20
BANZEL SUS 40MG/ML.....	28	BREO ELLIPTA.....	65
BANZEL TAB 200MG.....	28	<i>briellyn</i>	44
BANZEL TAB 400MG.....	28	BRILINTA.....	54
BARACLUDE.....	14	<i>brimonidine sol 0.15%</i>	62
BASAGLAR KWIKPEN.....	40	<i>brimonidine sol 0.2%</i>	62
BCG VACCINE.....	57	BRIVIACT INJ 50MG/5ML.....	28
BD ALCOHOL SWABS.....	40	BRIVIACT SOL 10MG/ML.....	28
BD ULTRAFINE INSULIN SYRINGE.....	40	BRIVIACT TAB 100MG.....	28
BD ULTRAFINE/NANO PEN NEEDLES.....	40	BRIVIACT TAB 10MG.....	28
<i>bekyree</i>	44	BRIVIACT TAB 25MG.....	28
BELSOMRA.....	37	BRIVIACT TAB 50MG.....	28
<i>benazepril & hydrochlorothiazide</i>	23	BRIVIACT TAB 75MG.....	28
<i>benazepril hcl</i>	23	<i>bromfenac sodium (ophth)</i>	61
BENDEKA.....	17	<i>bromocriptine mesylate</i>	33
BENLYSTA.....	56	BROMSITE.....	61
<i>benzoyl peroxide-erythromycin</i>	65	BRUKINSA.....	20
<i>benztropine mesylate inj</i>	33	<i>budesonide (inhalation)</i>	64
<i>benztropine mesylate tab 0.5mg</i>	33	<i>budesonide ec</i>	51
<i>benztropine mesylate tab 1mg</i>	33	<i>bumetanide inj 0.25/ml</i>	27
<i>benztropine mesylate tab 2mg</i>	33	<i>bumetanide tab</i>	27
BEPREVE.....	61	<i>buprenorphine hcl</i>	39
BERINERT.....	54	<i>buprenorphine hcl-naloxone hcl</i>	
BESIVANCE.....	60	<i>dihydrate 12-3mg</i>	39

<i>buprenorphine hcl-naloxone hcl dihydrate 2-0.5mg</i>	39	<i>cefazolin sodium</i>	14
<i>buprenorphine hcl-naloxone hcl dihydrate 4-1mg</i>	39	CEFAZOLIN SODIUM 1 GM/50ML.....	14
<i>buprenorphine hcl-naloxone hcl dihydrate 8-2mg</i>	39	<i>cefdinir</i>	14
<i>buprenorphine hcl-naloxone hcl sl</i>	40	<i>cefepime for inj</i>	14
<i>bupropion hcl</i>	32	<i>cefixime</i>	14
<i>bupropion hcl (smoking deterrent)</i>	40	<i>cefoxitin for inj</i>	14
<i>buspirone hcl</i>	28	<i>cefpodoxime proxetil</i>	14
<i>butorphanol tartrate</i>	7	<i>cefprozil</i>	14
BYDUREON BCISE	40	<i>ceftazidime</i>	15
BYDUREON PEN	40	CEFTAZIDIME/DEXTROSE.....	15
BYETTA.....	40	<i>ceftriaxone sodium</i>	15
BYSTOLIC	25	<i>cefuroxime axetil</i>	15
<i>cabergoline</i>	49	<i>cefuroxime sodium</i>	15
CABOMETYX	20	<i>celecoxib</i>	7
<i>calcipotriene</i>	66	CELONTIN	28
<i>calcitonin (salmon)</i>	49	<i>cephalexin</i>	15
<i>calcitrene</i>	66	CERDELGA	47
<i>calcitriol</i>	60	CEREZYME	47
<i>calcitriol inj</i>	60	<i>cetirizine syrup</i>	63
<i>calcitriol oral soln 1 mcg/ml</i>	60	<i>cevimeline hcl</i>	68
<i>calcium acetate (phosphate binder)</i> ...	50	CHANTIX.....	40
CALQUENCE	20	CHANTIX CONTINUING MONTH.....	40
<i>camila</i>	44	CHANTIX STARTER PACK	40
CAPLYTA	34	CHEMET	44
CAPRELSA.....	20	<i>chlorhexidine gluconate (mouth-throat)</i>	68
<i>captopril</i>	23	<i>chloroquine phosphate</i>	11
<i>captopril & hydrochlorothiazide</i>	23	<i>chlorothiazide</i>	27
CARBAGLU	47	<i>chlorpromazine hcl</i>	34
<i>carbamazepine</i>	28	CHLORPROMAZINE INJ	34
<i>carbidopa/levodopa/entacapone</i>	33	<i>chlorthalidone</i>	27
<i>carbidopa-levodopa</i>	33	<i>cholestyramine</i>	24
<i>carboplatin</i>	22	<i>cholestyramine light pack</i>	24
<i>carteolol hcl (ophth)</i>	62	<i>cholestyramine light powd</i>	24
<i>cartia xt</i>	25	<i>ciclopirox</i>	65
<i>carvedilol</i>	25	<i>cilostazol</i>	54
<i>caspofungin acetate</i>	11	CILOXAN.....	60
CAYSTON	9	CIMDUO.....	13
<i>caziant pak</i>	44	<i>cinacalcet hcl</i>	49
<i>cefaclor</i>	14	CIPRO.....	15
CEFACLOR ER TAB 500MG.....	14	CIPRODEX.....	68
<i>cefadroxil</i>	14	<i>ciprofloxacin hcl (ophth)</i>	60
CEFAZOLIN IN DEXTROSE 2GM/100ML-4%	14	<i>ciprofloxacin hcl tab</i>	15
<i>cefazolin inj</i>	14	<i>ciprofloxacin in d5w</i>	15
		<i>cisplatin</i>	22
		<i>citalopram hydrobromide</i>	32
		<i>claravis</i>	65

<i>clarithromycin</i>	15	<i>compro supp</i>	50
<i>clarithromycin er</i>	15	<i>constulose</i>	51
<i>clarithromycin for susp</i>	15	COPIKTRA	20
<i>clindamycin cap 300 mg</i>	10	CORLANOR.....	27
<i>clindamycin cap 75mg</i>	9	<i>cortisone acetate</i>	48
<i>clindamycin hcl cap 150 mg</i>	10	COTELLIC.....	20
<i>clindamycin phosphate (topical)</i>	65	COUMADIN.....	53
<i>clindamycin phosphate in d5w</i>	10	CREON.....	52
CLINDAMYCIN PHOSPHATE IN NAACL ..	10	CRIXIVAN.....	11
<i>clindamycin phosphate inj</i>	10	<i>cromolyn sod neb 20mg/2ml</i>	64
<i>clindamycin phosphate vaginal</i>	53	<i>cromolyn sodium (mastocytosis)</i>	52
<i>clindamycin soln 75mg/5ml</i>	10	<i>cromolyn sodium (ophth)</i>	61
CLINIMIX 4.25%/DEXTROSE 5%.....	58	<i>cryselle-28</i>	44
CLINIMIX 5%/DEXTROSE 15%	58	<i>cyclafem 1/35</i>	44
CLINIMIX 5%/DEXTROSE 20%	58	<i>cyclafem 7/7/7</i>	44
CLINIMIX INJ 4.25/D10	58	<i>cyclobenzaprine hcl</i>	39
<i>clinisol sf 15%</i>	58	<i>cyclophosphamide</i>	17
CLINOLIPID	58	<i>cycloserine</i>	13
<i>clobazam</i>	28	<i>cyclosporine</i>	56
<i>clomipramine hcl</i>	32	<i>cyclosporine modified (for</i> <i>microemulsion)</i>	56
<i>clonazepam</i>	29	<i>cyproheptadine hcl</i>	63
<i>clonidine hcl</i>	27	<i>cyred tab</i>	44
<i>clonidine hcl ptwk</i>	27	CYSTADANE	47
<i>clopidogrel tab 75mg</i>	54	CYSTAGON	47
<i>clorazepate dipotassium</i>	29	CYSTARAN	62
<i>clotrimazole</i>	68	<i>cytarabine</i>	17
<i>clotrimazole (topical)</i>	66	<i>dalfampridine</i>	39
<i>clotrimazole w/ betamethasone</i>	66	DALIRESP	64
<i>clovique</i>	44	<i>danazol</i>	47
<i>clozapine odt</i>	34	<i>dantrolene sodium</i>	39
<i>clozapine tab 100mg</i>	34	<i>dapsone</i>	10
<i>clozapine tab 200mg</i>	34	DAPTACEL	57
<i>clozapine tab 25mg</i>	34	<i>daptomycin</i>	10
<i>clozapine tab 50mg</i>	34	<i>dasetta 1/35</i>	44
COARTEM.....	11	<i>dasetta 7/7/7</i>	44
<i>colchicine w/ probenecid</i>	7	DAURISMO	18
COLCRYS	7	<i>deblitane</i>	45
<i>colesevelam hcl</i>	24	<i>deferasirox tab</i>	44
<i>colestipol hcl gran</i>	24	DELESTROGEN.....	48
<i>colestipol hcl pack</i>	24	DELSTRIGO	13
<i>colestipol hcl tabs</i>	24	DEM SER.....	27
<i>colistimethate sodium</i>	10	DEPO-PROVERA INJ 400/ML	19
<i>colocort</i>	51	DESCOVY	13
COMBIGAN	62	<i>desipramine hcl</i>	32
COMBIVENT RESPIMAT	62	<i>desmopressin acetate spray</i>	50
COMETRIQ	20	<i>desmopressin acetate spray refrigerated</i>	
COMPLERA	13		

.....	50	DIFICID	15
<i>desmopressin acetate tabs</i>	50	<i>diflunisal</i>	7
<i>desmopressin inj 4mcg/ml</i>	50	<i>digitek</i>	26
<i>desogestrel & ethinyl estradiol</i>	45	<i>digox</i>	26
<i>desogestrel-ethinyl estradiol (biphasic)</i>	45	<i>digoxin</i>	26
<i>desvenlafaxine succinate</i>	32	<i>digoxin inj</i>	26
<i>dexamethasone</i>	48	<i>digoxin sol 50mcg/ml</i>	26
DEXAMETHASONE	48	<i>dihydroergotamine mesylate inj 1</i> <i>mg/ml</i>	38
<i>dexamethasone sodium phosphate</i>	48	<i>dihydroergotamine mesylate nasal spr 4</i> <i>mg/ml</i>	38
<i>dexamethasone sodium phosphate</i> <i>(ophth)</i>	61	DILANTIN CAP 100MG	29
DEXILANT	52	DILANTIN CAP 30MG	29
<i>dexmethylphenidate hcl</i>	37	DILANTIN CHEW TAB 50MG.....	29
<i>dextrose 10% flex contain</i>	59	DILANTIN-125 SUSP.....	29
DEXTROSE 10% W/ SODIUM CHLORIDE 0.2%	59	<i>diltiazem cap 240mg cd</i>	26
<i>dextrose 10%/nacl 0.45%</i>	59	<i>diltiazem cap 360mg cd</i>	26
<i>dextrose 2.5%/nacl 0.45%</i>	59	<i>diltiazem cap er/12hr</i>	26
<i>dextrose 5%</i>	59	<i>diltiazem hcl</i>	26
DEXTROSE 5% /ELECTROLYTE.....	59	<i>diltiazem hcl coated beads</i>	26
<i>dextrose 5%/nacl 0.2%</i>	59	<i>diltiazem hcl coated beads cap sr 24hr</i>	26
<i>dextrose 5%/nacl 0.225%</i>	59	<i>diltiazem hcl extended release beads</i> <i>cap sr</i>	26
DEXTROSE 5%/NAACL 0.3%	59	<i>diltiazem inj</i>	26
<i>dextrose 5%/nacl 0.45%</i>	59	<i>dilt-xr cap</i>	25
<i>dextrose 5%/nacl 0.9%</i>	59	<i>diphenhydramine hcl inj 50mg/ml</i>	63
<i>dextrose 5%/potassium chl</i>	59	<i>diphenoxylate w/ atropine</i>	52
<i>dextrose 50%</i>	59	DIPHThERIA/TETANUS TOXOID	57
<i>dextrose in lactated ringers</i>	59	<i>disopyramide phosphate</i>	24
<i>dextrose inj 70%</i>	59	<i>disulfiram</i>	40
DIASSTAT ACUDIAL	29	<i>divalproex sodium</i>	29
DIASSTAT PEDIATRIC.....	29	<i>docetaxel</i>	17
<i>diazepam</i>	29	DOCETAXEL.....	17
<i>diazepam gel</i>	29	<i>dofetilide</i>	24
<i>diazepam inj</i>	29	<i>donepezil hydrochloride</i>	31
<i>diazepam intensol</i>	29	<i>dorzolamide hcl</i>	62
<i>diazepam oral soln 1 mg/ml</i>	29	<i>dorzolamide hcl-timolol maleate</i>	62
<i>diazoxide</i>	49	DOVATO	13
<i>diclofenac potassium</i>	7	<i>doxazosin mesylate</i>	23
<i>diclofenac sodium</i>	7	<i>doxepin hcl</i>	32
<i>diclofenac sodium (ophth)</i>	61	<i>doxepin hcl (sleep)</i>	37
<i>diclofenac sodium (topical) 1% gel</i>	67	<i>doxorubicin hcl</i>	17
<i>dicloxacillin sodium</i>	16	<i>doxorubicin hcl liposomal</i>	17
<i>dicyclomine hcl cap 10mg</i>	51	<i>doxy 100</i>	16
<i>dicyclomine hcl soln 10mg/5ml</i>	51	<i>doxycycline (monohydrate)</i>	16
<i>dicyclomine hcl tab 20mg</i>	51	<i>doxycycline hyclate</i>	16
<i>didanosine</i>	11		

<i>doxycycline hyclate 100 mg</i>	17	<i>epinephrine (anaphylaxis)</i>	64
<i>doxycycline hyclate 20 mg</i>	16	<i>epirubicin hcl</i>	17
DRIZALMA SPRINKLE.....	32	<i>epitol</i>	29
<i>dronabinol</i>	50	EPIVIR HBV	14
<i>drospirenone-ethinyl estradiol</i>	45	<i>eplerenone</i>	23
DROXIA	54	<i>ergotamine w/ caffeine</i>	38
<i>duloxetine hcl</i>	32	ERIVEDGE	18
DUREZOL	61	ERLEADA.....	19
<i>dutasteride</i>	53	<i>erlotinib hcl</i>	20
<i>dutasteride-tamsulosin hcl</i>	53	<i>errin</i>	45
<i>ec-naproxen</i>	7	<i>ertapenem sodium</i>	10
EDURANT	11	<i>ery pad 2%</i>	65
<i>efavirenz</i>	11	<i>ery-tab</i>	15
<i>eletriptan hydrobromide</i>	38	ERYTHROCIN LACTOBIONATE	15
ELIQUIS.....	53	<i>erythrocin stearate</i>	15
ELIQUIS STARTER PACK.....	53	<i>erythromycin (acne aid)</i>	65
ELLA.....	45	<i>erythromycin (ophth)</i>	60
<i>eluryng</i>	45	<i>erythromycin base</i>	15
EMCYT	17	<i>erythromycin cap 250mg ec</i>	15
EMEND	50	<i>erythromycin ethylsuccinate</i>	15
EMGALITY	38	<i>erythromycin tab ec</i>	15
<i>emoquette</i>	45	ESBRIET	64
EMSAM	32	<i>escitalopram oxalate</i>	32
EMTRIVA.....	11	<i>esomeprazole magnesium</i>	52
EMVERM	10	<i>estarylla tab 0.25-35</i>	45
<i>enalapril maleate</i>	23	<i>estradiol</i>	48
<i>enalapril maleate & hydrochlorothiazide</i>	23	<i>estradiol vaginal cream</i>	48
ENBREL.....	55	<i>estradiol vaginal tab</i>	48
ENBREL MINI.....	55	<i>estradiol valerate inj</i>	48
ENBREL SURECLICK	55	<i>ethambutol hcl</i>	13
ENDARI.....	54	<i>ethosuximide</i>	29
<i>endocet 10-325mg</i>	8	<i>ethynodiol diacet & eth estrad</i>	45
<i>endocet 2.5-325mg</i>	7	<i>ethynodiol tab 1-50</i>	45
<i>endocet 5-325mg</i>	8	<i>etodolac</i>	7
<i>endocet 7.5-325mg</i>	8	<i>etonogestrel-ethinyl estradiol</i>	45
ENGERIX-B.....	57	<i>etoposide</i>	22
<i>enoxaparin sodium</i>	53	<i>euthyrox</i>	50
<i>enpresse-28</i>	45	<i>everolimus</i>	20
<i>enskyce</i>	45	<i>everolimus (immunosuppressant)</i>	56
ENSTILAR.....	66	EVOTAZ	13
<i>entacapone</i>	33	<i>exemestane</i>	19
<i>entecavir</i>	14	<i>ezetimibe</i>	24
ENTRESTO	23	FABRAZYME.....	47
<i>enulose</i>	51	<i>falmina</i>	45
EPCLUSA.....	14	<i>famciclovir</i>	14
EPIDIOLEX	29	<i>famotidine</i>	51
		<i>famotidine in nacl</i>	51

<i>famotidine inj</i>	51	<i>fluphenazine decanoate</i>	34
FANAPT.....	34	<i>fluphenazine hcl</i>	34
FANAPT TITRATION PACK.....	34	<i>flurbiprofen</i>	7
FARXIGA	41	<i>flurbiprofen sodium</i>	61
FARYDAK	18	<i>flutamide</i>	19
FASENRA	64	<i>fluticasone propionate</i>	67
FASENRA PEN	64	<i>fluticasone propionate (nasal)</i>	64
<i>felbamate</i>	29	<i>fluvoxamine maleate</i>	28
<i>felodipine</i>	26	<i>fondaparinux sodium</i>	53
<i>femynor</i>	45	FORTEO	49
<i>fenofibrate</i>	25	<i>fosamprenavir tab 700 mg</i>	11
<i>fenofibrate micronized</i>	25	<i>fosinopril sodium</i>	23
<i>fentanyl citrate</i>	8	<i>fosinopril sodium & hydrochlorothiazide</i>	23
<i>fentanyl patch 100 mcg/hr</i>	8	FREAMINE HBC 6.9%.....	58
<i>fentanyl patch 12 mcg/hr</i>	8	FREAMINE III.....	58
<i>fentanyl patch 25 mcg/hr</i>	8	<i>fulvestrant</i>	19
<i>fentanyl patch 50 mcg/hr</i>	8	<i>furosemide</i>	27
<i>fentanyl patch 75 mcg/hr</i>	8	<i>furosemide inj</i>	27
FETZIMA	32	FUZEON	12
FETZIMA TITRATION PACK	32	<i>fyavolv</i>	48
FIASP	40	FYCOMPA	29
FIASP FLEXTOUCH.....	40	<i>gabapentin</i>	29, 30
FIASP PENFILL.....	40	<i>galantamine hydrobromide</i>	31
<i>finasteride</i>	53	<i>galantamine hydrobromide er</i>	31
<i>flac</i>	69	GAMASTAN.....	56
FLAREX.....	61	GAMMAGARD LIQUID.....	56
<i>flecainide acetate</i>	24	GAMMAGARD S/D	56
FLOVENT DISKUS.....	64	GAMMAKED	56
FLOVENT HFA	65	GAMMAPLEX	56
<i>fluconazole</i>	11	GAMMAPLEX 10GM/100ML.....	56
<i>fluconazole inj nacl 200</i>	11	GAMUNEX-C	56
<i>fluconazole inj nacl 400</i>	11	<i>ganciclovir sodium</i>	14
<i>flucytosine</i>	11	GARDASIL 9	57
<i>fludrocortisone acetate</i>	48	<i>gatifloxacin (ophth)</i>	60
<i>flunisolide (nasal)</i>	64	GATTEX	52
<i>fluocinolone acetonide</i>	66	GAUZE PADS 2	40
<i>fluocinolone acetonide (otic)</i>	69	<i>gavilyte-c</i>	51
<i>fluocinolone acetonide oil body</i>	66	<i>gavilyte-g</i>	51
<i>fluocinonide</i>	67	<i>gavilyte-n/flower pack</i>	51
<i>fluocinonide emulsified base</i>	67	<i>gemcitabine inj soln</i>	17
<i>fluorometholone</i>	61	<i>gemcitabine inj solr</i>	17
<i>fluorouracil</i>	17	<i>gemfibrozil</i>	25
<i>fluorouracil (topical)</i>	67	<i>generlac</i>	51
<i>fluoxetine cap 10mg</i>	32	<i>gengraf</i>	56
<i>fluoxetine cap 20mg</i>	32	GENOTROPIN.....	49
<i>fluoxetine cap 40mg</i>	32	GENOTROPIN MINIQUICK.....	49
<i>fluoxetine hcl</i>	32		

<i>gentak</i>	60	<i>heparin sod inj 20000/ml</i>	53
<i>gentamicin in saline</i>	9	<i>heparin sod inj 5000/ml</i>	53
<i>gentamicin sulfate</i>	9	HEPARIN SODIUM/NACL 0.45%	53
<i>gentamicin sulfate (topical)</i>	65	<i>hepatamine</i>	58
<i>gentamicin sulfate soln (ophth)</i>	61	HERCEPTIN	18
GENVOYA	13	HERCEPTIN HYLECTA	18
GEODON	34	HERZUMA	18
<i>gianvi tab 3-0.02mg</i>	45	HETLIOZ	37
GILENYA	39	HIBERIX	57
GILOTRIF TAB 20MG	20	HUMIRA	55
GILOTRIF TAB 30MG	20	HUMIRA INJ 10MG/0.2ML	55
GILOTRIF TAB 40MG	20	HUMIRA KIT 20MG/0.4ML	55
<i>glatiramer acetate 20mg/ml</i>	39	HUMIRA KIT 40MG/0.8ML	55
<i>glatiramer acetate 40mg/ml</i>	39	HUMIRA PEDIATRIC CROHNS DISEASE	55
<i>glatopa</i>	39	HUMIRA PEN	55
GLEOSTINE	17	HUMIRA PEN CD/UC/HS STARTER	55
<i>glimepiride</i>	41	HUMIRA PEN INJ CD/UC/HS STARTER	55
<i>glip/metform tab 2.5-250mg</i>	41	HUMIRA PEN INJ PS/UV STARTER	55
<i>glip/metform tab 2.5-500mg</i>	41	HUMIRA PEN-PS/UV STARTER	55
<i>glip/metform tab 5-500mg</i>	41	HUMULIN R INJ U-500	40
<i>glipizide</i>	41, 42	HUMULIN R U-500 KWIKPEN	40
<i>glipizide xl</i>	42	<i>hydralazine hcl</i>	27
GLUCAGEN HYPOKIT	49	<i>hydrochlorothiazide</i>	27
GLUCAGON EMERGENCY KIT	49	<i>hydroco/apap tab 10-325mg</i>	8
<i>glycopyrrolate tab 1mg</i>	51	<i>hydroco/apap tab 5-325mg</i>	8
<i>glycopyrrolate tab 2mg</i>	51	<i>hydroco/apap tab 7.5-325</i>	8
<i>glydo</i>	67	<i>hydrocodone-acetaminophen 7.5-325 mg/15ml</i>	8
GLYXAMBI	42	<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	8
GOLYTELY	51	<i>hydrocortisone</i>	48
<i>granisetron hcl</i>	50	<i>hydrocortisone (enema)</i>	51
<i>griseofulvin microsize</i>	11	<i>hydrocortisone (topical) cream 1%</i>	67
<i>griseofulvin ultramicrosize</i>	11	<i>hydrocortisone (topical) cream 2.5%</i>	67
<i>guanfacine er (adhd)</i>	37	<i>hydrocortisone (topical) lotion 2.5%</i>	67
GVOKE HYPOPEN 2-PACK	49	<i>hydrocortisone (topical) oint 2.5%</i>	67
GVOKE PFS	49	<i>hydrocortisone butyrate cream 0.1%</i>	67
HAEGARDA	54	<i>hydrocortisone butyrate oint 0.1%</i>	67
<i>halobetasol propionate</i>	67	<i>hydromorphone hcl</i>	8
<i>haloperidol</i>	34	<i>hydroxychloroquine sulfate</i>	55
<i>haloperidol conc 2mg/ml</i>	34	<i>hydroxyurea</i>	22
<i>haloperidol decanoate</i>	34	<i>hydroxyzine hcl</i>	63
<i>haloperidol lactate inj 5mg/ml</i>	34	<i>hydroxyzine hcl inj</i>	63
HARVONI	14	<i>hydroxyzine pamoate</i>	63
HAVRIX	57	HYSINGLA ER	8
<i>heather</i>	45	<i>ibandronate sodium tabs</i>	44
<i>heparin sod (porcine) in d5w</i>	53		
<i>heparin sod inj 1000/ml</i>	53		
<i>heparin sod inj 10000/ml</i>	53		

IBRANCE.....	18	<i>irinotecan hcl</i>	22
<i>ibu tab 600mg</i>	7	ISENTRESS	12
<i>ibu tab 800mg</i>	7	ISENTRESS HD	12
<i>ibuprofen</i>	7	<i>isibloom</i>	45
<i>icatibant acetate</i>	54	ISOLYTE P.....	59
ICLUSIG.....	20	ISOLYTE S.....	59
IDHIFA	18	<i>isoniazid</i>	13
ILEVRO	61	<i>isoniazid syp 50mg/5ml</i>	13
<i>imatinib mesylate</i>	20	<i>isosorb mononitrate tab</i>	27
IMBRUVICA	20	<i>isosorbide dinitrate</i>	27
<i>imipenem-cilastatin</i>	10	<i>isosorbide mononitrate er</i>	27
<i>imipramine hcl</i>	32	<i>isotretinoin</i>	65
<i>imiquimod</i>	68	<i>isradipine</i>	26
IMOVAX RABIES (H.D.C.V.)	57	<i>itraconazole</i>	11
<i>incassia</i>	45	<i>ivermectin</i>	10
INCRELEX	49	IXIARO	57
INCRUSE ELLIPTA	62	JADENU	44
<i>indapamide</i>	27	JADENU SPRINKLE	44
INFANRIX.....	57	JAKAFI.....	21
INGREZZA.....	38	<i>jantoven</i>	54
INLYTA	20	JANUMET	42
INREBIC.....	20	JANUMET XR TAB 100-1000.....	42
INSULIN PEN NEEDLE	40	JANUMET XR TAB 50-1000	42
INSULIN SAFETY NEEDLES	40	JANUMET XR TAB 50-500MG.....	42
INSULIN SYRINGE.....	40	JANUVIA	42
INTELENCE.....	12	JARDIANCE	42
INTRALIPID 30%.....	58	<i>jasmiel</i>	45
INTRALIPID INJ 20%	58	JENTADUETO	42
INTRON-A INJ 10MU.....	56	JENTADUETO TAB XR 2.5-1000 MG ...	42
INTRON-A INJ 18MU.....	56	JENTADUETO TAB XR 5-1000 MG	42
INTRON-A INJ 25MU.....	56	<i>jinteli</i>	48
INTRON-A INJ 50MU.....	56	<i>jolessa tab 0.15-0.03 mg</i>	45
<i>introvale</i>	45	<i>jolivette</i>	45
INVEGA SUST INJ 117 MG/0.75 ML ...	35	<i>juleber</i>	45
INVEGA SUST INJ 156MG/ML.....	35	JULUCA.....	13
INVEGA SUST INJ 234 MG/1.5 ML	35	<i>junel 1.5/30</i>	45
INVEGA SUST INJ 39 MG/0.25 ML	35	<i>junel 1/20</i>	45
INVEGA SUST INJ 78 MG/0.5 ML	35	<i>junel fe 1.5/30</i>	45
INVEGA TRINZA	35	<i>junel fe 1/20</i>	45
INVIRASE.....	12	JUXTAPID.....	25
IPOL INACTIVATED IPV	57	KADCYLA	18
<i>ipratropium bromide</i>	62	KALETRA TAB 100-25MG.....	13
<i>ipratropium bromide (nasal)</i>	62	KALETRA TAB 200-50MG.....	13
<i>ipratropium-albuterol nebu</i>	62	KALYDECO	64
<i>irbesartan</i>	24	KANJINTI	18
<i>irbesartan-hydrochlorothiazide</i>	23	<i>kariva</i>	45
IRESSA.....	21	<i>kcl 0.075%/d5w/nacl 0.45%</i>	59

KCL 0.15%/D5W/NAACL 0.225%	59	LASTACRAFT	61
<i>kcl 0.15%/d5w/nacl 0.9%</i>	59	<i>latanoprost</i>	62
<i>kcl 0.3%/d5w/nacl 0.45%</i>	59	LATUDA	35
KCL 0.3%/D5W/NAACL 0.9%	59	<i>leena tab</i>	45
<i>kcl/d5w/nacl inj .15/.45%</i>	59	<i>leflunomide</i>	55
<i>kcl/d5w/nacl inj 0.22%/0.45%</i>	59	LENVIMA 10 MG DAILY DOSE	21
<i>kcl/nacl inj 0.15%-0.9%</i>	59	LENVIMA 12MG DAILY DOSE	21
<i>kcl/nacl inj 0.3-0.9</i>	59	LENVIMA 14 MG DAILY DOSE	21
<i>kcl0.15%/d5w/nacl0.2%</i>	59	LENVIMA 18 MG DAILY DOSE	21
<i>kelnor 1/35</i>	45	LENVIMA 20 MG DAILY DOSE	21
<i>kelnor 1/50</i>	45	LENVIMA 24 MG DAILY DOSE	21
<i>ketoconazole</i>	11	LENVIMA 4 MG DAILY DOSE	21
<i>ketoconazole cream</i>	66	LENVIMA 8 MG DAILY DOSE	21
<i>ketoconazole shampoo</i>	66	<i>lessina</i>	45
<i>ketorolac tromethamine (ophth)</i>	61	<i>letrozole</i>	19
KEYTRUDA	18	<i>leucovorin calcium</i>	22
KINRIX	57	LEUKERAN.....	17
<i>kionex sus 15gm/60ml</i>	44	<i>leuprolide inj 1mg/0.2</i>	19
KISQALI.....	18	<i>levalbuterol hcl</i>	63
KISQALI FEMARA 200 DOSE	18	<i>levalbuterol hcl soln nebu conc 1.25</i>	
KISQALI FEMARA 400 DOSE	18	<i>mg/0.5ml</i>	63
KISQALI FEMARA 600 DOSE	18	<i>levalbuterol tartrate hfa</i>	63
<i>klor-con 10</i>	58	LEVEMIR	40
<i>klor-con 8</i>	58	LEVEMIR FLEXTOUCH	40
<i>klor-con m10</i>	58	<i>levetiracetam</i>	30
<i>klor-con m15</i>	58	<i>levetiracetam in sodium chloride</i>	30
<i>klor-con m20</i>	58	<i>levetiracetam oral soln 100 mg/ml</i>	30
<i>klor-con pak 20meq</i>	58	<i>levobunolol hcl</i>	62
<i>klor-con spr cap 10meq</i>	58	<i>levocarnitine (metabolic modifiers)</i>	47
<i>klor-con spr cap 8meq</i>	58	<i>levocetirizine dihydrochloride</i>	63
KORLYM	49	<i>levofloxacin</i>	15
<i>kurvelo</i>	45	<i>levofloxacin in d5w</i>	15
KUVAN.....	47	<i>levofloxacin inj 25mg/ml</i>	15
<i>labetalol hcl</i>	25	<i>levofloxacin oral soln 25 mg/ml</i>	15
<i>lactated ringer's</i>	59	<i>levonest</i>	45
<i>lactulose</i>	52	<i>levonor/ethi tab</i>	45
<i>lactulose (encephalopathy)</i>	52	<i>levonorgestrel & eth estradiol</i>	45
<i>lamivudine</i>	12	<i>levonorgestrel-ethinyl estradiol (91-</i>	
<i>lamivudine (hbv)</i>	14	<i>day)</i>	46
<i>lamivudine-zidovudine</i>	13	<i>levora 0.15/30-28</i>	46
<i>lamotrigine</i>	30	<i>levo-t</i>	50
<i>lansoprazole</i>	52	<i>levothyroxine sodium</i>	50
<i>larin 1.5/30</i>	45	<i>levoxyl</i>	50
<i>larin 1/20</i>	45	LEXIVA	12
<i>larin fe 1.5/30</i>	45	<i>lidocaine</i>	67
<i>larin fe 1/20</i>	45	<i>lidocaine hcl</i>	67
<i>larissia tab</i>	45	<i>lidocaine hcl (local anesth.)</i>	9

<i>lidocaine hcl (mouth-throat)</i>	68	LYNPARZA	18
<i>lidocaine inj 0.5%</i>	9	LYRICA CR	38
<i>lidocaine inj 1%</i>	9	LYSODREN	19
<i>lidocaine inj 1.5% preservative free (pf)</i>	9	<i>lyza</i>	46
<i>lidocaine oint 5%</i>	67	<i>magnesium sulfate</i>	58
<i>lidocaine-prilocaine</i>	67	MAGNESIUM SULFATE	58
<i>linezolid in sodium chloride</i>	10	MAGNESIUM SULFATE IN D5W.....	58
<i>linezolid inj</i>	10	<i>magnesium sulfate in dextrose</i>	58
<i>linezolid susp</i>	10	<i>magnesium sulfate inj 50%</i>	58
<i>linezolid tab 600mg</i>	10	<i>malathion</i>	68
LINZESS	52	<i>maprotiline hcl</i>	32
<i>liothyronine sodium</i>	50	<i>marlissa</i>	46
<i>lisinopril</i>	23	MARPLAN TAB 10MG.....	32
<i>lisinopril & hydrochlorothiazide</i>	23	MATULANE	22
<i>lithium carbonate</i>	38	MAVYRET	14
<i>lithium carbonate er</i>	38	<i>meclizine hcl</i>	50
LITHIUM SOLN 8MEQ/5ML.....	38	<i>medroxyprogesterone acetate</i> (contraceptive)	46
LOKELMA	44	<i>medroxyprogesterone acetate tab</i>	50
LONSURF	22	<i>mefloquine hcl</i>	11
<i>loperamide hcl</i>	52	<i>megestrol ac sus 40mg/ml</i>	19
<i>lopinavir-ritonavir</i>	13	<i>megestrol ac tab 20mg</i>	19
<i>lorazepam</i>	28	<i>megestrol ac tab 40mg</i>	19
<i>lorazepam intensol</i>	28	<i>megestrol sus 625mg/5ml</i>	19
LORBRENA	21	MEKINIST	21
<i>lorcet hd tab 10-325mg</i>	8	MEKTOVI.....	21
<i>lorcet plus tab 7.5-325</i>	8	<i>meloxicam</i>	7
<i>lorcet tab 5-325mg</i>	8	<i>memantine hcl cp24</i>	31
<i>loryna</i>	46	<i>memantine soln</i>	31
<i>losartan potassium</i>	24	<i>memantine tabs</i>	31
<i>losartan-hydrochlorothiazide</i>	23	MENACTRA	57
LOTEMAX	61	MENVEO	57
<i>loteprednol etabonate</i>	61	<i>mercaptopurine</i>	17
<i>lovastatin</i>	24	<i>meropenem</i>	10
<i>low-ogestrel</i>	46	<i>mesalamine</i>	51
<i>loxapine succinate</i>	35	<i>mesalamine w/ cleanser</i>	51
LUMIGAN	62	MESNEX.....	22
LUMIZYME.....	47	<i>metadate er tab 20mg</i>	37
LUPRON DEPOT (1-MONTH).....	19	<i>metformin er</i>	42
LUPRON DEPOT INJ 11.25MG (3- MONTH).....	19	<i>metformin hcl</i>	42
LUPRON DEPOT-PED (1-MONTH	49	<i>methadone hcl</i>	8
LUPRON DEPOT-PED (3-MONTH	49	<i>methadone hcl 10mg</i>	8
LUPRON DEP-PED INJ 11.25MG (3- MONTH).....	49	<i>methadone hcl 5mg</i>	8
LUPRON DEP-PED INJ 7.5MG	49	<i>methadone hcl intensol</i>	8
<i>lutera</i>	46	<i>methazolamide</i>	27
		<i>methenamine hippurate</i>	10
		<i>methimazole</i>	50

<i>methotrexate sodium inj soln</i>	17	<i>morphine ext-rel tab</i>	8
<i>methotrexate sodium inj solr</i>	17	<i>morphine sul inj 1mg/ml</i>	8
<i>methotrexate sodium tabs</i>	55	<i>morphine sulfate</i>	8, 9
<i>methylphenidate hcl</i>	37	MORPHINE SULFATE	8
<i>methylphenidate hcl oral soln</i>	37	<i>morphine sulfate oral soln 100mg/5ml</i>	9
<i>methylphenidate hcl tbc 10 mg</i>	37	<i>morphine sulfate oral soln 10mg/5ml..</i>	9
<i>methylphenidate hcl tbc 20mg</i>	37	<i>morphine sulfate oral soln 20mg/5ml..</i>	9
<i>methylpr ss inj</i>	48	MOVANTIK	52
<i>methylpred pak 4mg</i>	48	MOXEZA.....	61
<i>methylpred tab 16mg</i>	48	<i>moxifloxacin hcl (ophth)</i>	61
<i>methylpred tab 32mg</i>	48	MULTAQ	24
<i>methylpred tab 4mg</i>	48	<i>mupirocin</i>	65
<i>methylpred tab 8mg</i>	48	MVASI	18
<i>methylprednisolone acetate</i>	48	MYCAMINE	11
<i>metoclopramide hcl</i>	50	<i>mycophenolate mofetil</i>	56
<i>metoclopramide hcl inj</i>	50	<i>mycophenolate sodium tbec</i>	56
<i>metolazone</i>	27	<i>myorisan</i>	65
<i>metoprolol & hydrochlorothiazide</i>	25	MYRBETRIQ	53
<i>metoprolol succinate</i>	25	<i>nabumetone</i>	7
<i>metoprolol tartrate</i>	25	<i>nadolol</i>	25
<i>metronidazole</i>	10	<i>nafcillin sodium for inj</i>	16
<i>metronidazole (topical)</i>	68	NAFCILLIN SODIUM FOR INJ 10GM....	16
<i>metronidazole gel 0.75%</i>	68	NAGLAZYME	47
<i>metronidazole in nacl</i>	10	<i>nalbuphine hcl</i>	7
<i>metronidazole vaginal</i>	53	<i>naloxone inj 0.4mg/ml</i>	40
<i>micafungin sodium</i>	11	<i>naloxone inj 1mg/ml</i>	40
<i>microgestin 1.5/30</i>	46	<i>naltrexone hcl</i>	40
<i>microgestin 1/20</i>	46	NAMZARIC	31
<i>microgestin fe 1.5/30</i>	46	<i>naproxen</i>	7
<i>microgestin fe 1/20</i>	46	<i>naproxen dr</i>	7
<i>midodrine hcl</i>	27	<i>naproxen sodium</i>	7
<i>miglustat</i>	47	<i>naratriptan hcl</i>	38
<i>mili</i>	46	NARCAN.....	40
<i>minitran</i>	27	NATACYN	61
<i>minocycline hcl</i>	17	<i>nateglinide</i>	42
<i>minoxidil</i>	27	NATPARA	49
<i>mirtazapine</i>	32	NAYZILAM	30
<i>misoprostol</i>	52	<i>necon 0.5/35-28</i>	46
MITIGARE	7	<i>nefazodone hcl</i>	32
M-M-R II	57	<i>neomycin sulfate</i>	9
M-NATAL PLUS.....	60	<i>neomycin-bacitracin zn-polymyxin</i>	61
<i>moexipril hcl</i>	23	<i>neomycin-polymy-dexameth</i>	60
<i>molindone hcl</i>	35	<i>neomycin-polymyxin-gramicidin</i>	61
<i>mometasone furoate</i>	67	<i>neomycin-polymyxin-hc (ophth)</i>	60
<i>mondoxyne nl cap 100mg</i>	17	<i>neomycin-polymyxin-hc (otic)</i>	69
<i>mono-lynyah tab 0.25-35</i>	46	NEPHRAMINE	59
<i>montelukast sodium</i>	63	NERLYNX.....	21

NEUPRO	33	<i>nortrel 1/35</i>	46
<i>nevirapine susp 50 mg/5ml</i>	12	<i>nortrel 7/7/7</i>	46
<i>nevirapine tab 100mg er</i>	12	<i>nortriptyline hcl</i>	32
<i>nevirapine tab 200mg</i>	12	NORVIR PACK.....	12
<i>nevirapine tab 400mg er</i>	12	NORVIR SOLN.....	12
NEXAVAR	21	NOVOLIN 70/30	41
<i>niacin (antihyperlipidemic)</i>	25	NOVOLIN 70/30 FLEXPEN.....	41
<i>niacin er (antihyperlipidemic)</i>	25	NOVOLIN N	41
<i>niacor</i>	25	NOVOLIN N FLEXPEN	41
<i>nicardipine hcl</i>	26	NOVOLIN R	41
NICOTROL INHALER	40	NOVOLIN R FLEXPEN	41
NICOTROL NS.....	40	NOVOLOG	41
<i>nifedipine</i>	26	NOVOLOG 70/30 FLEXPEN.....	41
<i>nifedipine er</i>	26	NOVOLOG FLEXPEN	41
<i>nikki</i>	46	NOVOLOG MIX 70/30.....	41
<i>nilutamide</i>	19	NOVOLOG PENFILL.....	41
<i>nimodipine</i>	26	NOXAFIL	11
NINLARO.....	18	NUBEQA.....	19
<i>nitisinone</i>	47	NUCALA	64
NITRO-BID	27	NUCYNTA ER	9
NITRO-DUR DIS 0.3MG/HR.....	27	NUDEXTA	38
NITRO-DUR DIS 0.8MG/HR.....	27	NULOJIX	56
<i>nitrofurantoin macrocrystal</i>	10	NULYTELY/FLAVOR PACKS	52
<i>nitrofurantoin monohyd macro</i>	10	NUPLAZID CAPS.....	35
<i>nitroglycerin</i>	27	NUPLAZID TABS 10MG.....	35
<i>nitroglycerin td patch</i>	27	NUTRILIPID INJ 20%	59
NITYR	47	<i>nyamyc</i>	66
<i>nizatidine</i>	51	NYMALIZE	26
<i>nora-be tab 0.35mg</i>	46	<i>nystatin</i>	11
<i>norethindrone (contraceptive)</i>	46	<i>nystatin (mouth-throat)</i>	68
<i>norethindrone acet & eth estra</i>	46	<i>nystatin (topical)</i>	66
<i>norethindrone acetate</i>	50	<i>nystop</i>	66
<i>norethindrone acetate-ethinyl estradiol</i>	48	<i>ocella tab 3-0.03mg</i>	46
<i>norgest/ethi tab 0.25/35</i>	46	OCTAGAM	56
<i>norgestimate-ethinyl estradiol</i> (triphasic) 0.18-25/0.215-25/0.25-25 <i>mg-mcg</i>	46	<i>octreotide acetate</i>	49
<i>norgestimate-ethinyl estradiol</i> (triphasic) 0.18-35/0.215-35/0.25-35 <i>mg-mcg</i>	46	ODEFSEY	13
NORMOSOL-M IN D5W.....	59	ODOMZO.....	18
NORMOSOL-R	59	OFEV	64
NORMOSOL-R IN D5W	59	<i>ofloxacin (ophth)</i>	61
NORPACE CR	24	<i>ofloxacin (otic)</i>	69
NORTHERA	27	OGIVRI	18
<i>nortrel 0.5/35 (28)</i>	46	<i>olanzapine</i>	35
		<i>olmesartan medoxomil</i>	24
		<i>olmesartan medoxomil-amlodipine-</i> <i>hydrochlorothiazide</i>	23
		<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide</i>	23

<i>olopatadine hcl 0.2%</i>	61	<i>paricalcitol</i>	60
<i>omeprazole cap 10mg</i>	52	<i>paroex sol 0.12%</i>	68
<i>omeprazole cap 20mg</i>	52	<i>paromomycin sulfate</i>	9
<i>omeprazole cap 40mg</i>	52	<i>paroxetine hcl tabs</i>	32
<i>ondansetron hcl</i>	50	PASER D/R	13
<i>ondansetron hcl inj</i>	50	PAXIL	32
<i>ondansetron hcl oral soln</i>	50	PAZEO	61
<i>ondansetron odt</i>	51	PEDIARIX	57
ONE VITE WOMENS PRENATAL.....	60	PEDVAX HIB	57
ONTRUZANT	18	<i>peg 3350-kcl-sod bicarb-sod chloride-</i> <i>sod sulfate</i>	52
OPSUMIT	28	<i>peg 3350-potassium chloride-sod</i> <i>bicarbonate-sod chloride</i>	52
ORFADIN.....	47	PEGANONE	30
ORKAMBI	64	PEGASYS.....	14
<i>orsythia</i>	46	PEGASYS PROCLICK	14
<i>oseltamivir phosphate</i>	14	PEMAZYRE.....	21
OSPHENA	49	<i>penicillamine</i>	44
<i>oxacillin sodium</i>	16	PENICILLIN G POT IN DEXTROSE 2MU	16
<i>oxaliplatin inj 100mg</i>	22	PENICILLIN G POT IN DEXTROSE 3MU	16
<i>oxaliplatin inj 100mg/20ml</i>	22	PENICILLIN G PROCAINE.....	16
<i>oxaliplatin inj 50mg</i>	22	<i>penicillin g sodium</i>	16
<i>oxaliplatin inj 50mg/10ml</i>	22	<i>penicillin v potassium</i>	16
<i>oxandrolone tab 10mg</i>	40	<i>penicilln gk inj 20mu</i>	16
<i>oxandrolone tab 2.5mg</i>	40	<i>penicilln gk inj 5mu</i>	16
<i>oxcarbazepine</i>	30	PENTACEL	57
<i>oxybutynin chloride</i>	53	<i>pentamidine isethionate inh</i>	10
<i>oxycodone hcl</i>	9	<i>pentamidine isethionate inj</i>	10
<i>oxycodone w/ acetaminophen 10-</i> <i>325mg</i>	9	<i>pentoxifylline</i>	54
<i>oxycodone w/ acetaminophen 2.5-</i> <i>325mg</i>	9	<i>perindopril erbumine</i>	23
<i>oxycodone w/ acetaminophen 5-325mg</i>	9	<i>periogard</i>	68
<i>oxycodone w/ acetaminophen 7.5-</i> <i>325mg</i>	9	<i>permethrin cre 5%</i>	68
OZEMPIC INJ 0.25 OR 0.5MG/DOSE ..	41	<i>perphenazine</i>	35
OZEMPIC INJ 1MG/DOSE.....	41	PERSERIS	35
<i>pacerone</i>	24	<i>pfizerpen-g inj 20mu</i>	16
<i>paclitaxel</i>	17	<i>pfizerpen-g inj 5mu</i>	16
<i>paliperidone</i>	35	<i>phenelzine sulfate</i>	32
<i>pamidronate disodium</i>	44	<i>phenobarbital</i>	30
PAMIDRONATE DISODIUM.....	44	<i>phenobarbital sodium</i>	30
<i>pamidronate inj 30mg</i>	44	PHENYTEK.....	30
<i>pamidronate inj 90mg</i>	44	<i>phenytoin</i>	30
PANRETIN	68	<i>phenytoin sodium extended</i>	30
<i>pantoprazole sodium</i>	52	<i>phenytoin sodium inj 50mg/ml</i>	30
<i>pantoprazole sodium tbec</i>	52	<i>philith</i>	46
PANZYGA	56	PHOSPHOLINE IODIDE.....	62

PICATO	68	<i>pred sod pho sol 5mg/5ml</i>	48
PIFELTRO	12	<i>prednisolone acetate (ophth)</i>	61
<i>pilocarpine hcl</i>	62	<i>prednisolone sodium phosphate</i>	48
<i>pilocarpine hcl (oral)</i>	68	PREDNISOLONE SODIUM PHOSPHATE	
<i>pimozide</i>	35	(OPHTH)	61
<i>pimtrea</i>	46	<i>prednisolone sol 15mg/5ml</i>	48
<i>pindolol</i>	25	<i>prednisolone sol 25mg/5ml</i>	48
<i>pioglitazone hcl</i>	42	PREDNISONE CON 5MG/ML	48
<i>piper/tazoba inj 12-1.5gm</i>	16	<i>prednisone pak 10mg</i>	48
<i>piper/tazoba inj 2-0.25gm</i>	16	<i>prednisone pak 5mg</i>	48
<i>piper/tazoba inj 3-0.375gm</i>	16	<i>prednisone sol 5mg/5ml</i>	48
<i>piper/tazoba inj 36-4.5gm</i>	16	<i>prednisone tab 10mg</i>	48
<i>piper/tazoba inj 4-0.5gm</i>	16	<i>prednisone tab 1mg</i>	48
PIQRAY 200MG DAILY DOSE	21	<i>prednisone tab 2.5mg</i>	48
PIQRAY 250MG DAILY DOSE	21	<i>prednisone tab 20mg</i>	48
PIQRAY 300MG DAILY DOSE	21	<i>prednisone tab 50mg</i>	48
<i>pirmella 1/35</i>	46	<i>prednisone tab 5mg</i>	48
<i>piroxicam</i>	7	<i>pregabalin</i>	30
PLASMA-LYTE A	59	PREMASOL 10%	59
PLASMA-LYTE-148	59	PRENATAL	60
<i>plenamine</i>	59	PRENATAL PLUS	60
PLENVU	52	PRENATAL PLUS LOW IRON	60
PNV FOLIC ACID + IRON MUL	60	<i>prevalite</i>	25
<i>podofilox</i>	68	<i>previfem</i>	46
<i>polymyxin b-trimethoprim</i>	61	PREZCOBIX	13
POMALYST	19	PREZISTA	12
<i>portia-28</i>	46	PRIFTIN	13
<i>posaconazole</i>	11	<i>primaquine phosphate</i>	11
<i>pot chloride inj 2meq/ml</i>	60	PRIMAQUINE PHOSPHATE	11
<i>potassium chloride</i>	58, 60	<i>primidone</i>	30
POTASSIUM CHLORIDE	60	PRIVIGEN	56
<i>potassium chloride in nacl</i>	60	<i>probenecid</i>	7
<i>potassium chloride microencapsulated</i>		PROCALAMINE	59
<i>crystals er</i>	58	<i>prochlorperazine inj</i>	51
<i>potassium citrate (alkalinizer) er tabs</i>	53	<i>prochlorperazine maleate</i>	51
PRADAXA	54	<i>prochlorperazine supp</i>	51
PRALUENT	25	PROCRIT	54
<i>pramipexole tab 0.125mg</i>	33	<i>procto-med hc</i>	68
<i>pramipexole tab 0.25mg</i>	33	<i>procto-pak</i>	68
<i>pramipexole tab 0.5mg</i>	33	<i>proctosol hc cre 2.5%</i>	68
<i>pramipexole tab 0.75mg</i>	33	<i>proctozone-hc</i>	68
<i>pramipexole tab 1.5mg</i>	33	PROGLYCEM SUS 50MG/ML	49
<i>pramipexole tab 1mg</i>	33	PROGRAF	56
<i>prasugrel hcl</i>	54	PROLASTIN-C	64
<i>pravastatin sodium</i>	24	PROLENSA	61
<i>praziquantel</i>	10	PROLIA	49
<i>prazosin hcl</i>	23	PROMACTA	54

<i>promethazine hcl</i>	51	<i>ribavirin cap 200mg</i>	14
<i>promethazine hcl inj</i>	51	<i>ribavirin tab 200mg</i>	14
<i>propafenone hcl</i>	24	<i>rifabutin</i>	13
<i>propafenone hcl 12hr</i>	24	<i>rifampin</i>	13
<i>proparacaine hcl</i>	62	<i>riluzole</i>	39
<i>propranolol & hydrochlorothiazide</i>	25	<i>rimantadine hydrochloride</i>	14
<i>propranolol cap er</i>	25	RINVOQ	55
<i>propranolol hcl</i>	25	RISPERDAL INJ 12.5MG	35
<i>propranolol oral sol</i>	25	RISPERDAL INJ 25MG	35
<i>propylthiouracil</i>	50	RISPERDAL INJ 37.5MG	35
PROQUAD	57	RISPERDAL INJ 50MG	36
PROSOL	59	<i>risperidone</i>	36
<i>protriptyline hcl</i>	33	<i>ritonavir</i>	12
PULMICORT FLEXHALER	65	RITUXAN	18
PULMOZYME	64	RITUXAN HYCELA.....	18
PURIXAN	17	<i>rivastigmine tartrate</i>	31
<i>pyrazinamide</i>	13	<i>rivastigmine td patch 24hr 13.3</i>	
<i>pyridostigmine tab 60mg</i>	38	<i>mg/24hr</i>	31
QINLOCK	21	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	
QUADRACEL	57	31
<i>quetiapine fumarate</i>	35	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	
<i>quinapril hcl</i>	23	31
<i>quinapril-hydrochlorothiazide</i>	23	<i>rizatriptan benzoate</i>	38
<i>quinidine sulfate</i>	24	<i>rizatriptan benzoate odt</i>	38
<i>quinine sulfate</i>	11	<i>ropinirole tab 0.25mg</i>	33
RABAVERT.....	57	<i>ropinirole tab 0.5mg</i>	33
<i>raloxifene tab 60mg</i>	49	<i>ropinirole tab 1mg</i>	34
<i>ramipril</i>	23	<i>ropinirole tab 2mg</i>	34
<i>ranolazine</i>	27	<i>ropinirole tab 3mg</i>	34
<i>rasagiline mesylate</i>	33	<i>ropinirole tab 4mg</i>	34
RAYALDEE	60	<i>ropinirole tab 5mg</i>	34
<i>reclipsen</i>	46	<i>rosadan cre 0.75%</i>	68
RECOMBIVAX HB.....	57	<i>rosuvastatin calcium</i>	24
RECTIV	68	ROTARIX.....	57
REGRANEX	68	ROTATEQ	57
RELENZA DISKHALER	14	<i>rowepra</i>	30
RELISTOR	52	<i>rowepra xr</i>	30
REMICADE.....	55	ROZLYTREK	21
RENFLEXIS	55	RUBRACA	18
<i>repaglinide</i>	42, 43	RUXIENCE	18
RESTASIS	62	RYBELSUS	43
RESTASIS MULTIDOSE.....	62	RYDAPT	21
RETEVMO	21	SANDIMMUNE.....	56
REVLIMID.....	19	SANTYL.....	68
REXULTI	35	SAPHRIS	36
REYATAZ.....	12	<i>scopolamine</i>	51
RHOPRESSA	62	SECUADO.....	36

<i>selegiline hcl</i>	34	STIVARGA	21
<i>selenium sulfide</i>	66	<i>streptomycin sulfate</i>	9
SELZENTRY	12	STRIBILD	13
SEREVENT DISKUS.....	63	<i>subvenite tab</i>	30
<i>sertraline hcl</i>	33	<i>sucrafate</i>	52
<i>setlakin tab</i>	46	<i>sulfacetamide sodium (acne)</i>	65
<i>sevelamer carbonate</i>	50	<i>sulfacetamide sodium (ophth)</i>	61
<i>sharobel</i>	46	<i>sulfacetamide sod-prednisolone</i>	60
SHINGRIX	57	SULFADIAZINE	9
SIGNIFOR	49	<i>sulfamethoxazole-trimethop ds</i>	10
<i>sildenafil citrate tab 20 mg (pulmonary hypertension)</i>	28	<i>sulfamethoxazole-trimethoprim inj</i>	10
<i>silver sulfadiazine</i>	65	<i>sulfamethoxazole-trimethoprim susp</i> .	10
SIMBRINZA	62	<i>sulfamethoxazole-trimethoprim tab 400-80mg</i>	10
<i>simvastatin</i>	24	SULFAMYLON.....	65
<i>sirolimus</i>	56	<i>sulfasalazine</i>	51
SIRTURO.....	13	<i>sulfasalazine ec</i>	51
SIVEXTRO	10	<i>sulindac</i>	7
SKYRIZI.....	55	<i>sumatriptan</i>	38
<i>sodium chlor sol 0.9% irr</i>	68	<i>sumatriptan inj 4mg/0.5ml</i>	38
<i>sodium chloride</i>	58, 60	<i>sumatriptan inj 6mg/0.5ml</i>	38
<i>sodium chloride 0.45%</i>	60	<i>sumatriptan succinate</i>	38
<i>sodium chloride inj 0.9%</i>	60	SUPREP BOWEL PREP KIT.....	52
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	58	SUTENT	21
<i>sodium phenylbutyrate</i>	47	<i>syeda</i>	46
<i>sodium polystyrene sulfonate powder</i> ..	44	SYLATRON.....	22
<i>sodium polystyrene sulfonate susp</i>	44	SYMBICORT.....	65
SOLIQUA 100/33.....	41	SYMDEKO.....	64
SOLTAMOX	19	SYMFI.....	13
SOLU-CORTEF	48	SYMFI LO	13
SOMATULINE DEPOT	49	SYMJEPI.....	64
SOMAVERT	49	SYMPAZAN	30
<i>sorine</i>	24	SYMTUZA.....	13
<i>sotalol hcl</i>	24	SYNAREL.....	47
<i>sotalol hcl (afib/afl)</i>	24	SYNERCID.....	10
<i>spironolactone</i>	23	SYNJARDY TAB 12.5-1000MG	43
<i>spironolactone & hydrochlorothiazide</i> .	27	SYNJARDY TAB 12.5-500MG	43
<i>sprintec 28</i>	46	SYNJARDY TAB 5-1000MG.....	43
SPRITAM	30	SYNJARDY TAB 5-500MG.....	43
SPRYCEL	21	SYNJARDY XR TAB 10-1000MG	43
<i>sps susp 15gm/60ml</i>	44	SYNJARDY XR TAB 12.5-1000MG	43
<i>sronyx</i>	46	SYNJARDY XR TAB 25-1000MG	43
<i>ssd</i>	65	SYNJARDY XR TAB 5-1000MG	43
<i>stavudine</i>	12	SYNRIBO.....	22
STELARA.....	55	SYNTHROID.....	50
STIMATE	50	TABLOID	17
		TABRECTA.....	21

<i>tacrolimus</i>	56	<i>timolol maleate</i>	25
<i>tacrolimus (topical)</i>	68	<i>timolol maleate (ophth) soln</i>	62
TAFINLAR.....	21	<i>timolol maleate gel</i>	62
TAGRISSE.....	21	<i>timolol maleate ophth soln 0.5% (once-daily)</i>	62
TALZENNA.....	18	TIVICAY	12
<i>tamoxifen citrate</i>	19	TIVICAY PD	12
<i>tamsulosin hcl</i>	53	<i>tizanidine hcl</i>	39
TARGRETIN	68	TOBRADEX	60
<i>tarina fe 1/20</i>	46	TOBRADEX ST	60
TASIGNA.....	21	<i>tobramycin</i>	9
TAXOTERE.....	17	<i>tobramycin (ophth)</i>	61
<i>tazarotene</i>	66	<i>tobramycin inj 1.2 gm/30ml</i>	9
<i>tazicef</i>	15	<i>tobramycin inj 1.2gm</i>	9
TAZORAC	66	<i>tobramycin inj 10mg/ml</i>	9
<i>taztia xt</i>	26	<i>tobramycin inj 80mg/2ml</i>	9
TAZVERIK	22	<i>tobramycin sulfate</i>	9
TDVAX	57	<i>tobramycin-dexamethasone</i>	60
TECENTRIQ	18	<i>tolterodine tartrate</i>	53
TEFLARO	15	<i>topiramate</i>	30
<i>telmisartan</i>	24	<i>toposar</i>	22
<i>temazepam</i>	37	<i>toremifene citrate</i>	19
TEMIXYS	13	<i>torseamide tabs</i>	27
TENIVAC	57	TOVIAZ.....	53
<i>tenofovir disoproxil fumarate</i>	12	TPN ELECTROLYTES.....	58
<i>terazosin hcl</i>	23	TRADJENTA	43
<i>terbinafine hcl</i>	11	<i>tramadol hcl tab 50 mg</i>	7
<i>terbutaline sulfate</i>	63	<i>tramadol-acetaminophen</i>	7
<i>terconazole vaginal</i>	53	<i>trandolapril</i>	23
<i>testosterone</i>	40	<i>tranexamic acid</i>	54
<i>testosterone cypionate</i>	40	<i>tranylcypromine sulfate</i>	33
<i>testosterone enanthate</i>	40	TRAVASOL.....	59
<i>tetrabenazine</i>	39	<i>travoprost</i>	62
<i>tetracycline hcl</i>	17	TRAZIMERA	18
TEXACORT SOLN 2.5%	67	<i>trazodone hcl</i>	33
THALOMID	19	TRECATOR	13
THEO-24	64	TRELEGY ELLIPTA.....	62
<i>theophylline</i>	64	TRELSTAR DEP INJ 3.75MG	19
<i>theophylline tab er 12hr 300 mg</i>	64	TRELSTAR LA INJ 11.25MG.....	19
<i>theophylline tab er 12hr 450 mg</i>	64	<i>treprostinil</i>	28
<i>theophylline tab sr 24hr</i>	64	TRESIBA FLEXTOUCH.....	41
<i>thioridazine hcl</i>	36	TRESIBA INJ.....	41
<i>thiothixene</i>	36	<i>tretinoin</i>	65
<i>tiadylt er</i>	26	<i>tretinoin (chemotherapy)</i>	22
<i>tiagabine hcl</i>	30	<i>triamcinolone acetonide (mouth)</i>	68
TIBSOVO.....	18	<i>triamcinolone acetonide (topical)</i>	67
<i>tigecycline</i>	10	<i>triamterene & hydrochlorothiazide cap</i>	
<i>tilia fe</i>	46		

37.5-25 mg	27	TWINRIX INJ	57
<i>triamterene & hydrochlorothiazide tabs</i>		TYBOST	12
.....	27	TYKERB.....	21
TRICARE	60	TYMLOS	49
<i>trientine hcl</i>	44	TYPHIM VI.....	57
<i>tri-estarylla</i>	47	<i>unithroid</i>	50
<i>trifluoperazine hcl</i>	36	<i>ursodiol</i>	52
<i>trifluridine</i>	61	<i>valacyclovir hcl</i>	14
<i>trihexyphenidyl hcl</i>	34	VALCHLOR	68
TRIJARDY XR TAB ER 24HR 10-5-1000		<i>valganciclovir hcl</i>	14
MG	43	<i>valproate sodium</i>	31
TRIJARDY XR TAB ER 24HR 12.5-2.5-		<i>valproate sodium oral soln</i>	31
1000MG	43	<i>valproic acid</i>	31
TRIJARDY XR TAB ER 24HR 25-5-1000		<i>valsartan</i>	24
MG	43	<i>valsartan-hydrochlorothiazide</i>	23
TRIJARDY XR TAB ER 24HR 5-2.5-		VALTOCO	31
1000MG	43	<i>vancomycin hcl</i>	10
TRIKAFTA.....	64	VANCOMYCIN IN NAACL.....	10
<i>tri-legest fe</i>	47	<i>vandazole</i>	53
<i>tri-linyah</i>	47	VAQTA.....	57
<i>tri-lo marzia</i>	47	VARIVAX	57
<i>tri-lo-estarylla</i>	47	VASCEPA.....	25
<i>tri-lo-sprintec</i>	47	VELCADE.....	18
<i>trilyte</i>	52	<i>velivet</i>	47
<i>trimethoprim</i>	10	VELTASSA	44
<i>tri-mili</i>	47	VEMLIDY	14
<i>trimipramine maleate</i>	33	VENCLEXTA	18
TRINTELLIX	33	VENCLEXTA STARTING PACK	19
<i>tri-previfem</i>	47	<i>venlafaxine hcl</i>	33
<i>tri-sprintec</i>	47	VENTAVIS	28
TRIUMEQ	13	VENTOLIN HFA.....	63
<i>trivora-28</i>	47	<i>verapamil cap er</i>	26
<i>tri-vylibra</i>	47	<i>verapamil hcl</i>	26
<i>tri-vylibra lo</i>	47	<i>verapamil tab er</i>	26
TROGARZO.....	12	VERSACLOZ.....	36
TROPHAMINE INJ 10%.....	59	VERZENIO	19
<i>tropium chloride</i>	53	VICTOZA.....	41
TRULICITY.....	41	<i>vienva</i>	47
TRUMENBA	57	<i>vigabatrin powd pack 500mg</i>	31
TRUVADA TAB 100-150.....	13	<i>vigabatrin tab 500mg</i>	31
TRUVADA TAB 133-200.....	13	<i>vigadrone</i>	31
TRUVADA TAB 167-250.....	13	VIIBRYD STARTER PACK	33
TRUVADA TAB 200-300.....	13	VIIBRYD TAB	33
TRUXIMA.....	18	VIMPAT	31
TUKYSA	21	VIMPAT INJ 200MG/20ML.....	31
<i>tulana</i>	47	VIMPAT SOL 10MG/ML.....	31
TURALIO	21	<i>vincristine sulfate</i>	18

<i>vinorelbine tartrate</i>	18	XPOVIO 80 MG TWICE WEEKLY	22
<i>viorele</i>	47	XTANDI.....	19
VIRACEPT.....	12	<i>xulane dis 150-35</i>	47
VIREAD.....	12	XULTOPHY 100/3.6.....	41
VITRAKVI.....	21	XYREM.....	39
VIVITROL.....	40	YF-VAX	57
VIZIMPRO	21	<i>yuvaferm vaginal tablet 10mcg</i>	48
<i>voriconazole</i>	11	<i>zafirlukast</i>	64
VOSEVI.....	14	<i>zarah</i>	47
VOTRIENT	21	ZARXIO.....	54
VRAYLAR.....	36	ZEJULA	19
VRAYLAR THERAPY PACK.....	36	ZELBORAF.....	21
<i>vyfemla</i>	47	ZEMAIRA.....	64
<i>vylibra</i>	47	<i>zenatane</i>	65
<i>warfarin sodium</i>	54	ZENPEP.....	52
<i>water for irrigation, sterile</i>	68	ZERVIAE	61
XALKORI.....	21	<i>zidovudine cap 100mg</i>	12
XARELTO.....	54	<i>zidovudine syp 50mg/5ml</i>	12
XARELTO STARTER PACK	54	<i>zidovudine tab 300mg</i>	12
XATMEP	55	<i>ziprasidone hcl</i>	36
XCOPRI MAINTENANCE PAK 150-200MG	31	<i>ziprasidone mesylate</i>	36
XCOPRI PAK 12.5-25MG.....	31	ZIRABEV	19
XCOPRI PAK 50-100MG.....	31	ZIRGAN	61
XCOPRI PAK 50-200MG.....	31	<i>zoledronic acid inj 4mg/100ml</i>	44
XCOPRI TABS	31	<i>zoledronic acid inj 5mg/100ml</i>	44
XCOPRI TITRATION PAK 150-200MG .	31	<i>zoledronic inj 4mg/5ml</i>	44
XELJANZ	56	ZOLINZA.....	19
XELJANZ XR	56	<i>zolmitriptan</i>	38
XGEVA.....	49	<i>zolmitriptan odt</i>	38
XIFAXAN	52	<i>zolpidem tartrate</i>	37
XIGDUO XR TAB 10-1000MG	43	<i>zonisamide</i>	31
XIGDUO XR TAB 10-500MG	43	ZORTRESS TAB 0.25MG	57
XIGDUO XR TAB 2.5-1000MG	43	ZORTRESS TAB 0.5MG.....	56
XIGDUO XR TAB 5-1000MG	43	ZORTRESS TAB 0.75MG	57
XIGDUO XR TAB 5-500MG	43	ZORTRESS TAB 1MG.....	57
XOLAIR.....	64	ZOSTAVAX	57
XOSPATA	21	<i>zovia 1/35e</i>	47
XPOVIO 100 MG ONCE WEEKLY	22	ZYDELIG	21
XPOVIO 40 MG ONCE WEEKLY	22	ZYKADIA.....	22
XPOVIO 40 MG TWICE WEEKLY	22	ZYLET.....	60
XPOVIO 60 MG ONCE WEEKLY	22	ZYPREXA RELPREVV	36
XPOVIO 60 MG TWICE WEEKLY.....	22	ZYPREXA RELPREVV INJ 210MG	36
XPOVIO 80 MG ONCE WEEKLY	22	ZYTIGA	19

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

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

သတိပဋိရန်။ ။ ခဏ္ဍာ ဗမာစကား ဝေဟတတ္ထိဌာ ဘာသာစကား လူိအပွ; အကူအညီမထားကိုိ အခဲဲ
ေဆာဋြကုေပးေနပါသည။ ဖုနးနံပါတ 1-844-280-5555 (TTY: 711) ကိုိ ေခးုိုငါသည။

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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-844-280-5555 (TTY: 711).

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

خيردار 1-844-280-5555 (TTY: 711) کريں کال - بيں دستياب ميں مفت خدمات کي مدد کي زبان کو آپ تو بيں، بولتے اردو آپ اگر: خبيردار 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 09/01/2020.

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.



This formulary was updated on 09/01/2020
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