



## Generations State of Oklahoma Group Retirees (HMO)

---

# DRUG FORMULARY FORMULARIO DE MEDICAMENTOS

January 1–December 31, 2023  
Entre el 1 de enero y el 31 de diciembre del 2023

---

This document contains a list of covered drugs for Generations State of Oklahoma Group Retirees (HMO). The Drug Formulary was updated on 09/01/2022. For more recent information or other questions, please contact GlobalHealth Customer Care.

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

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

Este documento contiene una lista de medicamentos cubiertos para Generations State of Oklahoma Group Retirees (HMO). El Formulario de medicamentos se actualizó el 09/01/2022. Para obtener información más reciente u otras preguntas, comuníquese con Atención al cliente de GlobalHealth.

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

GlobalHealth es un plan HMO con un contrato con Medicare. La inscripción en GlobalHealth depende de la renovación del contrato.

# Generations State of Oklahoma Group Retirees (HMO)

## 2023 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 00023230, Version Number 6

This formulary was updated on 09/01/2022. For more recent information or other questions, please contact GlobalHealth Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit [www.GlobalHealth.com](http://www.GlobalHealth.com).

- **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.
- **Important Message About What You Pay for Insulin** – You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. For D-SNP, our plan covers insulin at no cost to you.

**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 State of Oklahoma Group Retirees (HMO).

This document includes a list of the drugs (formulary) for our plan which is current as of 09/01/2022. 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, 2023, and from time to time during the year.

## **What is the Generations State of Oklahoma Group Retirees (HMO) Formulary?**

A formulary is a list of covered drugs selected by Generations State of Oklahoma Group Retirees (HMO) 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. Generations State of Oklahoma Group Retirees (HMO) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Generations State of Oklahoma Group Retirees (HMO) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

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

## **Can the Formulary (drug list) change?**

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

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

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

information in the section below titled “How do I request an exception to the Generations State of Oklahoma Group Retirees (HMO)’s Formulary?”

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
  - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Generations State of Oklahoma Group Retirees (HMO)’s Formulary?”

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 09/01/2022. To get updated information about the drugs covered by Generations State of Oklahoma Group Retirees (HMO) please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

## **How do I use the Formulary?**

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

### **Medical Condition**

The formulary begins on page 17. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular”.

If you know what your drug is used for, look for the category name in the list that begins on 91. 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 91. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

### **What are generic drugs?**

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

### **Are there any restrictions on my coverage?**

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 17. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Generations State of Oklahoma Group Retirees (HMO)'s formulary?" on page 5 for information about how to request an exception.

## What if my drug is not on the Formulary?

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

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

- You can ask Member Services 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 State of Oklahoma Group Retirees (HMO)'s Formulary?

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

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

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

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

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

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is

limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

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

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

### **For more information**

For more detailed information about your Generations State of Oklahoma Group Retirees (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 State of Oklahoma Group Retirees (HMO) Formulary**

The formulary below 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 91.

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

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

## Drug Tier

Tier 1 = Preferred Generic

Tier 2 = Generic

Tier 3 = Preferred Brand

Tier 4 = Non-Preferred Drug

Tier 5 = Specialty Tier

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

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



# Generations State of Oklahoma Group Retirees (HMO)

## Formulario 2023

### (Lista de Medicamentos Cubiertos)

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

Identificación de Presentación del Archivo de la Lista de Medicamentos Aprobada por el HPMS  
00023230, versión 6

Esta lista se actualizó el 09/01/2022. Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio de Atención al Cliente al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite [www.GlobalHealth.com](http://www.GlobalHealth.com).

- **Mensaje importante sobre lo que paga por las vacunas** - nuestro plan cubre la mayoría de las vacunas de la Parte D sin costo alguno para usted. Llame a Servicios para miembros para obtener más información.
- **Mensaje importante sobre lo que paga por la insulina** - no pagará más de \$35 por un suministro de un mes de cada producto de insulina cubierto por nuestro plan, sin importar en qué nivel de costo compartido se encuentre. Para D-SNP, nuestro plan cubre la insulina sin costo alguno para usted.

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

Cuando en esta lista de medicamentos (lista) se hace referencia a "nosotros" o "nuestro", se hace referencia a GlobalHealth, Inc. Cuando se hace referencia a "plan" o "nuestro plan", se hace referencia a Generations State of Oklahoma Group Retirees (HMO).

Este documento incluye una lista de los medicamentos (lista) de nuestro plan que entra en vigor a partir del 09/01/2022. Para obtener una lista actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

Por lo general, debe usar las farmacias de la red para usar su beneficio de medicamentos recetados. Los beneficios, la lista, la red de farmacias o los copagos y coseguros pueden cambiar el 1 de enero de 2023 y de manera periódica durante el año.

## **¿Qué es la Lista de Medicamentos de Generations State of Oklahoma Group Retirees (HMO)?**

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

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

## **¿Puede cambiar la Lista (lista de medicamentos)?**

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

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

- **Nuevos medicamentos genéricos.** Podemos eliminar inmediatamente un medicamento de marca registrada de nuestra Lista de Medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de costo compartido o uno más bajo, y con las mismas o con menos restricciones. Además, al agregar el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca registrada

en nuestra Lista de Medicamentos, pero inmediatamente moverlo a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente usted está tomando ese medicamento de marca registrada, podríamos no avisarle con anticipación que realizaremos ese cambio, pero luego le proporcionaremos información sobre el cambio o los cambios específicos que hicimos.

- Si realizamos ese cambio, usted o el recetador pueden solicitarnos hacer una excepción y continuar con la cobertura de su medicamento de marca registrada. El aviso que le enviaremos también incluirá información sobre cómo solicitar una excepción, y puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción a la Lista de Medicamentos de Generations State of Oklahoma Group Retirees (HMO)?”
- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento incluido en nuestra lista de medicamentos no es seguro, o si el fabricante del medicamento lo retira del mercado, lo retiraremos de nuestra lista de inmediato y se lo notificaremos a los miembros que toman el medicamento.
- **Otros cambios.** Es posible que realicemos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos agregar un medicamento genérico que es nuevo en el mercado para reemplazar un medicamento de marca registrada que se encuentra actualmente en la lista de medicamentos, o podemos agregar nuevas restricciones al medicamento de marca registrada, moverlo a un nivel de costo compartido diferente, o ambas cosas. También podemos realizar cambios basados en nuevas pautas clínicas. Si retiramos medicamentos de nuestra lista de medicamentos, agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada para un medicamento, o cambiamos un medicamento a un nivel de costo compartido más alto, debemos notificar a los miembros afectados sobre el cambio al menos 30 días antes de que el cambio entre en vigor, o cuando el miembro solicita un nuevo surtido del medicamento, momento en el cual recibirá un suministro por 30 días del medicamento.
  - Si realizamos estos cambios, usted o el recetador pueden solicitarnos hacer una excepción y continuar con la cobertura de su medicamento de marca registrada. El aviso que le enviaremos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción a la Lista de medicamentos de Generations State of Oklahoma Group Retirees (HMO)?”

**Cambios que no le afectarán si actualmente está tomando el medicamento.** Por lo general, si usted está tomando un medicamento de nuestra Lista de Medicamentos 2023 que estaba cubierto al comienzo del año, no interrumpiremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2023, salvo lo descrito anteriormente. Esto significa que estos medicamentos seguirán disponibles con el mismo costo compartido y sin nuevas restricciones para aquellos

miembros que los tomen durante el resto del año de cobertura. Este año no se le notificarán directamente sobre los cambios que no lo afecten. Sin embargo, el

1 de enero del año siguiente, dichos cambios pueden afectarlo, y es importante revisar la Lista de Medicamentos del nuevo año de beneficios para ver si hay cambios en los medicamentos.

La lista adjunta entra en vigor a partir del 09/01/2022. Para obtener información actualizada sobre los medicamentos cubiertos por nuestro plan, comuníquese con nosotros. Nuestra información de contacto aparece en la portada y en la contraportada. En caso de que se produzcan cambios a mediados de año en la lista de medicamentos que no sean de mantenimiento, las listas se actualizarán mensualmente y se publicarán en nuestro sitio web.

## **¿Cómo utilizo la Lista de Medicamentos?**

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

### **Afección Médica**

La lista comienza en la página 17. Los medicamentos de esta lista de medicamentos están agrupados en categorías según el tipo de afección médica para la que se utilizan. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca se enumeran en la categoría “Cardiovascular”. Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 91. Luego busque su medicamento en el nombre de la categoría.

### **Listado Alfabético**

Si no está seguro en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 91. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca registrada como los medicamentos genéricos figuran en el Índice. Busque en el Índice para encontrar su medicamento. Junto con su medicamento, verá el número de página donde puede encontrar información sobre la cobertura. Vaya a la página que aparece en el Índice y busque el nombre de su medicamento en la primera columna de la lista.

## **¿Qué son los medicamentos genéricos?**

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

## ¿Existe alguna restricción en mi cobertura?

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

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

Puede averiguar si su medicamento tiene requisitos o límites adicionales consultando la lista que comienza en la página 17. También puede obtener más información sobre las restricciones aplicadas a medicamentos cubiertos específicos visitando nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia escalonada. También puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

Puede solicitar que se haga una excepción a estas restricciones o límites en nuestros planes, o que le hagan una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección “¿Cómo solicito una excepción a la Lista de medicamentos de Generations State of Oklahoma Group Retirees (HMO)?” en la página 13 para obtener información sobre cómo solicitar una excepción.

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

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

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

- Puede solicitar al Servicio de Atención al Cliente una lista de medicamentos similares que estén cubiertos por nuestro plan. Cuando reciba la lista, muéstrasela a su médico y pídale que le recete un medicamento similar que esté cubierto por nuestro plan.

- Puede solicitar que nuestro plan haga una excepción para que cubra su medicamento. Consulte la siguiente sección para obtener información sobre cómo solicitar una excepción.

## ¿Cómo solicito una excepción a la Lista de Medicamentos de Generations State of Oklahoma Group Retirees (HMO)?

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

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

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

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

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

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

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

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

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

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

## **Para obtener más información**

Para obtener información más detallada sobre su cobertura de medicamentos recetados Generations State of Oklahoma Group Retirees (HMO), revise su Evidencia de Cobertura y otros materiales del plan.

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

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

## Lista de Medicamentos de Generations State of Oklahoma Group Retirees (HMO)

La lista de medicamentos que comienza en la página siguiente proporciona información de cobertura sobre los medicamentos cubiertos por nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, consulte el Índice que comienza en la página 91.

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

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

### Nivel de Medicamento

Nivel 1 = Genérico preferido

Nivel 2 = Genérico

Nivel 3 = Marca preferida

Nivel 4 = Medicamentos no preferidos

Nivel 5 = Nivel de especialidad

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

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



- **B/D** - Este medicamento puede estar cubierto por Medicare Parte B o Parte D, según las circunstancias. Es posible que sea necesario presentar información que describa el uso y el entorno del medicamento para tomar la decisión.
- **GC** - Etapa sin Cobertura (Gap Coverage). Brindamos cobertura adicional de este medicamento recetado en la etapa sin cobertura. Consulte su Evidencia de Cobertura para obtener más información sobre esta cobertura.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANALGESICS</b>		
<b>GOUT</b>		
<i>allopurinol</i> TABS 100mg, 300mg	1	GC
<i>colchicine</i> TABS .6mg	4	QL (120 tabs / 30 days)
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	3	
MITIGARE CAPS .6mg	3	QL (60 caps / 30 days)
<i>probenecid</i> TABS 500mg	3	
<b>NSAIDS</b>		
<i>celecoxib</i> CAPS 50mg, 100mg, 200mg	3	QL (60 caps / 30 days)
<i>celecoxib</i> CAPS 400mg	3	QL (30 caps / 30 days)
<i>diclofenac potassium</i> TABS 50mg	3	QL (120 tabs / 30 days)
<i>diclofenac sodium</i> TB24 100mg	3	
<i>diclofenac sodium</i> TBEC 25mg, 50mg, 75mg	2	GC
<i>diflunisal</i> TABS 500mg	3	
<i>ec-naproxen</i> TBEC 375mg	2	GC, QL (120 tabs / 30 days)
<i>ec-naproxen</i> TBEC 500mg	4	QL (90 tabs / 30 days)
<i>etodolac</i> CAPS 200mg, 300mg; TABS 400mg, 500mg; TB24 400mg, 500mg, 600mg	3	
<i>flurbiprofen</i> TABS 100mg	3	
<i>ibu</i> TABS 600mg, 800mg	1	GC
<i>ibuprofen</i> SUSP 100mg/5ml	3	
<i>ibuprofen</i> TABS 400mg, 600mg, 800mg	1	GC
<i>meloxicam</i> TABS 7.5mg, 15mg	1	GC
<i>nabumetone</i> TABS 500mg, 750mg	2	GC
<i>naproxen</i> TABS 250mg, 375mg, 500mg	1	GC
<i>naproxen</i> TBEC 375mg	2	GC, QL (120 tabs / 30 days)
<i>naproxen</i> TBEC 500mg	4	QL (90 tabs / 30 days)
<i>naproxen sodium</i> TABS 275mg, 550mg	3	
<i>piroxicam</i> CAPS 10mg, 20mg	3	
<i>sulindac</i> TABS 150mg, 200mg	2	GC
<b>OPIOID ANALGESICS, LONG-ACTING</b>		
<i>fentanyl</i> PT72 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr	4	QL (10 patches / 30 days), PA
<i>hydrocodone bitartrate</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	3	QL (450 mL / 30 days), PA
<i>methadone hcl</i> TABS 5mg, 10mg	3	QL (90 tabs / 30 days), PA
<i>methadone hydrochloride i</i> CONC 10mg/ml	3	QL (90 mL / 30 days), PA
<i>morphine sulfate</i> TBCR 15mg, 30mg, 60mg, 100mg, 200mg	3	QL (90 tabs / 30 days), PA

### **OPIOID ANALGESICS, SHORT-ACTING**

<i>acetaminophen w/ codeine soln</i> 120-12 mg/5ml	3	QL (2700 mL / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-15 mg	3	QL (400 tabs / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-30 mg	3	QL (360 tabs / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-60 mg	3	QL (180 tabs / 30 days)
<i>butorphanol tartrate</i> SOLN 1mg/ml, 2mg/ml	4	
<i>endocet tab</i> 2.5-325mg	3	QL (360 tabs / 30 days)
<i>endocet tab</i> 5-325mg	3	QL (360 tabs / 30 days)
<i>endocet tab</i> 7.5-325mg	3	QL (240 tabs / 30 days)
<i>endocet tab</i> 10-325mg	3	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP 200mcg	4	QL (120 lozenges / 30 days), PA
<i>fentanyl citrate</i> LPOP 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	5	QL (120 lozenges / 30 days), PA
<i>hydrocodone-acetaminophen soln</i> 7.5-325 mg/15ml	4	QL (2700 mL / 30 days)
<i>hydrocodone-acetaminophen tab</i> 5-325 mg	3	QL (240 tabs / 30 days)
<i>hydrocodone-acetaminophen tab</i> 7.5-325 mg	3	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen tab</i> 10-325 mg	3	QL (180 tabs / 30 days)
<i>hydrocodone-ibuprofen tab</i> 7.5-200 mg	3	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD 1mg/ml	4	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> TABS 2mg, 4mg, 8mg	3	QL (180 tabs / 30 days)
<i>MORPHINE SULFATE</i> 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
<i>morphine sulfate</i> SOLN 10mg/5ml, 20mg/5ml	3	QL (900 mL / 30 days)
<i>morphine sulfate</i> SOLN 20mg/ml	3	QL (180 mL / 30 days)
<i>morphine sulfate</i> TABS 15mg, 30mg	3	QL (180 tabs / 30 days)
<i>nalbuphine hcl</i> SOLN 10mg/ml, 20mg/ml	4	
<i>oxycodone hcl</i> CAPS 5mg	4	QL (180 caps / 30 days)
<i>oxycodone hcl</i> CONC 100mg/5ml	4	QL (180 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxycodone hcl</i> SOLN 5mg/5ml	4	QL (900 mL / 30 days)
<i>oxycodone hcl</i> TABS 5mg, 10mg, 15mg, 20mg, 30mg	3	QL (180 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	3	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	3	QL (240 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	3	QL (180 tabs / 30 days)
<i>tramadol hcl</i> TABS 50mg	2	GC, QL (240 tabs / 30 days)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	3	QL (240 tabs / 30 days)

## **ANESTHETICS**

### **LOCAL ANESTHETICS**

<i>lidocaine hcl (local anesth.)</i> SOLN .5%, 1%, 1.5%, 2%	3	B/D
---	---	-----

## **ANTI-INFECTIVES**

### **ANTI-INFECTIVES - MISCELLANEOUS**

<i>albendazole</i> TABS 200mg	5	
<i>amikacin sulfate</i> SOLN 1gm/4ml, 500mg/2ml	4	
<i>atovaquone</i> SUSP 750mg/5ml	4	
<i>aztreonam</i> SOLR 1gm, 2gm	4	
CAYSTON SOLR 75mg	5	NM, LA, PA
<i>clindamycin hcl</i> CAPS 75mg, 150mg, 300mg	2	GC
<i>clindamycin palmitate hydrochloride</i> SOLR 75mg/5ml	4	
<i>clindamycin phosphate</i> SOLN 300mg/2ml, 600mg/4ml, 900mg/6ml, 9000mg/60ml	3	
<i>clindamycin phosphate in d5w iv soln 300 mg/50ml</i>	4	
<i>clindamycin phosphate in d5w iv soln 600 mg/50ml</i>	4	
<i>clindamycin phosphate in d5w iv soln 900 mg/50ml</i>	4	
CLINDMYC/NAC INJ 300/50ML	4	
CLINDMYC/NAC INJ 600/50ML	4	
CLINDMYC/NAC INJ 900/50ML	4	
<i>colistimethate sodium</i> SOLR 150mg	4	
<i>dapsone</i> TABS 25mg, 100mg	3	
DAPTOMYCIN SOLR 350mg	5	
<i>daptomycin</i> SOLR 350mg, 500mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EMVERM CHEW 100mg	5	QL (12 tabs / year)
<i>ertapenem sodium SOLR 1gm</i>	4	
<i>gentamicin in saline inj 0.8 mg/ml</i>	3	
<i>gentamicin in saline inj 1 mg/ml</i>	3	
<i>gentamicin in saline inj 1.2 mg/ml</i>	3	
<i>gentamicin in saline inj 1.6 mg/ml</i>	3	
<i>gentamicin in saline inj 2 mg/ml</i>	3	
<i>gentamicin sulfate SOLN 10mg/ml, 40mg/ml</i>	3	
<i>imipenem-cilastatin intravenous for soln 250 mg</i>	4	
<i>imipenem-cilastatin intravenous for soln 500 mg</i>	4	
<i>ivermectin TABS 3mg</i>	3	QL (12 tabs / 90 days), PA
<i>linezolid SOLN 600mg/300ml</i>	4	
<i>linezolid SUSR 100mg/5ml</i>	5	QL (1800 mL / 30 days)
<i>linezolid TABS 600mg</i>	4	QL (60 tabs / 30 days)
<i>linezolid in sodium chloride iv soln 600 mg/300ml-0.9%</i>	4	
<i>meropenem SOLR 1gm, 500mg</i>	4	
<i>methenamine hippurate TABS 1gm</i>	4	
<i>metronidazole SOLN 500mg/100ml</i>	3	
<i>metronidazole TABS 250mg, 500mg</i>	1	GC
<i>neomycin sulfate TABS 500mg</i>	2	GC
<i>nitazoxanide TABS 500mg</i>	5	QL (6 tabs / 30 days)
<i>nitrofurantoin macrocrystal CAPS 50mg, 100mg</i>	3	
<i>nitrofurantoin monohyd macro CAPS 100mg</i>	3	
<i>paromomycin sulfate CAPS 250mg</i>	4	
<i>pentamidine isethionate inh SOLR 300mg</i>	4	B/D
<i>pentamidine isethionate inj SOLR 300mg</i>	4	
<i>praziquantel TABS 600mg</i>	4	
<i>SIVEXTRO SOLR 200mg; TABS 200mg</i>	5	
<i>streptomycin sulfate SOLR 1gm</i>	4	
<i>sulfadiazine TABS 500mg</i>	4	
<i>sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml</i>	4	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	3	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	GC
<i>sulfamethoxazole-trimethoprim tab 800-160 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SYNERCID INJ 500MG	5	
<i>tobramycin</i> NEBU 300mg/5ml	5	NM, PA
<i>tobramycin sulfate</i> SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	3	
TRIMETHOPRIM TABS 100mg	3	
<i>vancomycin hcl</i> CAPS 125mg	4	QL (80 caps / 180 days)
<i>vancomycin hcl</i> CAPS 250mg	4	QL (160 caps / 180 days)
<i>vancomycin hcl</i> SOLR 1gm, 5gm, 10gm, 500mg, 750mg	4	
VANCOMYCIN INJ 1 GM	4	
VANCOMYCIN INJ 500MG	4	
VANCOMYCIN INJ 750MG	4	

### **ANTIFUNGALS**

ABELCET SUSP 5mg/ml	4	B/D
<i>amphotericin b</i> SOLR 50mg	4	B/D
<i>amphotericin b liposome</i> SUSR 50mg	5	B/D
<i>caspofungin acetate</i> SOLR 50mg, 70mg	4	
<i>fluconazole</i> SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 200mg	3	
<i>fluconazole</i> TABS 150mg	2	GC
<i>fluconazole in nacl 0.9% inj 200 mg/100ml</i>	3	
<i>fluconazole in nacl 0.9% inj 400 mg/200ml</i>	3	
<i>flucytosine</i> CAPS 250mg, 500mg	5	PA
<i>griseofulvin microsize</i> SUSP 125mg/5ml; TABS 500mg	4	
<i>griseofulvin ultramicrosize</i> TABS 125mg, 250mg	4	
<i>itraconazole</i> CAPS 100mg	4	PA
<i>ketoconazole</i> TABS 200mg	3	PA
<i>miconazole sodium</i> SOLR 50mg, 100mg	5	
NOXAFIL SUSP 40mg/ml	5	QL (630 mL / 30 days), PA
<i>nystatin</i> TABS 500000unit	3	
<i>posaconazole</i> TBEC 100mg	5	QL (93 tabs / 30 days), PA
<i>terbinafine hcl</i> TABS 250mg	1	GC, QL (90 tabs / year)
<i>voriconazole</i> SOLR 200mg; SUSR 40mg/ml	5	PA
<i>voriconazole</i> TABS 50mg	4	QL (480 tabs / 30 days), PA
<i>voriconazole</i> TABS 200mg	4	QL (120 tabs / 30 days), PA

### **ANTIMALARIALS**

<i>atovaquone-proguanil hcl tab 62.5-25 mg</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. 21

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	4	
<i>chloroquine phosphate TABS 250mg, 500mg</i>	4	
COARTEM TAB 20-120MG	4	
<i>mefloquine hcl TABS 250mg</i>	3	
<i>primaquine phosphate TABS 26.3mg</i>	3	
PRIMAQUINE PHOSPHATE TABS 26.3mg	3	
<i>quinine sulfate CAPS 324mg</i>	4	PA
<b>ANTIRETROVIRAL AGENTS</b>		
<i>abacavir sulfate SOLN 20mg/ml</i>	4	
<i>abacavir sulfate TABS 300mg</i>	3	
APTIVUS CAPS 250mg	5	
<i>atazanavir sulfate CAPS 150mg, 200mg, 300mg</i>	4	
EDURANT TABS 25mg	5	
<i>efavirenz CAPS 50mg, 200mg; TABS 600mg</i>	4	
<i>emtricitabine CAPS 200mg</i>	3	
EMTRIVA SOLN 10mg/ml	4	
<i>etravirine TABS 100mg, 200mg</i>	5	
<i>fosamprenavir calcium TABS 700mg</i>	5	
FUZEON SOLR 90mg	5	
INTELENCE TABS 25mg	4	
ISENTRESS CHEW 25mg	4	
ISENTRESS CHEW 100mg; PACK 100mg; TABS 400mg	5	
ISENTRESS HD TABS 600mg	5	
<i>lamivudine SOLN 10mg/ml; TABS 150mg, 300mg</i>	3	
LEXIVA SUSP 50mg/ml	4	
<i>maraviroc TABS 150mg, 300mg</i>	5	
<i>nevirapine SUSP 50mg/5ml; TB24 100mg, 400mg</i>	4	
<i>nevirapine TABS 200mg</i>	2	GC
NORVIR PACK 100mg; SOLN 80mg/ml	4	
PIFELTRO TABS 100mg	5	
PREZISTA SUSP 100mg/ml	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 50mg	5	
<i>ritonavir TABS 100mg</i>	3	
RUKOBIA TB12 600mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SELZENTRY SOLN 20mg/ml; TABS 75mg	5	
SELZENTRY TABS 25mg	4	
stavudine CAPS 15mg, 20mg, 30mg, 40mg	4	
tenofovir disoproxil fumarate TABS 300mg	3	
TIVICAY TABS 10mg	3	
TIVICAY TABS 25mg, 50mg	5	
TIVICAY PD TBSO 5mg	5	
TROGARZO SOLN 200mg/1.33ml	5	LA
TYBOST TABS 150mg	3	
VIRACEPT TABS 250mg, 625mg	5	
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	5	
zidovudine CAPS 100mg; SYRP 50mg/5ml	4	
zidovudine TABS 300mg	3	
<b>ANTIRETROVIRAL COMBINATION AGENTS</b>		
abacavir sulfate-lamivudine tab 600-300 mg	3	
BIKTARVY TAB 30-120-15 MG	5	
BIKTARVY TAB 50-200-25 MG	5	
CIMDUO TAB 300-300	5	
COMPLERA TAB	5	
DELSTRIGO TAB	5	
DESCOVY TAB 120-15MG	5	QL (30 tabs / 30 days)
DESCOVY TAB 200/25MG	5	QL (30 tabs / 30 days)
DOVATO TAB 50-300MG	5	
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	5	
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	5	
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	5	
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	5	QL (30 tabs / 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	5	QL (30 tabs / 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	5	QL (30 tabs / 30 days)
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	5	QL (30 tabs / 30 days)
EVOTAZ TAB 300-150	5	
GENVOYA TAB	5	
JULUCA TAB 50-25MG	5	
lamivudine-zidovudine tab 150-300 mg	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.



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	4	
<i>lopinavir-ritonavir tab 100-25 mg</i>	4	
<i>lopinavir-ritonavir tab 200-50 mg</i>	4	
ODEFSEY TAB	5	
PREZCOBIX TAB 800-150	5	
STRIBILD TAB	5	
SYMTUZA TAB	5	
TRIUMEQ PD TAB	5	
TRIUMEQ TAB	5	
TRIZIVIR TAB	5	

### **ANTITUBERCULAR AGENTS**

<i>cycloserine CAPS 250mg</i>	5	
<i>ethambutol hcl TABS 100mg, 400mg</i>	3	
<i>isoniazid SYRP 50mg/5ml</i>	4	
<i>isoniazid TABS 100mg, 300mg</i>	1	GC
PASER PACK 4gm	4	
PRIFTIN TABS 150mg	4	
<i>pyrazinamide TABS 500mg</i>	4	
<i>rifabutin CAPS 150mg</i>	4	
<i>rifampin CAPS 150mg, 300mg</i>	3	
<i>rifampin SOLR 600mg</i>	4	
SIRTURO TABS 20mg, 100mg	5	NM, LA, PA
TRECTOR TABS 250mg	4	

### **ANTIVIRALS**

<i>acyclovir CAPS 200mg; TABS 400mg, 800mg</i>	2	GC
<i>acyclovir SUSP 200mg/5ml</i>	4	
<i>acyclovir sodium SOLN 50mg/ml</i>	4	B/D
<i>adefovir dipivoxil TABS 10mg</i>	5	
BARACLUDE SOLN .05mg/ml	5	
<i>entecavir TABS .5mg, 1mg</i>	4	
EPCLUSA PAK 150-37.5	5	NM, PA
EPCLUSA PAK 200-50MG	5	NM, PA
EPCLUSA TAB 200-50MG	5	NM, PA
EPCLUSA TAB 400-100	5	NM, PA
EPIVIR HBV SOLN 5mg/ml	4	
<i>famciclovir TABS 125mg, 250mg, 500mg</i>	3	
<i>ganciclovir sodium SOLR 500mg</i>	4	B/D
HARVONI PAK 33.75-150MG	5	NM, PA
HARVONI PAK 45-200MG	5	NM, PA
HARVONI TAB 45-200MG	5	NM, PA
HARVONI TAB 90-400MG	5	NM, PA
<i>lamivudine (hbv) TABS 100mg</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MAVYRET PAK 50-20MG	5	NM, PA
MAVYRET TAB 100-40MG	5	NM, PA
<i>oseltamivir phosphate</i> CAPS 30mg	3	QL (168 caps / year)
<i>oseltamivir phosphate</i> CAPS 45mg, 75mg	3	QL (84 caps / year)
<i>oseltamivir phosphate</i> SUSR 6mg/ml	3	QL (1080 mL / year)
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	5	NM, PA
PREVYMIS TABS 240mg, 480mg	5	QL (28 tabs / 28 days), PA
RELENZA DISKHALER AEPB 5mg/blister	3	QL (6 inhalers / year)
<i>ribavirin (hepatitis c)</i> CAPS 200mg	3	NM
<i>ribavirin (hepatitis c)</i> TABS 200mg	4	NM
<i>rimantadine hydrochloride</i> TABS 100mg	4	
<i>valacyclovir hcl</i> TABS 1gm, 500mg	3	
<i>valganciclovir hcl</i> SOLR 50mg/ml	5	
<i>valganciclovir hcl</i> TABS 450mg	3	
VEMLIDY TABS 25mg	5	PA
VOSEVI TAB	5	NM, PA
<b>CEPHALOSPORINS</b>		
<i>cefaclor</i> CAPS 250mg, 500mg	3	
<i>cefaclor</i> SUSR 125mg/5ml, 250mg/5ml, 375mg/5ml	4	
CEFACTOR ER TB12 500mg	4	
<i>cefadroxil</i> CAPS 500mg	2	GC
<i>cefadroxil</i> SUSR 250mg/5ml, 500mg/5ml	3	
CEFAZOLIN INJ 1GM/50ML	4	
<i>cefazolin sodium</i> SOLR 1gm, 2gm, 10gm, 500mg	3	
CEFAZOLIN SOLN 2GM/100ML-4%	4	
<i>cefdinir</i> CAPS 300mg	2	GC
<i>cefdinir</i> SUSR 125mg/5ml, 250mg/5ml	3	
<i>cefepime hcl</i> SOLR 1gm, 2gm	4	
<i>cefixime</i> CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	4	
<i>cefoxitin sodium</i> SOLR 1gm, 2gm, 10gm	4	
<i>cefpodoxime proxetil</i> SUSR 50mg/5ml, 100mg/5ml	4	
<i>cefpodoxime proxetil</i> TABS 100mg, 200mg	3	
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	3	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	4	
CEFTAZIDIME/ SOL D5W 1GM	4	
CEFTAZIDIME/ SOL D5W 2GM	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	4	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	3	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	3	
<i>cephalexin</i> CAPS 250mg, 500mg	1	GC
<i>cephalexin</i> SUSR 125mg/5ml, 250mg/5ml	3	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	4	
TEFLARO SOLR 400mg, 600mg	5	
<b>ERYTHROMYCINS/MACROLIDES</b>		
<i>azithromycin</i> PACK 1gm; SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml	3	
<i>azithromycin</i> TABS 250mg, 500mg, 600mg	1	GC
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml	4	
<i>clarithromycin</i> TABS 250mg, 500mg; TB24 500mg	3	
DIFICID SUSR 40mg/ml; TABS 200mg	5	
<i>e.e.s. 400</i> TABS 400mg	4	
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	4	
ERYTHROCIN LACTOBIONATE SOLR 500mg	4	
<i>erythrocin stearate</i> TABS 250mg	4	
<i>erythromycin base</i> CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	4	
<i>erythromycin ethylsuccinate</i> TABS 400mg	4	
<i>erythromycin lactobionate</i> SOLR 500mg	4	
<b>FLUOROQUINOLONES</b>		
CIPRO SUSR 500mg/5ml	4	
<i>ciprofloxacin 200 mg/100ml in d5w</i>	3	
<i>ciprofloxacin 400 mg/200ml in d5w</i>	3	
<i>ciprofloxacin hcl</i> TABS 100mg	4	
<i>ciprofloxacin hcl</i> TABS 250mg, 500mg, 750mg	1	GC
<i>levofloxacin</i> SOLN 25mg/ml	4	
<i>levofloxacin</i> TABS 250mg, 500mg, 750mg	1	GC
<i>levofloxacin in d5w iv soln 250 mg/50ml</i>	3	
<i>levofloxacin in d5w iv soln 500 mg/100ml</i>	3	
<i>levofloxacin in d5w iv soln 750 mg/150ml</i>	3	
<i>moxifloxacin hcl</i> TABS 400mg	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.

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PENICILLIN G PROCAINE SUSP 600000unit/ml	4	
<i>penicillin g sodium</i> SOLR 5000000unit	4	
<i>penicillin v potassium</i> SOLR 125mg/5ml, 250mg/5ml	2	GC
<i>penicillin v potassium</i> TABS 250mg, 500mg	1	GC
<i>pfizerpen</i> SOLR 5000000unit, 20000000unit	4	
<i>piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)</i>	4	
<i>piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)</i>	4	
<b>TETRACYCLINES</b>		
<i>doxy 100</i> SOLR 100mg	4	
<i>doxycycline (monohydrate)</i> CAPS 50mg, 100mg	2	GC
<i>doxycycline (monohydrate)</i> TABS 50mg, 75mg, 100mg	3	
<i>doxycycline hyclate</i> CAPS 50mg, 100mg; TABS 20mg, 100mg	3	
<i>doxycycline hyclate</i> SOLR 100mg	4	
<i>minocycline hcl</i> CAPS 50mg, 75mg, 100mg	3	
NUZYRA SOLR 100mg; TABS 150mg	5	NM, LA
<i>tetracycline hcl</i> CAPS 250mg, 500mg	4	PA
<i>tigecycline</i> SOLR 50mg	5	
TIGECYCLINE SOLR 50mg	5	
<b>ANTINEOPLASTIC AGENTS</b>		
<b>ALKYLATING AGENTS</b>		
BENDEKA SOLN 100mg/4ml	5	B/D, NM, LA
<i>carboplatin</i> SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	3	B/D
<i>cisplatin</i> SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	3	B/D
<i>cyclophosphamide</i> CAPS 25mg, 50mg	3	B/D
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cyclophosphamide</i> SOLR 1gm, 2gm, 500mg	5	B/D
CYCLOPHOSPHAMIDE TABS 25mg, 50mg	4	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	5	B/D
LEUKERAN TABS 2mg	4	
<i>oxaliplatin</i> SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml	4	B/D
<i>oxaliplatin</i> SOLR 50mg, 100mg	5	B/D
<i>paraplatin</i> SOLN 1000mg/100ml	3	B/D

### **ANTIBIOTICS**

<i>doxorubicin hcl</i> SOLN 2mg/ml	4	B/D
<i>doxorubicin hcl liposomal</i> INJ 2mg/ml	5	B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	4	B/D

### **ANTIMETABOLITES**

<i>azacitidine</i> SUSR 100mg	5	B/D, NM
<i>cytarabine</i> SOLN 20mg/ml	3	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	3	B/D
<i>gemcitabine hcl</i> SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	4	B/D
INQOVI TAB 35-100MG	5	NM, LA, PA
LONSURF TAB 15-6.14	5	NM, LA, PA
LONSURF TAB 20-8.19	5	NM, LA, PA
<i>mercaptopurine</i> TABS 50mg	3	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	3	B/D
ONUREG TABS 200mg, 300mg	5	NM, LA, PA
<i>pemetrexed disodium</i> SOLR 100mg, 500mg, 750mg, 1000mg	5	B/D
PURIXAN SUSP 2000mg/100ml	5	NM
TABLOID TABS 40mg	4	

### **HORMONAL ANTINEOPLASTIC AGENTS**

<i>abiraterone acetate</i> TABS 250mg, 500mg	5	NM, PA
<i>anastrozole</i> TABS 1mg	2	GC
<i>bicalutamide</i> TABS 50mg	2	GC
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	4	NM, PA
EMCYT CAPS 140mg	5	
ERLEADA TABS 60mg	5	NM, LA, PA
<i>exemestane</i> TABS 25mg	4	
<i>fulvestrant</i> SOLN 250mg/5ml	5	B/D
<i>letrozole</i> TABS 2.5mg	2	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>leuprolide acetate</i> KIT 1mg/0.2ml	4	NM, PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	5	NM, PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	5	NM, PA
LYSODREN TABS 500mg	5	NM
<i>megestrol acetate</i> TABS 20mg, 40mg	3	
<i>nilutamide</i> TABS 150mg	5	
NUBEQA TABS 300mg	5	NM, LA, PA
ORGOVYX TABS 120mg	5	NM, LA, PA
SOLTAMOX SOLN 10mg/5ml	5	
<i>tamoxifen citrate</i> TABS 10mg, 20mg	2	GC
<i>toremifene citrate</i> TABS 60mg	5	
XTANDI CAPS 40mg; TABS 40mg, 80mg	5	NM, LA, PA
<b>IMMUNOMODULATORS</b>		
<i>lenalidomide</i> CAPS 5mg, 10mg, 15mg	5	QL (28 caps / 28 days), NM, LA, PA
<i>lenalidomide</i> CAPS 25mg	5	QL (21 caps / 28 days), NM, LA, PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg	5	QL (21 caps / 28 days), NM, LA, PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg	5	QL (28 caps / 28 days), NM, LA, PA
REVLIMID CAPS 20mg, 25mg	5	QL (21 caps / 28 days), NM, LA, PA
THALOMID CAPS 50mg, 100mg	5	QL (28 caps / 28 days), NM, LA, PA
THALOMID CAPS 150mg, 200mg	5	QL (56 caps / 28 days), NM, LA, PA
<b>MISCELLANEOUS</b>		
BESREMI SOSY 500mcg/ml	5	NM, LA, PA
<i>bexarotene</i> CAPS 75mg	5	NM, PA
<i>hydroxyurea</i> CAPS 500mg	2	GC
<i>irinotecan hcl</i> SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	4	B/D
KISQALI 200 PAK FEMARA	5	QL (49 tabs / 28 days), NM, PA
KISQALI 400 PAK FEMARA	5	QL (70 tabs / 28 days), NM, PA
KISQALI 600 PAK FEMARA	5	QL (91 tabs / 28 days), NM, PA
MATULANE CAPS 50mg	5	NM, LA
SYNRIBO SOLR 3.5mg	5	NM, PA
<i>tretinoin (chemotherapy)</i> CAPS 10mg	5	
WELIREG TABS 40mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MITOTIC INHIBITORS</b>		
<i>docetaxel</i> CONC 20mg/ml	4	B/D
<i>docetaxel</i> CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	B/D
<i>etoposide</i> SOLN 100mg/5ml, 500mg/25ml	3	B/D
<i>paclitaxel</i> CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	4	B/D
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	5	B/D, NM
<i>toposar</i> SOLN 1gm/50ml, 100mg/5ml	3	B/D
<i>vincristine sulfate</i> SOLN 1mg/ml	2	GC, B/D
<i>vinorelbine tartrate</i> SOLN 10mg/ml, 50mg/5ml	4	B/D
<b>MOLECULAR TARGET AGENTS</b>		
ALECENSA CAPS 150mg	5	NM, LA, PA
ALUNBRIG TABS 30mg, 90mg, 180mg	5	NM, LA, PA
ALUNBRIG PAK	5	NM, LA, PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg	5	QL (30 tabs / 30 days), NM, LA, PA
BALVERSA TABS 3mg, 4mg, 5mg	5	NM, LA, PA
<i>bortezomib</i> SOLR 3.5mg	5	NM, PA
BORTEZOMIB SOLR 3.5mg	5	NM, PA
BOSULIF TABS 100mg, 400mg, 500mg	5	NM, PA
BRAFTOVI CAPS 75mg	5	NM, LA, PA
BRUKINSA CAPS 80mg	5	NM, LA, PA
CABOMETYX TABS 20mg, 40mg, 60mg	5	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE CAPS 100mg	5	QL (60 caps / 30 days), NM, LA, PA
CAPRELSA TABS 100mg, 300mg	5	NM, LA, PA
COMETRIQ (60MG DOSE) KIT 20mg	5	NM, LA, PA
COMETRIQ KIT 100MG	5	NM, LA, PA
COMETRIQ KIT 140MG	5	NM, LA, PA
COPIKTRA CAPS 15mg, 25mg	5	NM, LA, PA
COTELLIC TABS 20mg	5	NM, LA, PA
DAURISMO TABS 25mg, 100mg	5	NM, LA, PA
ERIVEDGE CAPS 150mg	5	NM, LA, PA
<i>erlotinib hcl</i> TABS 25mg	5	QL (90 tabs / 30 days), NM, PA
<i>erlotinib hcl</i> TABS 100mg, 150mg	5	QL (30 tabs / 30 days), NM, PA

**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.



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>everolimus</i> TABS 2.5mg, 5mg, 7.5mg, 10mg	5	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 2mg	5	QL (150 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 3mg	5	QL (90 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 5mg	5	QL (60 tabs / 30 days), NM, PA
EXKIVITY CAPS 40mg	5	NM, LA, PA
FOTIVDA CAPS .89mg, 1.34mg	5	QL (21 caps / 28 days), NM, LA, PA
GAVRETO CAPS 100mg	5	NM, LA, PA
GILOTRIF TABS 20mg, 30mg, 40mg	5	NM, LA, PA
HERCEP HYLEC SOL 60-10000	5	NM, LA, PA
HERCEPTIN SOLR 150mg	5	NM, LA, PA
HERZUMA SOLR 150mg, 420mg	5	NM, LA, PA
IBRANCE CAPS 75mg, 100mg, 125mg	5	QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS 75mg, 100mg, 125mg	5	QL (21 tabs / 28 days), NM, LA, PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg	5	QL (30 tabs / 30 days), NM, LA, PA
IDHIFA TABS 50mg, 100mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>imatinib mesylate</i> TABS 100mg	5	QL (90 tabs / 30 days), NM, PA
<i>imatinib mesylate</i> TABS 400mg	5	QL (60 tabs / 30 days), NM, PA
IMBRUVICA CAPS 70mg	5	QL (30 caps / 30 days), NM, LA, PA
IMBRUVICA CAPS 140mg	5	QL (120 caps / 30 days), NM, LA, PA
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg	5	QL (30 tabs / 30 days), NM, LA, PA
INLYTA TABS 1mg	5	QL (180 tabs / 30 days), NM, LA, PA
INLYTA TABS 5mg	5	QL (120 tabs / 30 days), NM, LA, PA
INREBIC CAPS 100mg	5	NM, LA, PA
IRESSA TABS 250mg	5	NM, LA, PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg	5	QL (60 tabs / 30 days), NM, LA, PA
KADCYLA SOLR 100mg, 160mg	5	B/D, NM, LA
KANJINTI SOLR 150mg, 420mg	5	NM, LA, PA
KEYTRUDA SOLN 100mg/4ml	5	NM, LA, PA

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KISQALI 200 DOSE TBPK 200mg	5	QL (21 tabs / 28 days), NM, PA
KISQALI 400 DOSE TBPK 200mg	5	QL (42 tabs / 28 days), NM, PA
KISQALI 600 DOSE TBPK 200mg	5	QL (63 tabs / 28 days), NM, PA
<i>lapatinib ditosylate</i> TABS 250mg	5	NM, PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg	5	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg	5	QL (60 caps / 30 days), NM, LA, PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg	5	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 12MG DAILY DOSE CPPK 4mg	5	QL (90 caps / 30 days), NM, LA, PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg	5	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 14 MG	5	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 18 MG	5	QL (90 caps / 30 days), NM, LA, PA
LENVIMA CAP 24 MG	5	QL (90 caps / 30 days), NM, LA, PA
LORBRENA TABS 25mg, 100mg	5	NM, LA, PA
LUMAKRAS TABS 120mg	5	NM, LA, PA
LYNPARZA TABS 100mg, 150mg	5	QL (120 tabs / 30 days), NM, LA, PA
MEKINIST TABS .5mg, 2mg	5	NM, LA, PA
MEKTOVI TABS 15mg	5	NM, LA, PA
MONJUVI SOLR 200mg	5	NM, LA, PA
MVASI SOLN 100mg/4ml, 400mg/16ml	5	NM, LA, PA
NERLYNX TABS 40mg	5	NM, LA, PA
NEXAVAR TABS 200mg	5	QL (120 tabs / 30 days), NM, LA, PA
NINLARO CAPS 2.3mg, 3mg, 4mg	5	QL (3 caps / 28 days), NM, PA
ODOMZO CAPS 200mg	5	NM, LA, PA
OGIVRI SOLR 150mg	5	NM, LA, PA
OGIVRI INJ 420MG	5	NM, LA, PA
ONTRUZANT SOLR 150mg, 420mg	5	NM, LA, PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	5	NM, LA, PA
PHESGO SOL	5	NM, LA, PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	5	NM, PA
PIQRAY 250MG TAB DOSE	5	NM, PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QINLOCK TABS 50mg	5	NM, LA, PA
RETEVMO CAPS 40mg, 80mg	5	NM, LA, PA
ROZLYTREK CAPS 100mg, 200mg	5	NM, LA, PA
RUBRACA TABS 200mg, 250mg, 300mg	5	QL (120 tabs / 30 days), NM, LA, PA
RYDAPT CAPS 25mg	5	NM, PA
SCEMBLIX TABS 20mg	5	QL (60 tabs / 30 days), NM, PA
SCEMBLIX TABS 40mg	5	QL (300 tabs / 30 days), NM, PA
<i>sorafenib tosylate</i> TABS 200mg	5	QL (120 tabs / 30 days), NM, PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg, 140mg	5	NM, PA
STIVARGA TABS 40mg	5	NM, LA, PA
<i>sunitinib malate</i> CAPS 12.5mg, 25mg, 37.5mg, 50mg	5	QL (30 caps / 30 days), NM, PA
TABRECTA TABS 150mg, 200mg	5	NM, PA
TAFINLAR CAPS 50mg, 75mg	5	NM, LA, PA
TAGRISSO TABS 40mg, 80mg	5	QL (30 tabs / 30 days), NM, LA, PA
TALZENNA CAPS .5mg, .75mg, 1mg	5	QL (30 caps / 30 days), NM, LA, PA
TALZENNA CAPS .25mg	5	QL (90 caps / 30 days), NM, LA, PA
TASIGNA CAPS 50mg, 150mg, 200mg	5	NM, PA
TAZVERIK TABS 200mg	5	NM, LA, PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	5	NM, LA, PA
TEPMETKO TABS 225mg	5	NM, LA, PA
TIBSOVO TABS 250mg	5	NM, LA, PA
TRAZIMERA SOLR 150mg, 420mg	5	NM, PA
TRUSELTIQ 50 MG DAILY DOSE CPPK 25mg	5	NM, LA, PA
TRUSELTIQ 75 MG DAILY DOSE CPPK 25mg	5	NM, LA, PA
TRUSELTIQ 100 MG DAILY DOSE CPPK 100mg	5	NM, LA, PA
TRUSELTIQ 125 MG DAILY DOSE	5	NM, LA, PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	5	NM, PA
TUKYSA TABS 50mg, 150mg	5	NM, LA, PA
TURALIO CAPS 200mg	5	NM, LA, PA
VENCLEXTA TABS 10mg	4	QL (112 tabs / 28 days), NM, LA, PA

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VENCLEXTA TABS 50mg	5	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 100mg	5	QL (180 tabs / 30 days), NM, LA, PA
VENCLEXTA TAB START PK	5	QL (42 tabs / 28 days), NM, LA, PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg	5	QL (56 tabs / 28 days), NM, LA, PA
VITRAKVI CAPS 25mg, 100mg; SOLN 20mg/ml	5	NM, LA, PA
VIZIMPRO TABS 15mg, 30mg, 45mg	5	NM, LA, PA
VONJO CAPS 100mg	5	QL (120 caps / 30 days), NM, LA, PA
VOTRIENT TABS 200mg	5	NM, LA, PA
XALKORI CAPS 200mg, 250mg	5	NM, LA, PA
XOSPATA TABS 40mg	5	NM, LA, PA
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg	5	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg	5	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg	5	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg	5	QL (24 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg	5	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg	5	QL (32 tabs / 28 days), NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg	5	QL (8 tabs / 28 days), NM, LA, PA
ZEJULA CAPS 100mg	5	QL (90 caps / 30 days), NM, LA, PA
ZELBORAF TABS 240mg	5	NM, LA, PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	5	NM, LA, PA
ZOLINZA CAPS 100mg	5	NM, PA
ZYDELIG TABS 100mg, 150mg	5	NM, LA, PA
ZYKADIA TABS 150mg	5	NM, LA, PA

### **PROTECTIVE AGENTS**

<i>leucovorin calcium</i> SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	4	B/D
<i>leucovorin calcium</i> TABS 5mg, 10mg, 15mg	3	
<i>leucovorin calcium</i> TABS 25mg	4	
MESNEX TABS 400mg	5	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CARDIOVASCULAR</b>		
<b>ACE INHIBITOR COMBINATIONS</b>		
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	GC, QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	GC, QL (30 caps / 30 days)
<i>benazepril &amp; hydrochlorothiazide tab 5-6.25mg</i>	1	GC
<i>benazepril &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>benazepril &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>benazepril &amp; hydrochlorothiazide tab 20-25 mg</i>	1	GC
<i>enalapril maleate &amp; hydrochlorothiazide tab 5-12.5 mg</i>	1	GC
<i>enalapril maleate &amp; hydrochlorothiazide tab 10-25 mg</i>	1	GC
<i>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>fosinopril sodium &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>lisinopril &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>lisinopril &amp; hydrochlorothiazide tab 20-25 mg</i>	1	GC
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	1	GC
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	1	GC
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	1	GC
<b>ACE INHIBITORS</b>		
<i>benazepril hcl TABS 5mg, 10mg, 20mg, 40mg</i>	1	GC
<i>captopril TABS 12.5mg, 25mg, 50mg, 100mg</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>enalapril maleate</i> TABS 2.5mg, 5mg, 10mg, 20mg	1	GC
<i>fosinopril sodium</i> TABS 10mg, 20mg, 40mg	1	GC
<i>lisinopril</i> TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	GC
<i>moexipril hcl</i> TABS 7.5mg, 15mg	1	GC
<i>perindopril erbumine</i> TABS 2mg, 4mg, 8mg	1	GC
<i>quinapril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC
<i>ramipril</i> CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	GC
<i>trandolapril</i> TABS 1mg, 2mg, 4mg	1	GC
<b>ALDOSTERONE RECEPTOR ANTAGONISTS</b>		
<i>eplerenone</i> TABS 25mg, 50mg	3	
KERENDIA TABS 10mg, 20mg	3	QL (30 tabs / 30 days)
<i>spironolactone</i> TABS 25mg, 50mg, 100mg	1	GC
<b>ALPHA BLOCKERS</b>		
<i>doxazosin mesylate</i> TABS 1mg, 2mg, 4mg, 8mg	2	GC
<i>prazosin hcl</i> CAPS 1mg, 2mg, 5mg	3	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	2	GC
<b>ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS</b>		
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	GC, QL (30 tabs / 30 days)
ENTRESTO TAB 24-26MG	3	
ENTRESTO TAB 49-51MG	3	
ENTRESTO TAB 97-103MG	3	
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	GC, QL (60 tabs / 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>losartan potassium &amp; hydrochlorothiazide tab 50-12.5 mg</i>	1	GC
<i>losartan potassium &amp; hydrochlorothiazide tab 100-12.5 mg</i>	1	GC
<i>losartan potassium &amp; hydrochlorothiazide tab 100-25 mg</i>	1	GC
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	GC, QL (30 tabs / 30 days)
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
<i>candesartan cilexetil TABS 4mg, 8mg, 16mg</i>	1	GC, QL (60 tabs / 30 days)
<i>candesartan cilexetil TABS 32mg</i>	1	GC, QL (30 tabs / 30 days)
<i>irbesartan TABS 75mg, 150mg, 300mg</i>	1	GC, QL (30 tabs / 30 days)
<i>losartan potassium TABS 25mg, 50mg, 100mg</i>	1	GC
<i>olmesartan medoxomil TABS 5mg</i>	1	GC, QL (60 tabs / 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>olmesartan medoxomil</i> TABS 20mg, 40mg	1	GC, QL (30 tabs / 30 days)
<i>telmisartan</i> TABS 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
<i>valsartan</i> TABS 40mg, 80mg, 160mg	1	GC, QL (60 tabs / 30 days)
<i>valsartan</i> TABS 320mg	1	GC, QL (30 tabs / 30 days)

### **ANTIARRHYTHMICS**

<i>amiodarone hcl</i> SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 400mg	4	
<i>amiodarone hcl</i> TABS 200mg	1	GC
<i>disopyramide phosphate</i> CAPS 100mg, 150mg	4	
<i>dofetilide</i> CAPS 125mcg, 250mcg, 500mcg	4	
<i>flecainide acetate</i> TABS 50mg, 100mg, 150mg	3	
MULTAQ TABS 400mg	4	
NORPACE CR CP12 100mg, 150mg	4	
<i>pacerone</i> TABS 100mg, 400mg	4	
<i>pacerone</i> TABS 200mg	1	GC
<i>propafenone hcl</i> CP12 225mg, 325mg, 425mg	4	
<i>propafenone hcl</i> TABS 150mg, 225mg, 300mg	3	
<i>quinidine sulfate</i> TABS 200mg, 300mg	3	
<i>sorine</i> TABS 80mg, 120mg, 160mg, 240mg	2	GC
<i>sotalol hcl</i> TABS 80mg, 120mg, 160mg, 240mg	2	GC
<i>sotalol hcl (afib/afl)</i> TABS 80mg, 120mg, 160mg	3	

### **ANTILIPEMICS, FIBRATES**

<i>fenofibrate</i> TABS 48mg, 54mg, 145mg, 160mg	3	
<i>fenofibrate micronized</i> CAPS 67mg, 134mg, 200mg	3	
<i>gemfibrozil</i> TABS 600mg	1	GC

### **ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS**

<i>atorvastatin calcium</i> TABS 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
<i>lovastatin</i> TABS 10mg, 20mg, 40mg	1	GC, QL (60 tabs / 30 days)
<i>pravastatin sodium</i> TABS 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)

**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.



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>rosuvastatin calcium</i> TABS 5mg, 10mg, 20mg, 40mg	1	GC, QL (30 tabs / 30 days)
<i>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg, 80mg	1	GC, QL (30 tabs / 30 days)
<b>ANTILIPEMICS, MISCELLANEOUS</b>		
<i>cholestyramine</i> PACK 4gm; POWD 4gm/dose	3	
<i>cholestyramine light</i> PACK 4gm; POWD 4gm/dose	3	
<i>colesevelam hcl</i> PACK 3.75gm; TABS 625mg	4	
<i>colestipol hcl</i> GRAN 5gm; PACK 5gm	4	
<i>colestipol hcl</i> TABS 1gm	3	
<i>ezetimibe</i> TABS 10mg	3	
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	GC, QL (30 tabs / 30 days)
<i>niacin (antihyperlipidemic)</i> TBCR 500mg, 750mg, 1000mg	3	QL (60 tabs / 30 days)
PRALUENT SOAJ 75mg/ml, 150mg/ml	3	NM, PA
<i>prevalite</i> PACK 4gm; POWD 4gm/dose	3	
VASCEPA CAPS .5gm, 1gm	4	
<b>BETA-BLOCKER/DIURETIC COMBINATIONS</b>		
<i>atenolol &amp; chlorthalidone tab 50-25 mg</i>	2	GC
<i>atenolol &amp; chlorthalidone tab 100-25 mg</i>	2	GC
<i>bisoprolol &amp; hydrochlorothiazide tab 2.5-6.25 mg</i>	2	GC
<i>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg</i>	2	GC
<i>bisoprolol &amp; hydrochlorothiazide tab 10-6.25 mg</i>	2	GC
<i>metoprolol &amp; hydrochlorothiazide tab 50-25 mg</i>	3	
<i>metoprolol &amp; hydrochlorothiazide tab 100-25 mg</i>	3	
<i>metoprolol &amp; hydrochlorothiazide tab 100-50 mg</i>	3	
<b>BETA-BLOCKERS</b>		
<i>acebutolol hcl</i> CAPS 200mg, 400mg	3	
<i>atenolol</i> TABS 25mg, 50mg, 100mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bisoprolol fumarate</i> TABS 5mg, 10mg	2	GC
<i>carvedilol</i> TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	GC
<i>labetalol hcl</i> TABS 100mg, 200mg, 300mg	3	
<i>metoprolol succinate</i> TB24 25mg, 50mg, 100mg, 200mg	2	GC
<i>metoprolol tartrate</i> SOLN 5mg/5ml	4	
<i>metoprolol tartrate</i> TABS 25mg, 50mg, 100mg	1	GC
<i>nadolol</i> TABS 20mg, 40mg, 80mg	3	
<i>nebivolol hcl</i> TABS 2.5mg, 5mg, 10mg	3	QL (30 tabs / 30 days)
<i>nebivolol hcl</i> TABS 20mg	3	QL (60 tabs / 30 days)
<i>pindolol</i> TABS 5mg, 10mg	3	
<i>propranolol hcl</i> CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml	3	
<i>propranolol hcl</i> TABS 10mg, 20mg, 40mg, 60mg, 80mg	2	GC
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	4	
<b>CALCIUM CHANNEL BLOCKERS</b>		
<i>amlodipine besylate</i> TABS 2.5mg, 5mg, 10mg	1	GC
<i>cartia xt</i> CP24 120mg, 180mg, 240mg, 300mg	2	GC
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	3	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg	4	
<i>diltiazem hcl</i> SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml	3	
<i>diltiazem hcl</i> TABS 30mg, 60mg, 90mg, 120mg	2	GC
<i>diltiazem hcl coated beads</i> CP24 120mg, 180mg, 240mg, 300mg	2	GC
<i>diltiazem hcl coated beads</i> CP24 360mg	4	
<i>diltiazem hcl extended release beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	GC
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	2	GC
<i>nicardipine hcl</i> CAPS 20mg, 30mg	4	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	3	
<i>nimodipine</i> CAPS 30mg	4	
NYMALIZE SOLN 6mg/ml	5	
<i>taztia xt</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg	2	GC
<i>tiadylt er</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>verapamil hcl</i> CP24 100mg, 120mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml	4	
<i>verapamil hcl</i> CP24 180mg, 240mg	3	
<i>verapamil hcl</i> TABS 40mg, 80mg, 120mg	1	GC
<i>verapamil hcl</i> TBCR 120mg, 180mg, 240mg	2	GC

### **DIURETICS**

<i>acetazolamide</i> CP12 500mg	4	
<i>acetazolamide</i> TABS 125mg, 250mg	3	
<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i>	2	GC
<i>amiloride hcl</i> TABS 5mg	2	GC
<i>bumetanide</i> SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	3	
<i>chlorthalidone</i> TABS 25mg, 50mg	2	GC
<i>furosemide</i> SOLN 8mg/ml, 10mg/ml	2	GC
<i>furosemide</i> TABS 20mg, 40mg, 80mg	1	GC
<i>furosemide inj</i> SOLN 10mg/ml	3	
<i>hydrochlorothiazide</i> CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	GC
<i>indapamide</i> TABS 1.25mg, 2.5mg	1	GC
<i>methazolamide</i> TABS 25mg, 50mg	4	
<i>metolazone</i> TABS 2.5mg, 5mg, 10mg	3	
<i>spironolactone &amp; hydrochlorothiazide tab 25-25 mg</i>	3	
<i>toremide</i> TABS 5mg, 10mg, 20mg, 100mg	2	GC
<i>triamterene &amp; hydrochlorothiazide cap 37.5-25 mg</i>	1	GC
<i>triamterene &amp; hydrochlorothiazide tab 37.5-25 mg</i>	1	GC
<i>triamterene &amp; hydrochlorothiazide tab 75-50 mg</i>	1	GC

### **MISCELLANEOUS**

ADRENALIN SOLN 1mg/ml	4	
<i>aliskiren fumarate</i> TABS 150mg, 300mg	4	
<i>clonidine</i> PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	3	
<i>clonidine hcl</i> TABS .1mg, .2mg, .3mg	1	GC
CORLANOR SOLN 5mg/5ml; TABS 5mg, 7.5mg	4	
<i>digox</i> TABS 125mcg, 250mcg	2	GC, QL (30 tabs / 30 days)
<i>digoxin</i> SOLN .05mg/ml, .25mg/ml	4	

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>digoxin</i> TABS 125mcg, 250mcg	2	GC, QL (30 tabs / 30 days)
<i>droxidopa</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA
<i>droxidopa</i> CAPS 200mg, 300mg	5	QL (180 caps / 30 days), NM, PA
<i>guanfacine hcl</i> TABS 1mg, 2mg	3	PA; PA if 70 years and older
<i>hydralazine hcl</i> SOLN 20mg/ml	4	
<i>hydralazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	2	GC
<i>metyrosine</i> CAPS 250mg	5	PA
<i>midodrine hcl</i> TABS 2.5mg, 5mg	3	
<i>midodrine hcl</i> TABS 10mg	4	
<i>minoxidil</i> TABS 2.5mg, 10mg	2	GC
<i>ranolazine</i> TB12 500mg, 1000mg	4	
VERQUVO TABS 2.5mg, 5mg, 10mg	3	

### **NITRATES**

<i>isosorbide dinitrate</i> TABS 5mg, 10mg, 20mg, 30mg	3	
<i>isosorbide mononitrate</i> TABS 10mg, 20mg	2	GC
<i>isosorbide mononitrate</i> TB24 30mg, 60mg, 120mg	1	GC
NITRO-BID OINT 2%	3	
<i>nitroglycerin</i> PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SUBL .3mg, .4mg, .6mg	3	

### **PULMONARY ARTERIAL HYPERTENSION**

ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	5	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i> TABS 5mg, 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan</i> TABS 62.5mg, 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT TABS 10mg	5	QL (30 tabs / 30 days), NM, LA, PA
<i>sildenafil citrate (pulmonary hypertension)</i> TABS 20mg	3	QL (90 tabs / 30 days), NM, PA
<i>treprostinil</i> SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	5	NM, LA, PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	5	NM, LA, PA

### **CENTRAL NERVOUS SYSTEM**

#### **ANTI-ANXIETY**

<i>alprazolam</i> TABS .25mg, .5mg, 1mg, 2mg	2	GC, QL (150 tabs / 30 days)
<i>buspirone hcl</i> TABS 5mg, 10mg, 15mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>buspirone hcl</i> TABS 7.5mg, 30mg	3	
<i>fluvoxamine maleate</i> TABS 25mg, 50mg, 100mg	3	
<i>lorazepam</i> CONC 2mg/ml	3	QL (150 mL / 30 days)
<i>lorazepam</i> SOLN 2mg/ml, 4mg/ml	2	GC
<i>lorazepam</i> TABS .5mg, 1mg, 2mg	2	GC, QL (150 tabs / 30 days)
<i>lorazepam intensol</i> CONC 2mg/ml	3	QL (150 mL / 30 days)

### **ANTICONVULSANTS**

APTIOM TABS 200mg, 400mg	5	QL (30 tabs / 30 days)
APTIOM TABS 600mg, 800mg	5	QL (60 tabs / 30 days)
BRIVIACT SOLN 10mg/ml	5	QL (600 mL / 30 days), PA
BRIVIACT SOLN 50mg/5ml	4	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg	5	QL (60 tabs / 30 days), PA
<i>carbamazepine</i> CHEW 100mg; TABS 200mg	3	
<i>carbamazepine</i> CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TB12 100mg, 200mg, 400mg	4	
CELONTIN CAPS 300mg	4	
<i>clobazam</i> SUSP 2.5mg/ml	4	QL (480 mL / 30 days), PA
<i>clobazam</i> TABS 10mg, 20mg	4	QL (60 tabs / 30 days), PA
<i>clonazepam</i> TABS 2mg	2	GC, QL (300 tabs / 30 days)
<i>clonazepam</i> TABS .5mg, 1mg	2	GC, 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>clorzepate dipotassium</i> TABS 3.75mg, 7.5mg, 15mg	4	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIACOMIT CAPS 250mg	5	QL (360 caps / 30 days), NM, LA, PA
DIACOMIT CAPS 500mg	5	QL (180 caps / 30 days), NM, LA, PA
DIACOMIT PACK 250mg	5	QL (360 packets / 30 days), NM, LA, PA
DIACOMIT PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diazepam</i> CONC 5mg/ml	3	QL (240 mL / 30 days), PA; PA if 65 years and older
<i>diazepam</i> SOLN 5mg/5ml	3	QL (1200 mL / 30 days), PA; PA if 65 years and older
<i>diazepam</i> TABS 2mg, 5mg, 10mg	2	GC, QL (120 tabs / 30 days), PA; PA if 65 years and older
<i>diazepam (anticonvulsant)</i> GEL 2.5mg, 10mg, 20mg	4	
<i>diazepam inj</i> SOLN 5mg/ml	4	
DILANTIN CAPS 30mg, 100mg	4	
DILANTIN INFATABS CHEW 50mg	4	
DILANTIN-125 SUSP 125mg/5ml	4	
<i>divalproex sodium</i> CSDR 125mg; TB24 250mg, 500mg	4	
<i>divalproex sodium</i> TBEC 125mg, 250mg, 500mg	3	
EPIDIOLEX SOLN 100mg/ml	5	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i> TABS 200mg	3	
EPRONTIA SOLN 25mg/ml	4	QL (480 mL / 30 days), PA
<i>ethosuximide</i> CAPS 250mg	4	
<i>ethosuximide</i> SOLN 250mg/5ml	3	
<i>felbamate</i> SUSP 600mg/5ml	5	
<i>felbamate</i> TABS 400mg, 600mg	4	
FINTEPLA SOLN 2.2mg/ml	5	QL (360 mL / 30 days), NM, LA, PA
FYCOMPA SUSP .5mg/ml	5	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg	5	QL (30 tabs / 30 days), PA
<i>gabapentin</i> CAPS 100mg, 300mg, 400mg	2	GC, QL (180 caps / 30 days)
<i>gabapentin</i> SOLN 250mg/5ml	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>lacosamide</i> SOLN 200mg/20ml	5	
<i>lacosamide</i> TABS 50mg	4	QL (120 tabs / 30 days)
<i>lacosamide</i> TABS 100mg, 150mg, 200mg	4	QL (60 tabs / 30 days)
<i>lacosamide oral</i> SOLN 10mg/ml	4	QL (1200 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lamotrigine</i> CHEW 5mg, 25mg	3	
<i>lamotrigine</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
<i>lamotrigine</i> TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	4	
<i>levetiracetam</i> SOLN 100mg/ml; TABS 250mg, 500mg, 750mg, 1000mg; TB24 500mg, 750mg	3	
<i>levetiracetam</i> SOLN 500mg/5ml	4	
<i>levetiracetam in sodium chloride iv soln</i> 500 mg/100ml	4	
<i>levetiracetam in sodium chloride iv soln</i> 1000 mg/100ml	4	
<i>levetiracetam in sodium chloride iv soln</i> 1500 mg/100ml	4	
NAYZILAM SOLN 5mg/0.1ml	4	
<i>oxcarbazepine</i> SUSP 300mg/5ml	4	
<i>oxcarbazepine</i> TABS 150mg, 300mg, 600mg	3	
<i>phenobarbital</i> ELIX 20mg/5ml	4	PA; PA if 70 years and older
<i>phenobarbital</i> TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	3	PA; PA if 70 years and older
<i>phenobarbital sodium</i> SOLN 65mg/ml, 130mg/ml	4	PA; PA if 70 years and older
PHENYTEK CAPS 200mg, 300mg	4	
<i>phenytoin</i> CHEW 50mg; SUSP 125mg/5ml	3	
<i>phenytoin sodium</i> SOLN 50mg/ml	3	
<i>phenytoin sodium extended</i> CAPS 100mg, 200mg, 300mg	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 20mg/ml	4	QL (900 mL / 30 days), PA
<i>primidone</i> TABS 50mg, 250mg	2	GC
<i>roweepra</i> TABS 500mg	3	
<i>rufinamide</i> SUSP 40mg/ml	5	QL (2400 mL / 30 days), PA
<i>rufinamide</i> TABS 200mg	4	QL (480 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>rufinamide</i> TABS 400mg	5	QL (240 tabs / 30 days), PA
SPRITAM TB3D 250mg	4	QL (360 tabs / 30 days)
SPRITAM TB3D 500mg	4	QL (180 tabs / 30 days)
SPRITAM TB3D 750mg	4	QL (120 tabs / 30 days)
SPRITAM TB3D 1000mg	4	QL (90 tabs / 30 days)
<i>subvenite</i> TABS 25mg, 100mg, 150mg, 200mg	1	GC
SYMPAZAN FILM 5mg, 10mg, 20mg	5	QL (60 films / 30 days), PA
<i>tiagabine hcl</i> TABS 2mg, 4mg, 12mg, 16mg	4	
<i>topiramate</i> CPSP 15mg, 25mg	3	
<i>topiramate</i> TABS 25mg, 50mg, 100mg, 200mg	2	GC
<i>valproate sodium</i> SOLN 100mg/ml	4	
<i>valproate sodium</i> SOLN 250mg/5ml	3	
<i>valproic acid</i> CAPS 250mg	3	
VALTOCO LIQD 5mg/0.1ml, 10mg/0.1ml; LQPK 7.5mg/0.1ml, 10mg/0.1ml	4	
<i>vigabatrin</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
<i>vigabatrin</i> TABS 500mg	5	QL (180 tabs / 30 days), NM, LA, PA
<i>vigadrone</i> PACK 500mg	5	QL (180 packets / 30 days), NM, LA, PA
VIMPAT SOLN 10mg/ml	5	QL (1200 mL / 30 days)
XCOPRI TABS 50mg, 100mg	5	QL (30 tabs / 30 days)
XCOPRI TABS 150mg, 200mg	5	QL (60 tabs / 30 days)
XCOPRI PAK 12.5-25	4	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	5	QL (28 tabs / 28 days)
XCOPRI PAK 100-150	5	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (MAINTENANCE)	5	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (TITRATION)	5	QL (28 tabs / 28 days)
<i>zonisamide</i> CAPS 25mg, 50mg, 100mg	2	GC

### **ANTIDEMENTIA**

<i>donepezil hydrochloride</i> TABS 5mg; TBDP 5mg	2	GC, QL (30 tabs / 30 days)
<i>donepezil hydrochloride</i> TABS 10mg; TBDP 10mg	2	GC
<i>galantamine hydrobromide</i> CP24 8mg, 16mg, 24mg	3	QL (30 caps / 30 days)
<i>galantamine hydrobromide</i> SOLN 4mg/ml	4	
<i>galantamine hydrobromide</i> TABS 4mg, 8mg, 12mg	3	QL (60 tabs / 30 days)

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>memantine hcl</i> CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml	4	PA; PA if < 30 yrs
<i>memantine hcl</i> TABS 5mg, 10mg	3	PA; PA if < 30 yrs
NAMZARIC CAP 7-10MG	4	
NAMZARIC CAP 14-10MG	4	
NAMZARIC CAP 21-10MG	4	
NAMZARIC CAP 28-10MG	4	
NAMZARIC CAP PACK	4	
<i>rivastigmine</i> PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	4	QL (30 patches / 30 days)
<i>rivastigmine tartrate</i> CAPS 1.5mg, 3mg, 4.5mg, 6mg	3	QL (60 caps / 30 days)
<b>ANTIDEPRESSANTS</b>		
<i>amitriptyline hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	3	
<i>amoxapine</i> TABS 25mg, 50mg, 100mg, 150mg	3	
<i>bupropion hcl</i> TABS 75mg, 100mg; TB12 100mg, 150mg, 200mg; TB24 150mg, 300mg	3	
<i>citalopram hydrobromide</i> SOLN 10mg/5ml	3	
<i>citalopram hydrobromide</i> TABS 10mg, 20mg, 40mg	1	GC
<i>clomipramine hcl</i> CAPS 25mg, 50mg, 75mg	4	PA
<i>desipramine hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	4	
<i>desvenlafaxine succinate</i> TB24 25mg, 50mg, 100mg	4	QL (30 tabs / 30 days), PA
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg; CONC 10mg/ml	3	
<i>doxepin hcl</i> CAPS 150mg	4	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg	4	QL (60 caps / 30 days), PA
<i>duloxetine hcl</i> CPEP 20mg, 30mg, 60mg	3	QL (60 caps / 30 days)
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr	5	QL (30 patches / 30 days), PA
<i>escitalopram oxalate</i> SOLN 5mg/5ml	4	
<i>escitalopram oxalate</i> TABS 5mg, 10mg, 20mg	1	GC
FETZIMA CP24 20mg, 40mg	4	QL (60 caps / 30 days), PA
FETZIMA CP24 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA CAP TITRATIO	4	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluoxetine hcl</i> CAPS 10mg, 20mg	1	GC
<i>fluoxetine hcl</i> CAPS 40mg	2	GC
<i>fluoxetine hcl</i> SOLN 20mg/5ml	3	
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	2	GC
MARPLAN TABS 10mg	4	QL (180 tabs / 30 days)
<i>mirtazapine</i> TABS 7.5mg; TBDP 15mg, 30mg, 45mg	3	
<i>mirtazapine</i> TABS 15mg, 30mg, 45mg	2	GC
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	4	
<i>nortriptyline hcl</i> CAPS 10mg, 25mg, 50mg, 75mg	2	GC
<i>nortriptyline hcl</i> SOLN 10mg/5ml	4	
<i>paroxetine hcl</i> SUSP 10mg/5ml	4	QL (900 mL / 30 days), PA
<i>paroxetine hcl</i> TABS 10mg, 20mg, 30mg, 40mg	2	GC
<i>phenelzine sulfate</i> TABS 15mg	3	
<i>protriptyline hcl</i> TABS 5mg, 10mg	4	
<i>sertraline hcl</i> CONC 20mg/ml	3	
<i>sertraline hcl</i> TABS 25mg, 50mg, 100mg	1	GC
<i>tranylcypromine sulfate</i> TABS 10mg	4	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	GC
<i>trimipramine maleate</i> CAPS 25mg, 50mg	4	QL (120 caps / 30 days)
<i>trimipramine maleate</i> CAPS 100mg	4	QL (60 caps / 30 days)
TRINTELLIX TABS 5mg, 10mg, 20mg	4	QL (30 tabs / 30 days)
<i>venlafaxine hcl</i> CP24 37.5mg, 75mg, 150mg	2	GC
<i>venlafaxine hcl</i> TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	3	
VIIBRYD KIT STARTER	4	
<i>vilazodone hcl</i> TABS 10mg, 20mg, 40mg	4	QL (30 tabs / 30 days)
<b>ANTIPARKINSONIAN AGENTS</b>		
<i>amantadine hcl</i> CAPS 100mg	3	QL (120 caps / 30 days)
<i>amantadine hcl</i> SOLN 50mg/5ml	3	
<i>amantadine hcl</i> TABS 100mg	4	
<i>benztropine mesylate</i> SOLN 1mg/ml	4	
<i>benztropine mesylate</i> TABS .5mg, 1mg, 2mg	3	PA; PA if 70 years and older
<i>bromocriptine mesylate</i> CAPS 5mg; TABS 2.5mg	4	
<i>carb/levo orally disintegrating tab 10-100mg</i>	4	
<i>carb/levo orally disintegrating tab 25-100mg</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>carb/levo orally disintegrating tab 25-250mg</i>	4	
<i>carbidopa &amp; levodopa tab 10-100 mg</i>	2	GC
<i>carbidopa &amp; levodopa tab 25-100 mg</i>	2	GC
<i>carbidopa &amp; levodopa tab 25-250 mg</i>	2	GC
<i>carbidopa &amp; levodopa tab er 25-100 mg</i>	3	
<i>carbidopa &amp; levodopa tab er 50-200 mg</i>	3	
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	4	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	4	
<i>entacapone TABS 200mg</i>	4	
KYNMOBI FILM 10mg, 15mg, 20mg, 25mg, 30mg	5	QL (150 films / 30 days), NM, PA
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	4	
<i>pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg</i>	2	GC
<i>rasagiline mesylate TABS .5mg, 1mg</i>	4	QL (30 tabs / 30 days)
<i>ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg</i>	2	GC
<i>selegiline hcl CAPS 5mg; TABS 5mg</i>	3	
<i>trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg</i>	3	PA; PA if 70 years and older
<b>ANTIPSYCHOTICS</b>		
ABILIFY MAINTENA PRSY 300mg, 400mg	5	QL (1 syringe / 28 days)
ABILIFY MAINTENA SRER 300mg, 400mg	5	QL (1 injection / 28 days)
<i>aripiprazole SOLN 1mg/ml</i>	4	QL (900 mL / 30 days)
<i>aripiprazole TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg</i>	4	QL (30 tabs / 30 days)
<i>aripiprazole TBDP 10mg, 15mg</i>	5	QL (60 tabs / 30 days)
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	5	QL (1 syringe / 28 days)
ARISTADA PRSY 1064mg/3.9ml	5	QL (1 syringe / 56 days)
ARISTADA INITIO PRSY 675mg/2.4ml	5	

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>asenapine maleate</i> SUBL 2.5mg, 5mg, 10mg	4	QL (60 tabs / 30 days)
CAPLYTA CAPS 42mg	4	QL (30 caps / 30 days), PA
<i>chlorpromazine hcl</i> SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	4	
CHLORPROMAZINE HYDROCHLOR CONC 30mg/ml, 100mg/ml	4	
<i>clozapine</i> TABS 25mg, 50mg	3	
<i>clozapine</i> TABS 100mg	4	QL (270 tabs / 30 days)
<i>clozapine</i> TABS 200mg	4	QL (120 tabs / 30 days)
<i>clozapine</i> TBDP 12.5mg, 25mg	4	PA
<i>clozapine</i> TBDP 100mg	4	QL (270 tabs / 30 days), PA
<i>clozapine</i> TBDP 150mg	4	QL (180 tabs / 30 days), PA
<i>clozapine</i> TBDP 200mg	5	QL (120 tabs / 30 days), PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg	4	QL (60 tabs / 30 days), PA
FANAPT PAK	4	PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	4	
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	4	
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	3	
<i>haloperidol decanoate</i> SOLN 50mg/ml, 100mg/ml	3	
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	3	
INVEGA SUSTENNA SUSY 39mg/0.25ml	4	QL (1 syringe / 28 days)
INVEGA SUSTENNA SUSY 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml	5	QL (1 syringe / 28 days)
LATUDA TABS 20mg, 40mg, 60mg, 120mg	4	QL (30 tabs / 30 days)
LATUDA TABS 80mg	4	QL (60 tabs / 30 days)
<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	3	
<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	4	
NUPLAZID CAPS 34mg	4	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10mg	4	QL (30 tabs / 30 days), NM, LA, PA
<i>olanzapine</i> SOLR 10mg	4	QL (3 vials / 1 day)

**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. 51

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>olanzapine</i> TABS 2.5mg, 5mg, 10mg	3	QL (60 tabs / 30 days)
<i>olanzapine</i> TABS 7.5mg, 15mg, 20mg	3	QL (30 tabs / 30 days)
<i>olanzapine</i> TBDP 5mg, 15mg, 20mg	4	QL (30 tabs / 30 days)
<i>olanzapine</i> TBDP 10mg	4	QL (60 tabs / 30 days)
<i>paliperidone</i> TB24 1.5mg, 3mg, 9mg	4	QL (30 tabs / 30 days)
<i>paliperidone</i> TB24 6mg	4	QL (60 tabs / 30 days)
<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	3	
PERSERIS PRSY 90mg, 120mg	5	QL (1 syringe / 30 days)
<i>pimozide</i> TABS 1mg, 2mg	4	
<i>quetiapine fumarate</i> TABS 25mg, 50mg, 100mg, 200mg, 300mg, 400mg	3	
<i>quetiapine fumarate</i> TB24 50mg, 300mg, 400mg	4	QL (60 tabs / 30 days), PA
<i>quetiapine fumarate</i> TB24 150mg, 200mg	4	QL (30 tabs / 30 days), PA
REXULTI TABS 3mg, 4mg	4	QL (30 tabs / 30 days)
REXULTI TABS .25mg, .5mg, 1mg, 2mg	4	QL (60 tabs / 30 days)
<i>risperidone</i> SOLN 1mg/ml	3	QL (240 mL / 30 days)
<i>risperidone</i> TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	2	GC
<i>risperidone</i> TBDP 1mg, 2mg, 3mg	4	QL (60 tabs / 30 days)
<i>risperidone</i> TBDP 4mg	4	QL (120 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, .5mg	4	QL (90 tabs / 30 days)
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr	4	QL (30 patches / 30 days)
<i>thioridazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	3	
<i>thiothixene</i> CAPS 1mg, 2mg, 5mg, 10mg	4	
<i>trifluoperazine hcl</i> TABS 1mg, 2mg, 5mg, 10mg	3	
VERSACLOZ SUSP 50mg/ml	4	QL (600 mL / 30 days), PA
VRAYLAR CAPS 1.5mg	4	QL (60 caps / 30 days)
VRAYLAR CAPS 3mg, 4.5mg, 6mg	4	QL (30 caps / 30 days)
VRAYLAR CAP 1.5-3MG	4	
<i>ziprasidone hcl</i> CAPS 20mg, 40mg, 60mg, 80mg	4	QL (60 caps / 30 days)
<i>ziprasidone mesylate</i> SOLR 20mg	4	QL (6 injections / 3 days)
ZYPREXA RELPREVV SUSR 210mg	4	QL (2 vials / 28 days), NM, PA
ZYPREXA RELPREVV SUSR 300mg	5	QL (2 vials / 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZYPREXA RELPREVV SUSR 405mg	5	QL (1 vial / 28 days), NM, PA

### **ATTENTION DEFICIT HYPERACTIVITY DISORDER**

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

### **HYPNOTICS**

BELSOMRA TABS 5mg, 10mg, 15mg, 20mg	4	QL (30 tabs / 30 days)
-------------------------------------	---	------------------------

**PA** - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. 53

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>doxepin hcl (sleep)</i> TABS 3mg, 6mg	3	QL (30 tabs / 30 days)
HETLIOZ CAPS 20mg	5	QL (30 caps / 30 days), NM, LA, PA
<i>temazepam</i> CAPS 7.5mg, 30mg	4	QL (30 caps / 30 days), PA; PA if 65 years and older
<i>temazepam</i> CAPS 15mg	4	QL (60 caps / 30 days), PA; PA if 65 years and older
<i>zolpidem tartrate</i> TABS 5mg, 10mg	2	GC, QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year

### **MIGRAINE**

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

### **MISCELLANEOUS**

AUSTEDO TABS 6mg	5	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO TABS 9mg, 12mg	5	QL (120 tabs / 30 days), NM, LA, PA
INGREZZA CAPS 40mg, 60mg, 80mg	5	QL (30 caps / 30 days), NM, LA, PA

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INGREZZA CAP 40-80MG	5	QL (28 caps / 28 days), NM, LA, PA
<i>lithium carbonate</i> CAPS 150mg, 300mg, 600mg	1	GC
<i>lithium carbonate</i> TABS 300mg; TBCR 300mg, 450mg	2	GC
NUEDEXTA CAP 20-10MG	4	QL (60 caps / 30 days), PA
<i>pyridostigmine bromide</i> TABS 60mg	3	
<i>riluzole</i> TABS 50mg	4	
<i>tetrabenazine</i> TABS 12.5mg	5	QL (90 tabs / 30 days), NM, PA
<i>tetrabenazine</i> TABS 25mg	5	QL (120 tabs / 30 days), NM, PA

### **MULTIPLE SCLEROSIS AGENTS**

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

### **MUSCULOSKELETAL THERAPY AGENTS**

<i>baclofen</i> TABS 10mg, 20mg	3	
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	3	PA; PA if 70 years and older
<i>dantrolene sodium</i> CAPS 25mg, 50mg, 100mg	4	
<i>tizanidine hcl</i> TABS 2mg, 4mg	2	GC

### **NARCOLEPSY/CATAPLEXY**

<i>armodafinil</i> TABS 50mg	3	QL (60 tabs / 30 days), PA
<i>armodafinil</i> TABS 150mg, 200mg, 250mg	3	QL (30 tabs / 30 days), PA

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XYREM SOLN 500mg/ml	5	QL (540 mL / 30 days), NM, LA, PA

### **PSYCHOTHERAPEUTIC-MISC**

<i>acamprosate calcium</i> TBEC 333mg	4	
<i>buprenorphine hcl</i> SUBL 2mg, 8mg	3	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	4	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	4	QL (60 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	2	GC, QL (90 tabs / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	2	GC, QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent)</i> TB12 150mg	3	
<i>disulfiram</i> TABS 250mg, 500mg	3	
<i>naloxone hcl</i> LIQD 4mg/0.1ml	3	
<i>naloxone hcl</i> SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	2	GC
<i>naltrexone hcl</i> TABS 50mg	3	
NICOTROL INHALER INHA 10mg	4	
NICOTROL NS SOLN 10mg/ml	4	
<i>varenicline tartrate</i> TABS .5mg, 1mg	4	QL (56 tabs / 28 days), PA
<i>varenicline tartrate tab 0.5 mg x 11 &amp; tab 1 mg x 42 pack</i>	4	PA
VIVITROL SUSR 380mg	5	NM

### **ENDOCRINE AND METABOLIC**

#### **ANDROGENS**

<i>oxandrolone</i> TABS 2.5mg	3	QL (120 tabs / 30 days), PA
<i>oxandrolone</i> TABS 10mg	4	QL (60 tabs / 30 days), PA
<i>testosterone</i> GEL 1%, 25mg/2.5gm, 50mg/5gm	4	QL (300 gm / 30 days), PA
<i>testosterone</i> GEL 1.62%	4	QL (150 gm / 30 days), PA
<i>testosterone cypionate</i> SOLN 100mg/ml, 200mg/ml	3	PA
<i>testosterone enanthate</i> SOLN 200mg/ml	3	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.

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

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
JARDIANCE TABS 10mg	3	GC, QL (60 tabs / 30 days)
JARDIANCE TABS 25mg	3	GC, QL (30 tabs / 30 days)
JENTADUETO TAB 2.5-500	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-850	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-1000	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000MG	3	GC, QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000MG	3	GC, QL (30 tabs / 30 days)
<i>metformin hcl</i> TABS 500mg	1	GC, QL (150 tabs / 30 days)
<i>metformin hcl</i> TABS 850mg	1	GC, QL (90 tabs / 30 days)
<i>metformin hcl</i> TABS 1000mg	1	GC, QL (75 tabs / 30 days)
<i>metformin hcl</i> TB24 500mg	1	GC, QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl</i> TB24 750mg	1	GC, QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>nateglinide</i> TABS 60mg, 120mg	1	GC, QL (90 tabs / 30 days)
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/1.5ml	3	QL (1 pen / 28 days)
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml	3	QL (1 pen / 28 days)
OZEMPIC (2MG/DOSE) SOPN 8MG/3ML	3	QL (1 pen / 28 days)
<i>pioglitazone hcl</i> TABS 15mg, 30mg, 45mg	1	GC, QL (30 tabs / 30 days)
<i>repaglinide</i> TABS 2mg	1	GC, QL (240 tabs / 30 days)
<i>repaglinide</i> TABS .5mg, 1mg	1	GC, QL (120 tabs / 30 days)
RYBELSUS TABS 3mg, 7mg, 14mg	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 12.5-500	3	GC, QL (60 tabs / 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SYNJARDY TAB 12.5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	3	GC, QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000	3	GC, QL (30 tabs / 30 days)
TRADJENTA TABS 5mg	3	GC, QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	3	GC, QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 10-5-1000MG	3	GC, QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	3	GC, QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000MG	3	GC, QL (30 tabs / 30 days)
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml	3	QL (4 pens / 28 days)
VICTOZA SOPN 18mg/3ml	3	QL (3 pens / 30 days)
XIGDUO XR TAB 2.5-1000	3	GC, QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	GC, QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	GC, QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	GC, QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000	3	GC, QL (30 tabs / 30 days)

### **ANTIDIABETICS, INSULINS**

BASAGLAR KWIKPEN SOPN 100unit/ml	3	GC
BD ALCOHOL SWABS	3	
FIASP FLEX INJ TOUCH	3	GC
FIASP INJ 100/ML	3	GC
FIASP PENFIL INJ U-100	3	GC
GAUZE PADS 2" X 2"	3	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml)	5	B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	5	
INSULIN PEN NEEDLES: BD/NOVO	3	GC
INSULIN SAFETY NEEDLES	3	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSULIN SYRINGES: BD	3	GC
LANTUS SOLN 100unit/ml	3	GC
LANTUS SOLOSTAR SOPN 100unit/ml	3	GC
LEVEMIR SOLN 100unit/ml	3	GC
LEVEMIR FLEXTOUCH SOPN 100unit/ml	3	GC
NOVOLIN INJ 70/30	3	GC; (brand RELION not covered)
NOVOLIN INJ 70/30 FP	3	GC; (brand RELION not covered)
NOVOLIN N SUSP 100unit/ml	3	GC; (brand RELION not covered)
NOVOLIN N FLEXPEN SUPN 100unit/ml	3	GC; (brand RELION not covered)
NOVOLIN R SOLN 100unit/ml	3	GC; (brand RELION not covered)
NOVOLIN R FLEXPEN SOPN 100unit/ml	3	GC; (brand RELION not covered)
NOVOLOG SOLN 100unit/ml	3	GC; (brand RELION not covered)
NOVOLOG FLEXPEN SOPN 100unit/ml	3	GC; (brand RELION not covered)
NOVOLOG MIX INJ 70/30	3	GC; (brand RELION not covered)
NOVOLOG MIX INJ FLEXPEN	3	GC; (brand RELION not covered)
NOVOLOG PENFILL SOCT 100unit/ml	3	GC; (brand RELION not covered)
OMNIPOD 5 G6 KIT INTRO	4	QL (1 kit / year), PA
OMNIPOD 5 G6 MIS PODS	4	QL (15 pods / 30 days), PA
OMNIPOD DASH KIT INTRO	4	QL (1 kit / year), PA
OMNIPOD DASH MIS PODS	4	QL (15 pods / 30 days), PA
OMNIPOD MIS CLASSIC	4	QL (15 pods / 30 days), PA
OMNIPOD PDM KIT CLASSIC	4	QL (1 kit / year), PA
SOLIQUA INJ 100/33	3	QL (5 pens / 25 days)
TOUJEO MAX SOLOSTAR SOPN 300unit/ml	3	GC
TOUJEO SOLOSTAR SOPN 300unit/ml	3	GC
TRESIBA SOLN 100unit/ml	3	GC
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	3	GC
V-GO 20 KIT	4	QL (1 kit / 30 days), PA
V-GO 30 KIT	4	QL (1 kit / 30 days), PA
V-GO 40 KIT	4	QL (1 kit / 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XULTOPHY INJ 100/3.6	3	QL (5 pens / 30 days)
<b>CALCIUM REGULATORS</b>		
<i>alendronate sodium</i> TABS 10mg, 35mg, 70mg	1	GC
<i>calcitonin (salmon) spray</i> SOLN 200unit/act	3	B/D
FORTEO SOPN 600mcg/2.4ml	5	NM, PA
<i>ibandronate sodium</i> TABS 150mg	3	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	5	NM, LA, PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	3	B/D
<i>pamidronate disodium</i> SOLN 30mg/10ml, 90mg/10ml	3	B/D
PROLIA SOSY 60mg/ml	4	QL (1 syringe / 180 days), NM
TERIPARATIDE SOPN 620mcg/2.48ml	5	NM, PA
XGEVA SOLN 120mg/1.7ml	5	NM, PA
<i>zoledronic acid</i> CONC 4mg/5ml; SOLN 4mg/100ml, 5mg/100ml	4	B/D, NM
<b>CHELATING AGENTS</b>		
CHEMET CAPS 100mg	4	
<i>deferasirox</i> PACK 90mg, 180mg, 360mg; TABS 180mg, 360mg	5	NM, PA
<i>deferasirox</i> TABS 90mg	3	NM, PA
LOKELMA PACK 5gm, 10gm	3	
<i>penicillamine</i> TABS 250mg	5	NM
<i>sodium polystyrene sulfonate powder</i>	3	
<i>sps</i> SUSP 15gm/60ml	3	
<i>trientine hcl</i> CAPS 250mg	5	NM, PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	3	
<b>CONTRACEPTIVES</b>		
<i>afirmelle</i>	2	GC
<i>altavera</i>	3	
<i>alyacen 1/35</i>	3	
<i>alyacen 7/7/7</i>	3	
<i>apri</i>	2	GC
<i>aranelle</i>	3	
<i>aubra eq</i>	2	GC
<i>aurovela 1/20</i>	3	
<i>aurovela fe 1.5/30</i>	2	GC
<i>aurovela fe 1/20</i>	2	GC
<i>aviane</i>	2	GC
<i>ayuna</i>	3	
<i>azurette</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>balziva</i>	3	
<i>blisovi fe 1.5/30</i>	2	GC
<i>briellyn</i>	3	
<i>camila TABS .35mg</i>	2	GC
<i>caziant</i>	3	
<i>chateal</i>	3	
<i>cryselle-28</i>	3	
<i>cyred eq</i>	2	GC
<i>dasetta 1/35</i>	3	
<i>dasetta 7/7/7</i>	3	
<i>deblitane TABS .35mg</i>	2	GC
<i>desogest-eth estrad &amp; eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	3	
<i>desogestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</i>	2	GC
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	3	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	3	
<i>elinest</i>	3	
<i>ELLA TABS 30mg</i>	3	
<i>eluryng</i>	4	
<i>emoquette</i>	2	GC
<i>enpresse-28</i>	2	GC
<i>enskyce</i>	2	GC
<i>errin TABS .35mg</i>	2	GC
<i>estarylla</i>	2	GC
<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-35 mcg</i>	2	GC
<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-50 mcg</i>	3	
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	4	
<i>falmina</i>	2	GC
<i>femynor</i>	2	GC
<i>hailey 1.5/30</i>	3	
<i>heather TABS .35mg</i>	2	GC
<i>iclevia</i>	3	
<i>incassia TABS .35mg</i>	2	GC
<i>introvale</i>	3	
<i>isibloom</i>	2	GC
<i>jasmiel</i>	3	
<i>jolessa</i>	3	
<i>juleber</i>	2	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>junel 1.5/30</i>	3	
<i>junel 1/20</i>	3	
<i>junel fe 1.5/30</i>	2	GC
<i>junel fe 1/20</i>	2	GC
<i>kariva</i>	3	
<i>kelnor 1/35</i>	2	GC
<i>kelnor 1/50</i>	3	
<i>kurvelo</i>	3	
<i>larin 1.5/30</i>	3	
<i>larin 1/20</i>	3	
<i>larin fe 1.5/30</i>	2	GC
<i>larin fe 1/20</i>	2	GC
<i>larissia</i>	2	GC
<i>leena</i>	3	
<i>lessina</i>	2	GC
<i>levonest</i>	2	GC
<i>levonorgestrel &amp; ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	3	
<i>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-20 mcg</i>	2	GC
<i>levonorgestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</i>	3	
<i>levonorgestrel-eth estra tab 0.05- 30/0.075-40/0.125-30mg-mcg</i>	2	GC
<i>levora 0.15/30-28</i>	3	
<i>lillow</i>	3	
<i>loestrin 1.5/30-21</i>	3	
<i>loestrin 1/20-21</i>	3	
<i>loestrin fe 1.5/30</i>	2	GC
<i>loestrin fe 1/20</i>	2	GC
<i>loryna</i>	3	
<i>low-ogestrel</i>	3	
<i>lutra</i>	2	GC
<i>lyleq TABS .35mg</i>	2	GC
<i>lyza TABS .35mg</i>	2	GC
<i>marlissa</i>	3	
<i>medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml</i>	3	
<i>microgestin 1.5/30</i>	3	
<i>microgestin 1/20</i>	3	
<i>microgestin fe 1.5/30</i>	2	GC
<i>microgestin fe 1/20</i>	2	GC
<i>mili</i>	2	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.



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mono-linyah</i>	2	GC
<i>necon 0.5/35-28</i>	3	
<i>nikki</i>	3	
<i>nora-be TABS .35mg</i>	2	GC
<i>norethindrone (contraceptive) TABS .35mg</i>	2	GC
<i>norethindrone ace &amp; ethinyl estradiol tab 1 mg-20 mcg</i>	3	
<i>norethindrone ace &amp; ethinyl estradiol tab 1.5 mg-30 mcg</i>	3	
<i>norethindrone ace &amp; ethinyl estradiol-fe tab 1 mg-20 mcg</i>	2	GC
<i>norgestimate &amp; ethinyl estradiol tab 0.25 mg-35 mcg</i>	2	GC
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	3	
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	3	
<i>norlyroc TABS .35mg</i>	2	GC
<i>nortrel 0.5/35 (28)</i>	3	
<i>nortrel 1/35 (21)</i>	3	
<i>nortrel 1/35 (28)</i>	3	
<i>nortrel 7/7/7</i>	3	
<i>nylia 1/35</i>	3	
<i>nylia 7/7/7</i>	3	
<i>nymyo</i>	2	GC
<i>ocella</i>	3	
<i>philith</i>	3	
<i>pimtrea</i>	3	
<i>pirmella 1/35</i>	3	
<i>portia-28</i>	3	
<i>reclipsen</i>	2	GC
<i>setlakin</i>	3	
<i>sharobel TABS .35mg</i>	2	GC
<i>simliya</i>	3	
<i>sprintec 28</i>	2	GC
<i>sronyx</i>	2	GC
<i>syeda</i>	3	
<i>tarina fe 1/20 eq</i>	2	GC
<i>tilia fe</i>	4	
<i>tri-estarylla</i>	3	
<i>tri-legest fe</i>	4	
<i>tri-linyah</i>	3	
<i>tri-lo-estarylla</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tri-lo-marzia</i>	3	
<i>tri-lo-mili</i>	3	
<i>tri-lo-sprintec</i>	3	
<i>tri-mili</i>	3	
<i>tri-nymyo</i>	3	
<i>tri-sprintec</i>	3	
<i>tri-vylibra</i>	3	
<i>tri-vylibra lo</i>	3	
<i>trivora-28</i>	2	GC
<i>velivet</i>	3	
<i>vestura</i>	3	
<i>vienva</i>	2	GC
<i>viorele</i>	3	
<i>vyfemla</i>	3	
<i>vylibra</i>	2	GC
<i>wera</i>	3	
<i>xulane</i>	4	
<i>zafemy</i>	4	
<i>zovia 1/35</i>	2	GC
<i>zumandimine</i>	3	

### **ENDOMETRIOSIS**

<i>danazol</i> CAPS 50mg, 100mg, 200mg	4	
<i>SYNAREL</i> SOLN 2mg/ml	5	

### **ESTROGENS**

<i>amabelz</i>	3	
<i>DELESTROGEN</i> OIL 10mg/ml	4	
<i>dotti</i> PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
<i>estradiol</i> PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	3	
<i>estradiol</i> TABS .5mg, 1mg, 2mg	2	GC
<i>estradiol &amp; norethindrone acetate tab 0.5-0.1 mg</i>	3	
<i>estradiol &amp; norethindrone acetate tab 1-0.5 mg</i>	3	
<i>estradiol vaginal</i> CREA .1mg/gm	3	
<i>estradiol vaginal</i> TABS 10mcg	4	
<i>estradiol valerate</i> OIL 20mg/ml, 40mg/ml	4	
<i>fyavolv tab 0.5mg-2.5mcg</i>	3	
<i>fyavolv tab 1mg-5mcg</i>	3	
<i>jinteli</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lyllana</i> PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
<i>mimvey</i>	3	
<i>norethindrone acetate-ethinyl estradiol tab</i> 0.5 mg-2.5 mcg	3	
<i>norethindrone acetate-ethinyl estradiol tab</i> 1 mg-5 mcg	3	
<i>yuvaferm</i> TABS 10mcg	4	
<b>GLUCOCORTICOIDS</b>		
<i>dexamethasone</i> ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	3	
DEXAMETHASONE INTENSOL CONC 1mg/ml	4	
<i>dexamethasone sodium phosphate</i> SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	3	
<i>fludrocortisone acetate</i> TABS .1mg	2	GC
<i>hydrocortisone</i> TABS 5mg, 10mg, 20mg	3	
<i>methylprednisolone</i> TABS 4mg, 8mg, 16mg, 32mg	3	B/D
<i>methylprednisolone</i> TBPK 4mg	2	GC
<i>methylprednisolone acetate</i> SUSP 40mg/ml, 80mg/ml	3	B/D
<i>methylprednisolone sod succ</i> SOLR 40mg, 125mg, 1000mg	3	B/D
<i>prednisolone</i> SOLN 15mg/5ml	2	GC, B/D
<i>prednisolone sodium phosphate</i> SOLN 5mg/5ml	4	B/D
<i>prednisolone sodium phosphate</i> SOLN 15mg/5ml	2	GC, B/D
<i>prednisolone sodium phosphate</i> SOLN 25mg/5ml	3	B/D
<i>prednisone</i> SOLN 5mg/5ml	4	B/D
<i>prednisone</i> TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	2	GC, B/D
<i>prednisone</i> TBPK 5mg, 10mg	3	
PREDNISONE INTENSOL CONC 5mg/ml	4	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	4	
<b>GLUCOSE ELEVATING AGENTS</b>		
<i>diazoxide</i> SUSP 50mg/ml	5	
GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	3	
GVOKE KIT SOLN 1mg/0.2ml	3	

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml	3	
<b>MISCELLANEOUS</b>		
ALDURAZYME SOLN 2.9mg/5ml	5	NM, LA, PA
<i>betaine powder for oral solution</i>	5	NM, LA
<i>cabergoline</i> TABS .5mg	3	
<i>carglumic acid</i> TBSO 200mg	5	NM, LA, PA
CERDELGA CAPS 84mg	5	NM, LA, PA
CEREZYME SOLR 400unit	5	NM, LA, PA
<i>cinacalcet hcl</i> TABS 30mg	4	B/D, QL (60 tabs / 30 days), NM
<i>cinacalcet hcl</i> TABS 60mg	5	B/D, QL (60 tabs / 30 days), NM
<i>cinacalcet hcl</i> TABS 90mg	5	B/D, QL (120 tabs / 30 days), NM
CYSTAGON CAPS 50mg, 150mg	4	NM, LA, PA
<i>desmopressin acetate</i> SOLN 4mcg/ml	5	
<i>desmopressin acetate</i> TABS .1mg, .2mg	3	
<i>desmopressin acetate spray</i> SOLN .01%	4	
<i>desmopressin acetate spray refrigerated</i> SOLN .01%	4	
FABRAZYME SOLR 5mg, 35mg	5	NM, LA, PA
GENOTROPIN CART 5mg, 12mg	5	NM, PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NM, PA
INCRELEX SOLN 40mg/4ml	5	NM, LA, PA
KORLYM TABS 300mg	5	NM, LA, PA
<i>levocarnitine (metabolic modifiers)</i> SOLN 1gm/10ml; TABS 330mg	4	B/D
LUMIZYME SOLR 50mg	5	NM, LA, PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	5	NM, PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	5	NM, PA
<i>miglustat</i> CAPS 100mg	5	QL (90 caps / 30 days), NM, PA
NAGLAZYME SOLN 1mg/ml	5	NM, LA, PA
<i>nitisinone</i> CAPS 2mg, 5mg, 10mg	5	NM, PA
<i>octreotide acetate</i> SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml; SOSY 50mcg/ml, 100mcg/ml	4	NM, PA
<i>octreotide acetate</i> SOLN 500mcg/ml, 1000mcg/ml; SOSY 500mcg/ml	5	NM, PA
<i>raloxifene hcl</i> TABS 60mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sapropterin dihydrochloride</i> PACK 100mg, 500mg; TABS 100mg	5	NM, PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	5	NM, LA, PA
<i>sodium phenylbutyrate</i> POWD 3gm/tsp; TABS 500mg	5	NM, PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	5	NM, LA, PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	5	NM, LA, PA

### **PHOSPHATE BINDER AGENTS**

<i>calcium acetate (phosphate binder)</i> CAPS 667mg	3	QL (360 caps / 30 days)
<i>calcium acetate (phosphate binder)</i> TABS 667mg	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 800mg	4	QL (540 tabs / 30 days)
VELPHORO CHEW 500mg	5	QL (180 tabs / 30 days)

### **PROGESTINS**

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

### **THYROID AGENTS**

<i>euthyrox</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	GC
<i>levo-t</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	GC
<i>levothyroxine sodium</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	GC
<i>levoxyI</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	GC
<i>liothyronine sodium</i> TABS 5mcg, 25mcg, 50mcg	3	
<i>methimazole</i> TABS 5mg, 10mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>propylthiouracil</i> TABS 50mg	3	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	4	
<i>unithroid</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	GC

### **VITAMIN D ANALOGS**

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

### **GASTROINTESTINAL**

#### **ANTIEMETICS**

<i>aprepitant</i> CAPS 40mg, 80mg, 125mg	4	B/D
<i>aprepitant capsule therapy pack 80 &amp; 125 mg</i>	4	B/D
<i>compro</i> SUPP 25mg	4	
<i>dronabinol</i> CAPS 2.5mg, 5mg, 10mg	4	B/D, QL (60 caps / 30 days)
<i>granisetron hcl</i> SOLN 1mg/ml, 4mg/4ml	4	
<i>granisetron hcl</i> TABS 1mg	4	B/D
<i>meclizine hcl</i> TABS 12.5mg, 25mg	2	GC
<i>metoclopramide hcl</i> SOLN 5mg/5ml, 5mg/ml	3	
<i>metoclopramide hcl</i> TABS 5mg, 10mg	1	GC
<i>ondansetron</i> TBDP 4mg, 8mg	3	B/D
<i>ondansetron hcl</i> SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	3	
<i>ondansetron hcl</i> SOLN 4mg/5ml	4	B/D
<i>ondansetron hcl</i> TABS 4mg, 8mg	3	B/D
<i>prochlorperazine</i> SUPP 25mg	4	
<i>prochlorperazine edisylate</i> SOLN 10mg/2ml	4	
<i>prochlorperazine maleate</i> TABS 5mg, 10mg	2	GC
<i>promethazine hcl</i> SOLN 25mg/ml, 50mg/ml; SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg	3	PA; PA if 70 years and older
<i>scopolamine</i> PT72 1mg/3days	4	QL (10 patches / 30 days), PA; PA if 70 years and older

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTISPASMODICS</b>		
<i>dicyclomine hcl</i> CAPS 10mg; TABS 20mg	3	
<i>dicyclomine hcl</i> SOLN 10mg/5ml	4	
<i>glycopyrrolate</i> TABS 1mg, 2mg	3	
<b>H2-RECEPTOR ANTAGONISTS</b>		
<i>famotidine</i> SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	3	
<i>famotidine</i> SUSR 40mg/5ml	4	QL (300 mL / 30 days)
<i>famotidine</i> TABS 20mg	1	GC, QL (120 tabs / 30 days)
<i>famotidine</i> TABS 40mg	1	GC, QL (60 tabs / 30 days)
<i>famotidine in nacl 0.9% iv soln</i> 20 mg/50ml	3	
<i>nizatidine</i> CAPS 150mg, 300mg	4	
<b>INFLAMMATORY BOWEL DISEASE</b>		
<i>balsalazide disodium</i> CAPS 750mg	3	
<i>budesonide</i> CPEP 3mg	4	QL (90 caps / 30 days), PA
<i>budesonide</i> TB24 9mg	5	QL (30 tabs / 30 days), PA
<i>hydrocortisone (intrarectal)</i> ENEM 100mg/60ml	4	
<i>mesalamine</i> CP24 .375gm	4	QL (120 caps / 30 days)
<i>mesalamine</i> CPDR 400mg	4	QL (180 caps / 30 days)
<i>mesalamine</i> ENEM 4gm; SUPP 1000mg	4	
<i>mesalamine</i> TBEC 1.2gm	4	QL (120 tabs / 30 days)
<i>mesalamine w/ cleanser</i> KIT 4gm	4	
<i>sulfasalazine</i> TABS 500mg	2	GC
<i>sulfasalazine</i> TBEC 500mg	3	
<b>LAXATIVES</b>		
<i>constulose</i> SOLN 10gm/15ml	3	
<i>enulose</i> SOLN 10gm/15ml	3	
<i>gavilyte-c</i>	2	GC
<i>gavilyte-g</i>	2	GC
<i>generlac</i> SOLN 10gm/15ml	3	
GOLYTELY SOL	3	
<i>lactulose</i> SOLN 10gm/15ml	3	
<i>lactulose (encephalopathy)</i> SOLN 10gm/15ml	3	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln</i> 236 gm	2	GC
<i>peg 3350-kcl-sod bicarb-nacl for soln</i> 420 gm	2	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PLENVU SOL	4	
SUPREP BOWEL SOL PREP KIT	4	
<b>MISCELLANEOUS</b>		
<i>alose tron hcl</i> TABS .5mg, 1mg	5	QL (60 tabs / 30 days), PA
<i>cromolyn sodium (mastocytosis)</i> CONC 100mg/5ml	4	
<i>diphenoxylate w/ atropine liq</i> 2.5-0.025 mg/5ml	4	
<i>diphenoxylate w/ atropine tab</i> 2.5-0.025 mg	3	
GATTEX KIT 5mg	5	NM, LA, PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	4	QL (30 caps / 30 days)
<i>loperamide hcl</i> CAPS 2mg	3	
<i>misoprostol</i> TABS 100mcg, 200mcg	3	
MOVANTIK TABS 12.5mg, 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	5	PA
<i>sucral fate</i> TABS 1gm	3	
<i>ursodiol</i> CAPS 300mg	3	
<i>ursodiol</i> TABS 250mg, 500mg	4	
XERMELO TABS 250mg	5	QL (90 tabs / 30 days), NM, LA, PA
XIFAXAN TABS 550mg	5	PA
<b>PANCREATIC ENZYMES</b>		
CREON CAP 3000UNIT	3	
CREON CAP 6000UNIT	3	
CREON CAP 12000UNT	3	
CREON CAP 24000UNT	3	
CREON CAP 36000UNT	3	
ZENPEP CAP 3000UNIT	4	
ZENPEP CAP 5000UNIT	4	
ZENPEP CAP 10000UNT	4	
ZENPEP CAP 15000UNT	4	
ZENPEP CAP 20000UNT	4	
ZENPEP CAP 25000	4	
ZENPEP CAP 40000	4	
<b>PROTON PUMP INHIBITORS</b>		
<i>esomeprazole magnesium</i> CPDR 20mg, 40mg	4	QL (30 caps / 30 days), ST
<i>lansoprazole</i> CPDR 15mg, 30mg	3	QL (60 caps / 30 days)
<i>omeprazole</i> CPDR 10mg, 20mg, 40mg	1	GC
<i>pantoprazole sodium</i> SOLR 40mg	4	
<i>pantoprazole sodium</i> TBEC 20mg, 40mg	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
<b>GENITOURINARY</b>		
<b>BENIGN PROSTATIC HYPERPLASIA</b>		
<i>alfuzosin hcl</i> TB24 10mg	2	GC, QL (30 tabs / 30 days)
<i>dutasteride</i> CAPS .5mg	3	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl cap</i> 0.5-0.4 mg	4	QL (30 caps / 30 days)
<i>finasteride</i> TABS 5mg	1	GC
<i>tamsulosin hcl</i> CAPS .4mg	2	GC
<b>MISCELLANEOUS</b>		
<i>acetic acid</i> SOLN .25%	2	GC
<i>bethanechol chloride</i> TABS 5mg, 10mg, 25mg, 50mg	3	
<i>potassium citrate (alkalinizer)</i> TBCR 15meq, 540mg, 1080mg	4	
<b>URINARY ANTISPASMODICS</b>		
<i>fesoterodine fumarate</i> TB24 4mg, 8mg	4	QL (30 tabs / 30 days)
GEMTESA TABS 75mg	4	QL (30 tabs / 30 days)
MYRBETRIQ SRER 8mg/ml	4	QL (300 mL / 28 days)
MYRBETRIQ TB24 25mg, 50mg	4	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> SYRP 5mg/5ml; TABS 5mg	3	
<i>oxybutynin chloride</i> TB24 5mg	3	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> TB24 10mg, 15mg	3	QL (60 tabs / 30 days)
<i>solifenacin succinate</i> TABS 5mg, 10mg	4	QL (30 tabs / 30 days)
<i>tolterodine tartrate</i> CP24 2mg, 4mg	4	QL (30 caps / 30 days), ST
<i>tolterodine tartrate</i> TABS 1mg, 2mg	4	QL (60 tabs / 30 days)
<i>tropium chloride</i> TABS 20mg	3	QL (60 tabs / 30 days)
<b>VAGINAL ANTI-INFECTIVES</b>		
<i>clindamycin phosphate vaginal</i> CREA 2%	3	
<i>metronidazole vaginal</i> GEL .75%	3	
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	3	
<b>HEMATOLOGIC</b>		
<b>ANTICOAGULANTS</b>		
<i>dabigatran etexilate mesylate</i> CAPS 75mg	4	QL (60 caps / 30 days)
ELIQUIS TABS 2.5mg	3	QL (60 tabs / 30 days)
ELIQUIS TABS 5mg	3	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK TBPK 5mg	3	QL (74 tabs / 30 days)
<i>enoxaparin sodium</i> SOLN 300mg/3ml; SOSY 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	4	
<i>fondaparinux sodium</i> SOLN 2.5mg/0.5ml	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fondaparinux sodium</i> SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	
HEP SOD/D5W INJ 20000UNT	3	
HEP SOD/D5W INJ 25000UNT	3	
HEP SOD/NACL INJ 25000UNT	3	
<i>heparin sodium (porcine)</i> SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	3	B/D
HEPARIN/NACL INJ 25000UNT	3	
<i>jantoven</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
PRADAXA CAPS 75mg, 150mg	4	QL (60 caps / 30 days)
PRADAXA CAPS 110mg	4	QL (120 caps / 30 days)
<i>warfarin sodium</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	GC
XARELTO SUSR 1mg/ml	3	QL (620 mL / 30 days)
XARELTO TABS 2.5mg	3	QL (60 tabs / 30 days)
XARELTO TABS 10mg, 15mg, 20mg	3	QL (30 tabs / 30 days)
XARELTO STAR TAB 15/20MG	3	QL (51 tabs / 30 days)
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	NM, PA
PROCRIT SOLN 20000unit/ml, 40000unit/ml	5	NM, PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	5	NM, PA
ZIEXTENZO SOSY 6mg/0.6ml	5	NM, PA
<b>MISCELLANEOUS</b>		
<i>anagrelide hcl</i> CAPS .5mg, 1mg	4	
BERINERT KIT 500unit	5	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i> TABS 50mg, 100mg	2	GC
DOPTELET TABS 20mg	5	NM, LA, PA
DROXIA CAPS 200mg, 300mg, 400mg	3	
ENDARI PACK 5gm	5	NM, LA, PA
HAEGARDA SOLR 2000unit	5	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA SOLR 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
<i>icatibant acetate</i> SOLN 30mg/3ml	5	QL (9 syringes / 30 days), NM, PA
<i>pentoxifylline</i> TBCR 400mg	2	GC
PROMACTA PACK 12.5mg	5	QL (360 packets / 30 days), NM, LA, PA

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PROMACTA PACK 25mg	5	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	5	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
<i>sajazir</i> SOLN 30mg/3ml	5	QL (9 syringes / 30 days), NM, LA, PA
<i>tranexamic acid</i> SOLN 1000mg/10ml	4	
<i>tranexamic acid</i> TABS 650mg	3	

### **PLATELET AGGREGATION INHIBITORS**

<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	4	
BRILINTA TABS 60mg, 90mg	3	
<i>clopidogrel bisulfate</i> TABS 75mg	1	GC
<i>dipyridamole</i> TABS 25mg, 50mg, 75mg	3	PA; PA if 70 years and older
<i>prasugrel hcl</i> TABS 5mg, 10mg	3	

### **IMMUNOLOGIC AGENTS**

#### **AUTOIMMUNE AGENTS**

DUPIXENT SOPN 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	5	NM, PA
ENBREL SOLN 25mg/0.5ml; SOLR 25mg	5	QL (16 vials / 28 days), NM, PA
ENBREL SOSY 25mg/0.5ml	5	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	5	QL (8 syringes / 28 days), NM, PA
ENBREL MINI SOCT 50mg/ml	5	QL (8 cartridges / 28 days), NM, PA
ENBREL SURECLICK SOAJ 50mg/ml	5	QL (8 pens / 28 days), NM, PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml	5	QL (2 syringes / 28 days), NM, PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml	5	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIA INJ CROHNS	5	NM, PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml	5	NM, PA
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml	5	QL (6 pens / 28 days), NM, PA
HUMIRA PEN PNKT 80mg/0.8ml	5	QL (4 pens / 28 days), NM, PA
HUMIRA PEN KIT PS/UV	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml	5	NM, PA
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml	5	NM, PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml	5	NM, PA
INFLIXIMAB SOLR 100mg	5	NM, LA, PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml	5	QL (2 pens / 28 days), NM, PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml	5	QL (2 syringes / 28 days), NM, PA
OTEZLA TABS 30mg	5	QL (60 tabs / 30 days), NM, PA
OTEZLA TAB 10/20/30	5	QL (110 tabs / year), NM, PA
REMICADE SOLR 100mg	5	NM, LA, PA
RENFLEXIS SOLR 100mg	5	NM, LA, PA
RINVOQ TB24 15mg, 30mg	5	QL (30 tabs / 30 days), NM, PA
RINVOQ TB24 45mg	5	QL (112 tabs / year), NM, PA
SKYRIZI SOSY 150mg/ml	5	QL (6 syringes / 365 days), NM, PA
SKYRIZI PEN SOAJ 150mg/ml	5	QL (6 pens / 365 days), NM, PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml	5	QL (3 syringes / 28 days), NM, LA, PA
XELJANZ SOLN 1mg/ml	5	QL (480 mL / 24 days), NM, PA
XELJANZ TABS 5mg, 10mg	5	QL (60 tabs / 30 days), NM, PA
XELJANZ XR TB24 11mg, 22mg	5	QL (30 tabs / 30 days), NM, PA

### ***DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)***

<i>hydroxychloroquine sulfate</i> TABS 200mg	3	
<i>leflunomide</i> TABS 10mg, 20mg	3	QL (30 tabs / 30 days)
<i>methotrexate sodium</i> TABS 2.5mg	3	
XATMEP SOLN 2.5mg/ml	4	B/D

### ***IMMUNOGLOBULINS***

BIVIGAM SOLN 5gm/50ml, 10%	5	NM, LA, PA
FLEBOGAMMA DIF SOLN 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	NM, PA
GAMASTAN INJ	4	B/D, NM, LA

**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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NM, PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	5	NM, PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	5	NM, PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	NM, LA, PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NM, PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 25gm/500ml, 30gm/300ml	5	NM, PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NM, PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NM, PA
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE SOLN 2000000unit/0.5ml	5	NM, LA, PA
ARCALYST SOLR 220mg	5	NM, LA, PA
INTRON A SOLR 10000000unit, 18000000unit, 50000000unit	5	B/D, NM, LA
<b>IMMUNOSUPPRESSANTS</b>		
<i>azathioprine</i> TABS 50mg	3	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	5	QL (8 syringes / 28 days), NM, LA, PA
BENLYSTA SOLR 120mg, 400mg	5	NM, LA, PA
<i>cyclosporine</i> CAPS 25mg, 100mg; SOLN 50mg/ml	4	B/D
<i>cyclosporine modified (for microemulsion)</i> CAPS 25mg, 50mg, 100mg; SOLN 100mg/ml	4	B/D
<i>everolimus (immunosuppressant)</i> TABS .25mg, .5mg, .75mg, 1mg	5	B/D
<i>gengraf</i> CAPS 25mg, 100mg; SOLN 100mg/ml	4	B/D
<i>mycophenolate mofetil</i> CAPS 250mg; TABS 500mg	3	B/D
<i>mycophenolate mofetil</i> SUSR 200mg/ml	5	B/D
<i>mycophenolate sodium</i> TBEC 180mg, 360mg	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NULOJIX SOLR 250mg	5	B/D
PROGRAF PACK .2mg, 1mg	4	B/D
REZUROCK TABS 200mg	5	NM, LA, PA
SANDIMMUNE SOLN 100mg/ml	4	B/D
<i>sirolimus</i> SOLN 1mg/ml	5	B/D
<i>sirolimus</i> TABS .5mg, 1mg, 2mg	4	B/D
<i>tacrolimus</i> CAPS .5mg, 1mg, 5mg	4	B/D

### **VACCINES**

ACTHIB INJ	3	
ADACEL INJ	3	
BCG VACCINE SOLR 50mg	3	
BEXSERO INJ	3	
BOOSTRIX INJ	3	
DAPTACEL INJ	3	
DENG VAXIA SUS	3	
DIP/TET PED INJ 25-5LFU	3	B/D
ENGERIX-B SUSP 10mcg/0.5ml, 20mcg/ml	3	B/D
GARDASIL 9 INJ	3	
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	3	
HIBERIX SOLR 10mcg	3	
IMOVAX RABIES (H.D.C.V.) INJ 2.5unit/ml	3	B/D
INFANRIX INJ	3	
I POL INJ INACTIVE	3	
IXIARO INJ	3	
KINRIX INJ	3	
M-M-R II INJ	3	
MENACTRA INJ	3	
MENQUADFI INJ	3	
MENVEO INJ	3	
PEDIARIX INJ 0.5ML	3	
PEDVAX HIB SUSP 7.5mcg/0.5ml	3	
PENTACEL INJ	3	
PREHEVBRIO SUSP 10mcg/ml	3	B/D
PRIORIX INJ	3	
PROQUAD INJ	3	
QUADRACEL INJ	3	
QUADRACEL INJ 0.5ML	3	
RABAVERT INJ	3	B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml	3	B/D
ROTARIX SUS	3	
ROTATEQ SOL	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SHINGRIX SUSR 50mcg/0.5ml	1	GC, QL (2 vials per lifetime)
TDVAX INJ 2-2 LF	3	B/D
TENIVAC INJ 5-2LF	3	B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	3	
TRUMENBA INJ	3	
TWINRIX INJ	1	GC
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	3	
VAQTA SUSP 25unit/0.5ml, 50unit/ml	3	
VARIVAX INJ 1350pfu/0.5ml	3	
YF-VAX INJ	3	

## **NUTRITIONAL/SUPPLEMENTS**

### ***ELECTROLYTES/MINERALS, INJECTABLE***

D2.5W/NACL INJ 0.45%	4	
D5W/LYTES INJ #48	4	
D10W/NACL INJ 0.2%	3	
<i>dextrose 2.5% w/ sodium chloride 0.45%</i>	3	
<i>dextrose 5% in lactated ringers</i>	3	
<i>dextrose 5% w/ sodium chloride 0.2%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.3%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.9%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.45%</i>	3	
<i>dextrose 5% w/ sodium chloride 0.225%</i>	3	
<i>dextrose 10% w/ sodium chloride 0.45%</i>	3	
ISOLYTE-P INJ /D5W	4	
ISOLYTE-S INJ	4	
ISOLYTE-S INJ PH 7.4	4	
<i>kcl 10 meq/l (0.075%) in dextrose 5% &amp; nacl 0.45% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in dextrose 5% &amp; nacl 0.2% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in dextrose 5% &amp; nacl 0.9% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in dextrose 5% &amp; nacl 0.45% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	3	
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	3	
KCL 20 MEQ/L (0.15%) IN NACL 0.45% INJ	4	
<i>kcl 30 meq/l (0.224%) in dextrose 5% &amp; nacl 0.45% inj</i>	3	
<i>kcl 40 meq/l (0.3%) in dextrose 5% &amp; nacl 0.45% inj</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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KCL 40 MEQ/L (0.3%) IN NAACL 0.9% INJ	4	
KCL/D5W/NAACL INJ 0.3/0.9%	4	
<i>lactated ringer's solution</i>	3	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
<i>magnesium sulfate</i> SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	3	
<i>magnesium sulfate in dextrose 5% iv soln</i> <i>1 gm/100ml</i>	3	
MG SO4/D5W INJ 10MG/ML	3	
PLASMA-LYTE INJ -148	4	
PLASMA-LYTE INJ -A	4	
<i>potassium chloride</i> SOLN 2meq/ml	3	
POTASSIUM CHLORIDE SOLN 10meq/50ml, 20meq/50ml	4	
<i>potassium chloride</i> SOLN 10meq/100ml, 20meq/100ml, 40meq/100ml	4	
<i>potassium chloride 20 meq/l (0.15%) in</i> <i>dextrose 5% inj</i>	3	
<i>sodium chloride</i> SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	3	
TPN ELECTROL INJ	4	B/D
<b>ELECTROLYTES/MINERALS/VITAMINS, ORAL</b>		
<i>klor-con</i> PACK 20meq	4	
<i>klor-con 8</i> TBCR 8meq	2	GC
<i>klor-con 10</i> TBCR 10meq	2	GC
<i>klor-con m10</i> TBCR 10meq	2	GC
<i>klor-con m15</i> TBCR 15meq	3	
<i>klor-con m20</i> TBCR 20meq	2	GC
M-NATAL PLUS TAB	3	
<i>potassium chloride</i> CPCR 8meq, 10meq	3	
<i>potassium chloride</i> PACK 20meq; SOLN 10%, 20%	4	
<i>potassium chloride</i> TBCR 8meq, 10meq, 20meq	2	GC
<i>potassium chloride microencapsulated</i> <i>crystals er</i> TBCR 10meq, 20meq	2	GC
<i>potassium chloride microencapsulated</i> <i>crystals er</i> TBCR 15meq	3	
PRENATAL TAB 27-1MG	3	
PRENATAL TAB PLUS	3	
PRENATAL VIT TAB LOW IRON	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.



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	2	GC
TRICARE TAB PRENATAL	3	

#### **IV NUTRITION**

CLINIMIX INJ 4.25/D5W	4	B/D
CLINIMIX INJ 4.25/D10	4	B/D
CLINIMIX INJ 5%/D15W	4	B/D
CLINIMIX INJ 5%/D20W	4	B/D
CLINIMIX INJ 6/5	4	B/D
CLINIMIX INJ 8/10	4	B/D
CLINIMIX INJ 8/14	4	B/D
<i>clinisol sf 15%</i>	4	B/D
CLINOLIPID EMU 20%	4	B/D
<i>dextrose SOLN 5%, 10%</i>	3	
<i>dextrose SOLN 50%, 70%</i>	3	B/D
FREAMINE III INJ 10%	4	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	4	B/D
NUTRILIPID EMUL 20gm/100ml	4	B/D
<i>plenamine</i>	4	B/D
PREMASOL SOL 10%	5	B/D
PROCALAMINE INJ 3%	4	B/D
PROSOL INJ 20%	4	B/D
TRAVASOL INJ 10%	4	B/D
TROPHAMINE INJ 10%	4	B/D

#### **OPHTHALMIC**

##### **ANTI-INFECTIVE/ANTI-INFLAMMATORY**

<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	3	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	2	GC
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	2	GC
<i>neomycin-polymyxin-hc ophth susp</i>	4	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	2	GC
TOBRADEX OIN 0.3-0.1%	3	
TOBRADEX ST SUS 0.3-0.05	3	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	4	
ZYLET SUS 0.5-0.3%	3	

##### **ANTI-INFECTIVES**

<i>bacitracin (ophthalmic) OINT 500unit/gm</i>	3	
<i>bacitracin-polymyxin b ophth oint</i>	2	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BESIVANCE SUSP .6%	3	
CILOXAN OINT .3%	3	
<i>ciprofloxacin hcl (ophth)</i> SOLN .3%	2	GC
<i>erythromycin (ophth)</i> OINT 5mg/gm	2	GC
<i>gatifloxacin (ophth)</i> SOLN .5%	3	
<i>gentak</i> OINT .3%	3	
<i>gentamicin sulfate (ophth)</i> SOLN .3%	2	GC
<i>moxifloxacin hcl (ophth)</i> SOLN .5%	3	
NATACYN SUSP 5%	4	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	3	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	3	
<i>ofloxacin (ophth)</i> SOLN .3%	2	GC
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	GC
<i>sulfacetamide sodium (ophth)</i> OINT 10%; SOLN 10%	3	
<i>tobramycin (ophth)</i> SOLN .3%	1	GC
<i>trifluridine</i> SOLN 1%	4	
ZIRGAN GEL .15%	4	
<b>ANTI-INFLAMMATORIES</b>		
ALREX SUSP .2%	3	
BROMSITE SOLN .075%	4	
<i>dexamethasone sodium phosphate (ophth)</i> SOLN .1%	3	
<i>diclofenac sodium (ophth)</i> SOLN .1%	2	GC
<i>difluprednate</i> EMUL .05%	4	
FLAREX SUSP .1%	4	
<i>fluorometholone (ophth)</i> SUSP .1%	3	
<i>flurbiprofen sodium</i> SOLN .03%	3	
ILEVRO SUSP .3%	3	
<i>ketorolac tromethamine (ophth)</i> SOLN .4%	3	
<i>ketorolac tromethamine (ophth)</i> SOLN .5%	2	GC
LOTEMAX OINT .5%	3	
<i>prednisolone acetate (ophth)</i> SUSP 1%	3	
PREDNISOLONE SODIUM PHOSP SOLN 1%	3	
PROLENSA SOLN .07%	3	
<b>ANTIALLERGICS</b>		
<i>azelastine hcl (ophth)</i> SOLN .05%	3	
<i>cromolyn sodium (ophth)</i> SOLN 4%	2	GC
<i>olopatadine hcl</i> SOLN .1%	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZERVIATE SOLN .24%	4	
<b>ANTIGLAUCOMA</b>		
ALPHAGAN P SOLN .1%	3	
<i>betaxolol hcl (ophth)</i> SOLN .5%	3	
BETOPTIC-S SUSP .25%	3	
<i>brimonidine tartrate</i> SOLN .2%	1	GC
<i>brimonidine tartrate</i> SOLN .15%	4	
<i>brinzolamide</i> SUSP 1%	4	
<i>carteolol hcl (ophth)</i> SOLN 1%	2	GC
COMBIGAN SOL 0.2/0.5%	3	
<i>dorzolamide hcl</i> SOLN 2%	2	GC
<i>dorzolamide hcl-timolol maleate ophth soln</i> 22.3-6.8 mg/ml	2	GC
<i>latanoprost</i> SOLN .005%	1	GC
<i>levobunolol hcl</i> SOLN .5%	2	GC
LUMIGAN SOLN .01%	3	
<i>pilocarpine hcl</i> SOLN 1%, 2%, 4%	3	
RHOPRESSA SOLN .02%	3	
SIMBRINZA SUS 1-0.2%	3	
<i>timolol maleate (ophth)</i> SOLG .25%, .5%	4	
<i>timolol maleate (ophth)</i> SOLN .25%, .5%	1	GC
VYZULTA SOLN .024%	4	
<b>MISCELLANEOUS</b>		
ATROPINE SULFATE SOLN 1%	3	
<i>atropine sulfate (ophthalmic)</i> SOLN 1%	3	
CYSTADROPS SOLN .37%	5	NM, LA, PA
CYSTARAN SOLN .44%	5	NM, LA, PA
ISOPTO ATROPINE SOLN 1%	3	
<i>proparacaine hcl</i> SOLN .5%	3	
RESTASIS EMUL .05%	3	
RESTASIS MULTIDOSE EMUL .05%	3	
XIIDRA SOLN 5%	3	
<b>OTIC</b>		
<b>OTIC AGENTS</b>		
<i>acetic acid (otic)</i> SOLN 2%	3	
<i>ciprofloxacin-dexamethasone otic susp</i> 0.3- 0.1%	4	
<i>flac</i> OIL .01%	3	
<i>fluocinolone acetonide (otic)</i> OIL .01%	3	
<i>neomycin-polymyxin-hc otic soln</i> 1%	3	
<i>neomycin-polymyxin-hc otic susp</i> 3.5 mg/ml-10000 unit/ml-1%	3	
<i>ofloxacin (otic)</i> SOLN .3%	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
<b>RESPIRATORY</b>		
<b>ANTICHOLINERGIC/BETA AGONIST COMBINATIONS</b>		
ANORO ELLIPT AER 62.5-25	3	QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	3	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE	3	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	3	QL (4 inhalers / 28 days)
COMBIVENT AER 20-100	4	QL (2 inhalers / 30 days)
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	3	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG	3	QL (60 blisters / 30 days)
TRELEGY AER ELLIPTA 200-62.5-25 MCG	3	QL (60 blisters / 30 days)
<b>ANTICHOLINERGICS</b>		
ATROVENT HFA AERS 17mcg/act	4	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA AEPB 62.5mcg/inh	3	QL (30 blisters / 30 days)
<i>ipratropium bromide SOLN .02%</i>	2	GC, B/D
<i>ipratropium bromide (nasal) SOLN .03%, .06%</i>	3	
<b>ANTI-HISTAMINES</b>		
<i>azelastine hcl SOLN .1%, .15%</i>	3	
<i>cetirizine hcl SOLN 1mg/ml</i>	2	GC
<i>cyproheptadine hcl SYRP 2mg/5ml; TABS 4mg</i>	3	PA; PA if 70 years and older
<i>diphenhydramine hcl SOLN 50mg/ml</i>	3	
<i>hydroxyzine hcl SOLN 25mg/ml, 50mg/ml</i>	4	PA; PA if 70 years and older
<i>hydroxyzine hcl SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg</i>	3	PA; PA if 70 years and older
<i>hydroxyzine pamoate CAPS 25mg, 50mg</i>	3	PA; PA if 70 years and older
<i>levocetirizine dihydrochloride SOLN 2.5mg/5ml</i>	4	
<i>levocetirizine dihydrochloride TABS 5mg</i>	3	
<b>BETA AGONISTS</b>		
<i>albuterol sulfate AERS 108mcg/act</i>	3	QL (2 inhalers / 30 days); (generic of Proair HFA)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>albuterol sulfate</i> AERS 108mcg/act	3	QL (2 inhalers / 30 days); (generic of Proventil 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	GC, B/D
<i>albuterol sulfate</i> SYRP 2mg/5ml	3	
<i>albuterol sulfate</i> TABS 2mg, 4mg	4	
<i>levalbuterol hcl</i> NEBU 1.25mg/0.5ml, 1.25mg/3ml	4	B/D
<i>levalbuterol tartrate</i> AERO 45mcg/act	3	QL (2 inhalers / 30 days), ST
SEREVENT DISKUS AEPB 50mcg/dose	3	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS 2.5mg, 5mg	4	
VENTOLIN HFA AERS 108mcg/act	3	QL (2 inhalers / 30 days)
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act	3	QL (6 inhalers / 30 days)
<b>LEUKOTRIENE MODULATORS</b>		
<i>montelukast sodium</i> CHEW 4mg, 5mg	3	
<i>montelukast sodium</i> PACK 4mg	4	
<i>montelukast sodium</i> TABS 10mg	1	GC
<i>zafirlukast</i> TABS 10mg, 20mg	3	
<b>MISCELLANEOUS</b>		
<i>acetylcysteine</i> SOLN 10%, 20%	4	B/D
ARALAST NP SOLR 500mg, 1000mg	5	NM, LA, PA
<i>cromolyn sodium</i> NEBU 20mg/2ml	3	B/D
DALIRESP TABS 250mcg, 500mcg	4	
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.3ml, .3mg/0.3ml	3	(generic of EpiPen)
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.15ml, .3mg/0.3ml	3	(generic of Adrenaclick)
ESBRIET CAPS 267mg	5	QL (270 caps / 30 days), NM, LA, PA
FASENRA SOSY 30mg/ml	5	NM, LA, PA
FASENRA PEN SOAJ 30mg/ml	5	NM, LA, PA
KALYDECO PACK 25mg, 50mg, 75mg	5	QL (56 packs / 28 days), NM, LA, PA
KALYDECO TABS 150mg	5	QL (60 tabs / 30 days), NM, LA, PA

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
OFEV CAPS 100mg, 150mg	5	QL (60 caps / 30 days), NM, LA, PA
ORKAMBI GRA 100-125	5	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 150-188	5	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI TAB 100-125	5	QL (112 tabs / 28 days), NM, LA, PA
ORKAMBI TAB 200-125	5	QL (112 tabs / 28 days), NM, LA, PA
<i>pirfenidone</i> TABS 267mg	5	QL (270 tabs / 30 days), NM, PA
<i>pirfenidone</i> TABS 801mg	5	QL (90 tabs / 30 days), NM, PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	5	NM, LA, PA
PULMOZYME SOLN 2.5mg/2.5ml	5	NM, PA
SYMDEKO TAB 50-75MG	5	QL (56 tabs / 28 days), NM, LA, PA
SYMDEKO TAB 100-150	5	QL (56 tabs / 28 days), NM, LA, PA
SYMJEPI SOSY .15mg/0.3ml, .3mg/0.3ml	4	
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	4	
<i>theophylline</i> SOLN 80mg/15ml; TB12 300mg, 450mg	4	
<i>theophylline</i> TB24 400mg, 600mg	3	
TRIKAFTA TAB 50-25-37.5MG & 75MG	5	QL (84 tabs / 28 days), NM, LA, PA
TRIKAFTA TAB 100-50-75MG & 150MG	5	QL (84 tabs / 28 days), NM, LA, PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	5	NM, LA, PA
ZEMAIRA SOLR 1000mg	5	NM, LA, PA
<b>NASAL STEROIDS</b>		
<i>flunisolide (nasal)</i> SOLN .025%	3	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i> SUSP 50mcg/act	2	GC, QL (1 bottle / 30 days)
XHANCE EXHU 93mcg/act	4	QL (32 mL / 30 days), PA
<b>STEROID INHALANTS</b>		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	3	QL (30 inhalations / 30 days)
<i>budesonide (inhalation)</i> SUSP .25mg/2ml, .5mg/2ml	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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FLOVENT DISKUS AEPB 50mcg/blist	3	QL (180 inhalations / 30 days)
FLOVENT DISKUS AEPB 100mcg/blist, 250mcg/blist	3	QL (240 inhalations / 30 days)
FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act	3	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 90mcg/act	4	QL (3 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 180mcg/act	4	QL (2 inhalers / 30 days)

### **STEROID/BETA-AGONIST COMBINATIONS**

ADVAIR DISKU AER 100/50	3	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 250/50	3	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 500/50	3	QL (60 inhalations / 30 days)
ADVAIR HFA AER 45/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	3	QL (1 inhaler / 30 days)
BREO ELLIPTA INH 100-25	3	QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	3	QL (60 blisters / 30 days)
SYMBICORT AER 80-4.5	3	QL (1 inhaler / 30 days)
SYMBICORT AER 160-4.5	3	QL (1 inhaler / 30 days)

### **TOPICAL**

#### **DERMATOLOGY, ACNE**

<i>acutane</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>amnesteem</i> CAPS 10mg, 20mg, 40mg	4	PA
<i>avita</i> CREA .025%; GEL .025%	4	QL (45 gm / 30 days), PA
<i>benzoyl peroxide-erythromycin gel</i> 5-3%	4	QL (46.6 gm / 30 days)
<i>claravis</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>clindamycin phosphate (topical)</i> GEL 1%	4	QL (75 gm / 30 days)
<i>clindamycin phosphate (topical)</i> LOTN 1%; SOLN 1%	3	QL (60 mL / 30 days)
<i>ery</i> PADS 2%	3	QL (60 pledgets / 30 days)
<i>erythromycin (acne aid)</i> SOLN 2%	3	QL (60 mL / 30 days)
<i>isotretinoin</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>myorisan</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<i>sulfacetamide sodium (acne)</i> LOTN 10%	4	QL (118 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.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tretinoin</i> CREA .025%, .05%, .1%; GEL .01%, .025%	4	QL (45 gm / 30 days), PA
<i>zenatane</i> CAPS 10mg, 20mg, 30mg, 40mg	4	PA
<b>DERMATOLOGY, ANTIBIOTICS</b>		
<i>gentamicin sulfate (topical)</i> CREA .1%	4	QL (30 gm / 30 days)
<i>gentamicin sulfate (topical)</i> OINT .1%	3	QL (30 gm / 30 days)
<i>mupirocin</i> OINT 2%	2	GC, QL (220 gm / 30 days)
<i>silver sulfadiazine</i> CREA 1%	2	GC
<i>ssd</i> CREA 1%	2	GC
SULFAMYLON CREA 85mg/gm	4	QL (453.6 gm / 30 days)
<b>DERMATOLOGY, ANTIFUNGALS</b>		
<i>ciclopirox olamine</i> CREA .77%	3	QL (90 gm / 30 days)
<i>ciclopirox olamine</i> SUSP .77%	3	QL (60 mL / 30 days)
<i>clotrimazole (topical)</i> CREA 1%	3	QL (45 gm / 30 days)
<i>clotrimazole (topical)</i> SOLN 1%	3	QL (30 mL / 30 days)
<i>clotrimazole w/ betamethasone cream 1- 0.05%</i>	3	QL (45 gm / 30 days)
<i>ketoconazole (topical)</i> CREA 2%	3	QL (60 gm / 30 days)
<i>nyamyc</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
<i>nystatin (topical)</i> CREA 100000unit/gm; OINT 100000unit/gm	3	QL (30 gm / 30 days)
<i>nystatin (topical)</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
<i>nystop</i> POWD 100000unit/gm	3	QL (60 gm / 30 days)
<b>DERMATOLOGY, ANTIPSORIATICS</b>		
<i>acitretin</i> CAPS 10mg, 17.5mg, 25mg	4	PA
<i>calcipotriene</i> OINT .005%	4	QL (120 gm / 30 days), PA
<i>calcipotriene</i> SOLN .005%	4	QL (120 mL / 30 days), PA
<i>calcitrene</i> OINT .005%	4	QL (120 gm / 30 days), PA
<i>tazarotene</i> CREA .1%	3	QL (60 gm / 30 days), PA
TAZORAC CREA .05%	4	QL (60 gm / 30 days), PA
<b>DERMATOLOGY, ANTISEBORRHEICS</b>		
<i>ketoconazole (topical)</i> SHAM 2%	2	GC, QL (120 mL / 30 days)
<i>selenium sulfide</i> LOTN 2.5%	2	GC
<b>DERMATOLOGY, CORTICOSTEROIDS</b>		
<i>ala-cort</i> CREA 1%	1	GC
<i>ala-cort</i> CREA 2.5%	2	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.



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>alclometasone dipropionate</i> CREA .05%; OINT .05%	3	QL (60 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> CREA .05%	3	QL (120 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> LOTN .05%	3	QL (120 mL / 30 days)
<i>betamethasone dipropionate (topical)</i> OINT .05%	4	QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> CREA .05%	2	GC, QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> GEL .05%; OINT .05%	4	QL (120 gm / 30 days)
<i>betamethasone dipropionate augmented</i> LOTN .05%	4	QL (120 mL / 30 days)
<i>betamethasone valerate</i> CREA .1%; OINT .1%	3	QL (120 gm / 30 days)
<i>betamethasone valerate</i> LOTN .1%	3	QL (120 mL / 30 days)
<i>clobetasol propionate</i> CREA .05%	3	QL (60 gm / 30 days)
<i>clobetasol propionate</i> GEL .05%; OINT .05%	4	QL (60 gm / 30 days)
<i>clobetasol propionate</i> SOLN .05%	4	QL (50 mL / 30 days)
<i>clobetasol propionate e</i> CREA .05%	4	QL (60 gm / 30 days)
ENSTILAR AER	4	QL (120 gm / 30 days), PA
<i>fluocinolone acetonide</i> CREA .01%	4	QL (60 gm / 30 days)
<i>fluocinolone acetonide</i> CREA .025%	4	QL (120 gm / 30 days)
<i>fluocinolone acetonide</i> OIL .01%	3	QL (118.28 mL / 30 days)
<i>fluocinolone acetonide</i> OINT .025%	3	QL (120 gm / 30 days)
<i>fluocinolone acetonide</i> SOLN .01%	4	QL (90 mL / 30 days)
<i>fluocinonide</i> CREA .05%	3	QL (120 gm / 30 days)
<i>fluocinonide</i> GEL .05%; OINT .05%	4	QL (60 gm / 30 days)
<i>fluocinonide</i> SOLN .05%	3	QL (60 mL / 30 days)
<i>fluocinonide emulsified base</i> CREA .05%	3	QL (120 gm / 30 days)
<i>fluticasone propionate</i> CREA .05%; OINT .005%	3	
<i>halobetasol propionate</i> CREA .05%; OINT .05%	4	QL (50 gm / 30 days)
<i>hydrocortisone (topical)</i> CREA 1%	1	GC
<i>hydrocortisone (topical)</i> CREA 2.5%; LOTN 2.5%; OINT 2.5%	2	GC
<i>mometasone furoate</i> CREA .1%; OINT .1%; SOLN .1%	3	
<i>triamcinolone acetonide (topical)</i> CREA .1%	2	GC, QL (454 gm / 30 days)

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>triamcinolone acetonide (topical)</i> CREA .025%, .5%; OINT .025%, .1%, .5%	2	GC
<i>triamcinolone acetonide (topical)</i> LOTN .025%, .1%	3	

### **DERMATOLOGY, LOCAL ANESTHETICS**

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

### **DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE**

<i>bexarotene (topical)</i> GEL 1%	5	QL (60 gm / 30 days), NM, PA
<i>diclofenac sodium (topical)</i> GEL 1%	3	QL (1000 gm / 30 days)
<i>fluorouracil (topical)</i> CREA 5%	4	QL (40 gm / 30 days)
<i>fluorouracil (topical)</i> SOLN 2%, 5%	3	QL (10 mL / 30 days)
<i>hydrocortisone (rectal)</i> CREA 2.5%	2	GC
<i>imiquimod</i> CREA 5%	3	QL (24 packets / 30 days)
<i>lactic acid (ammonium lactate)</i> CREA 12%	2	GC
<i>lactic acid (ammonium lactate)</i> LOTN 12%	3	
<i>metronidazole (topical)</i> CREA .75%	4	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> GEL .75%	3	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> LOTN .75%	4	QL (59 mL / 30 days)
PANRETIN GEL .1%	5	QL (60 gm / 30 days), PA
<i>podofilox</i> SOLN .5%	3	QL (7 mL / 28 days)
<i>procto-med hc</i> CREA 2.5%	3	
<i>procto-pak</i> CREA 1%	3	
<i>proctosol hc</i> CREA 2.5%	3	
<i>proctozone-hc</i> CREA 2.5%	3	
RECTIV OINT .4%	4	QL (30 gm / 30 days)
<i>rosadan</i> CREA .75%	4	QL (45 gm / 30 days)
<i>tacrolimus (topical)</i> OINT .03%, .1%	4	QL (100 gm / 30 days)
VALCHLOR GEL .016%	5	QL (60 gm / 30 days), NM, LA, PA

### **DERMATOLOGY, SCABICIDES AND PEDICULIDES**

<i>malathion</i> LOTN .5%	4	QL (59 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. 89

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>permethrin</i> CREA 5%	3	QL (60 gm / 30 days)
<b>DERMATOLOGY, WOUND CARE AGENTS</b>		
REGRANEX GEL .01%	5	QL (30 gm / 30 days), PA
SANTYL OINT 250unit/gm	4	QL (180 gm / 30 days)
<i>sodium chloride (gu irrigant)</i> SOLN .9%	3	
<i>water for irrigation, sterile irrigation soln</i>	2	GC
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<i>chlorhexidine gluconate (mouth-throat)</i> SOLN .12%	1	GC
<i>clotrimazole</i> TROC 10mg	4	QL (150 lozenges / 30 days)
<i>lidocaine hcl (mouth-throat)</i> SOLN 2%	2	GC
<i>nystatin (mouth-throat)</i> SUSP 100000unit/ml	3	
<i>periogard</i> SOLN .12%	1	GC
<i>pilocarpine hcl (oral)</i> TABS 5mg, 7.5mg	3	
<i>triamcinolone acetonide (mouth)</i> PSTE .1%	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.

## Index

<b>A</b>	
<i>abacavir sulfate</i> .....	12
<i>abacavir sulfate-lamivudine tab 600-300 mg</i> .....	13
ABELCET.....	11
ABILIFY MAINTENA.....	41
<i>abiraterone acetate</i> .....	19
<i>acamprosate calcium</i> .....	46
<i>acarbose</i> .....	47
<i>accutane</i> .....	77
<i>acebutolol hcl</i> .....	31
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i> .....	8
<i>acetaminophen w/ codeine tab 300-15 mg</i> .....	8
<i>acetaminophen w/ codeine tab 300-30 mg</i> .....	8
<i>acetaminophen w/ codeine tab 300-60 mg</i> .....	8
<i>acetazolamide</i> .....	32
<i>acetic acid</i> .....	62
<i>acetic acid (otic)</i> .....	73
<i>acetylcysteine</i> .....	75
<i>acitretin</i> .....	78
ACTHIB INJ.....	67
ACTIMMUNE.....	67
<i>acyclovir</i> .....	14
<i>acyclovir sodium</i> .....	14
ADACEL INJ.....	67
<i>adefovir dipivoxil</i> .....	14
ADEMPAS.....	33
ADRENALIN.....	32
ADVAIR DISKU AER 100/50.....	77
ADVAIR DISKU AER 250/50.....	77
ADVAIR DISKU AER 500/50.....	77
ADVAIR HFA AER 115/21.....	77
ADVAIR HFA AER 230/21.....	77
ADVAIR HFA AER 45/21.....	77
<i>afirmelle</i> .....	52
AIMOVIG.....	44
<i>ala-cort</i> .....	78
<i>albendazole</i> .....	9
<i>albuterol sulfate</i> .....	74
<i>alclometasone dipropionate</i> .....	78
ALDURAZYME.....	57
ALECENSA.....	21
<i>alendronate sodium</i> .....	51
<i>alfuzosin hcl</i> .....	62
<i>aliskiren fumarate</i> .....	32
<i>allopurinol</i> .....	7
<i>alosetron hcl</i> .....	61
ALPHAGAN P.....	72
<i>alprazolam</i> .....	34
ALREX.....	72
<i>altavera</i> .....	52
ALUNBRIG.....	21
ALUNBRIG PAK.....	21
<i>alyacen 1/35</i> .....	52
<i>alyacen 7/7/7</i> .....	52
<i>amabelz</i> .....	56
<i>amantadine hcl</i> .....	40
<i>ambrisentan</i> .....	33
<i>amikacin sulfate</i> .....	9
<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i> .....	32
<i>amiloride hcl</i> .....	32
<i>amiodarone hcl</i> .....	29
<i>amitriptyline hcl</i> .....	38
<i>amlodipine besylate</i> .....	31
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i> .....	26
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i> .....	26
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i> .....	26
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i> .....	26
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i> .....	26
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i> .....	26
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i> .....	27
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i> .....	27
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i> .....	27
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i> .....	27
<i>amlodipine besylate-valsartan tab 10-160 mg</i> .....	27

<i>amlodipine besylate-valsartan tab 10-320 mg</i> .....	27	<i>ampicillin &amp; sulbactam sodium for inj 1.5 (1-0.5) gm</i> .....	17
<i>amlodipine besylate-valsartan tab 5-160 mg</i> .....	27	<i>ampicillin &amp; sulbactam sodium for inj 3 (2-1) gm</i> .....	17
<i>amlodipine besylate-valsartan tab 5-320 mg</i> .....	27	<i>ampicillin &amp; sulbactam sodium for iv soln 1.5 (1-0.5) gm</i> .....	17
<i>amnesteem</i> .....	77	<i>ampicillin &amp; sulbactam sodium for iv soln 15 (10-5) gm</i> .....	17
<i>amoxapine</i> .....	38	<i>ampicillin &amp; sulbactam sodium for iv soln 3 (2-1) gm</i> .....	17
<i>amoxicillin</i> .....	17	<i>ampicillin sodium</i> .....	17
<i>amoxicillin &amp; k clavulanate chew tab 200-28.5 mg</i> .....	17	<i>anagrelide hcl</i> .....	64
<i>amoxicillin &amp; k clavulanate chew tab 400-57 mg</i> .....	17	<i>anastrozole</i> .....	19
<i>amoxicillin &amp; k clavulanate for susp 200-28.5 mg/5ml</i> .....	17	ANORO ELLIPT AER 62.5-25 .....	73
<i>amoxicillin &amp; k clavulanate for susp 250-62.5 mg/5ml</i> .....	17	<i>aprepitant</i> .....	59
<i>amoxicillin &amp; k clavulanate for susp 400-57 mg/5ml</i> .....	17	<i>aprepitant capsule therapy pack 80 &amp; 125 mg</i> .....	60
<i>amoxicillin &amp; k clavulanate for susp 600-42.9 mg/5ml</i> .....	17	<i>apri</i> .....	52
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i> .....	17	APTIOM.....	34
<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i> .....	17	APTIVUS .....	12
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i> .....	17	ARALAST NP .....	75
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-62.5 mg</i> .....	17	<i>aranelle</i> .....	52
<i>amphetamine-dextroamphetamine tab 10 mg</i> .....	43	ARCALYST .....	67
<i>amphetamine-dextroamphetamine tab 12.5 mg</i> .....	43	<i>aripiprazole</i> .....	41
<i>amphetamine-dextroamphetamine tab 15 mg</i> .....	43	ARISTADA .....	41
<i>amphetamine-dextroamphetamine tab 20 mg</i> .....	43	ARISTADA INITIO.....	41
<i>amphetamine-dextroamphetamine tab 30 mg</i> .....	43	<i>armodafinil</i> .....	46
<i>amphetamine-dextroamphetamine tab 5 mg</i> .....	43	ARNUITY ELLIPTA.....	76
<i>amphetamine-dextroamphetamine tab 7.5 mg</i> .....	43	<i>asenapine maleate</i> .....	41
<i>amphotericin b</i> .....	11	<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i> .....	64
<i>amphotericin b liposome</i> .....	11	<i>atazanavir sulfate</i> .....	12
<i>ampicillin</i> .....	17	<i>atenolol</i> .....	31
		<i>atenolol &amp; chlorthalidone tab 100-25 mg</i> .....	30
		<i>atenolol &amp; chlorthalidone tab 50-25 mg</i> .....	30
		<i>atomoxetine hcl</i> .....	43
		<i>atorvastatin calcium</i> .....	30
		<i>atovaquone</i> .....	9
		<i>atovaquone-proguanil hcl tab 250-100 mg</i> .....	12
		<i>atovaquone-proguanil hcl tab 62.5-25 mg</i> .....	12
		ATROPINE SULFATE.....	73
		<i>atropine sulfate (ophthalmic)</i> .....	73
		ATROVENT HFA.....	74

<i>aubra eq</i> .....	52	BESREMI .....	20
<i>aurovela 1/20</i> .....	52	<i>betaine powder for oral solution</i> .....	57
<i>aurovela fe 1.5/30</i> .....	52	<i>betamethasone dipropionate (topical)</i>	
<i>aurovela fe 1/20</i> .....	52	.....	78
AUSTEDO .....	45	<i>betamethasone dipropionate</i>	
<i>aviane</i> .....	52	<i>augmented</i> .....	78, 79
<i>avita</i> .....	77	<i>betamethasone valerate</i> .....	79
<i>ayuna</i> .....	52	BETASERON .....	45
AYVAKIT .....	21	<i>betaxolol hcl (ophth)</i> .....	72
<i>azacitidine</i> .....	19	<i>bethanechol chloride</i> .....	62
<i>azathioprine</i> .....	67	BETOPTIC-S .....	72
<i>azelastine hcl</i> .....	74	BEVESPI AER 9-4.8MCG .....	73
<i>azelastine hcl (ophth)</i> .....	72	<i>bexarotene</i> .....	20
<i>azithromycin</i> .....	16	<i>bexarotene (topical)</i> .....	80
<i>aztreonam</i> .....	9	BEXSERO INJ .....	67
<i>azurette</i> .....	52	<i>bicalutamide</i> .....	19
<b>B</b>		BICILLIN L-A .....	17
<i>bacitracin (ophthalmic)</i> .....	71	BIKTARVY TAB 30-120-15 MG .....	13
<i>bacitracin-polymyxin b ophth oint</i> .....	71	BIKTARVY TAB 50-200-25 MG .....	13
<i>bacitracin-polymyxin-neomycin-hc</i>		<i>bisoprolol &amp; hydrochlorothiazide tab</i>	
<i>ophth oint 1%</i> .....	71	10-6.25 mg .....	30
<i>baclofen</i> .....	46	<i>bisoprolol &amp; hydrochlorothiazide tab</i>	
BAFIERTAM .....	45	2.5-6.25 mg .....	30
<i>balsalazide disodium</i> .....	60	<i>bisoprolol &amp; hydrochlorothiazide tab 5-</i>	
BALVERSA .....	21	6.25 mg .....	30
<i>balziva</i> .....	52	<i>bisoprolol fumarate</i> .....	31
BARACLUDE .....	14	BIVIGAM .....	66
BASAGLAR KWIKPEN .....	50	<i>blisovi fe 1.5/30</i> .....	52
BCG VACCINE .....	67	BOOSTRIX INJ .....	67
BD ALCOHOL SWABS .....	50	<i>bortezomib</i> .....	21
BELSOMRA .....	44	BORTEZOMIB .....	21
<i>benazepril &amp; hydrochlorothiazide tab</i>		<i>bosentan</i> .....	33
10-12.5 mg .....	26	BOSULIF .....	21
<i>benazepril &amp; hydrochlorothiazide tab</i>		BRAFTOVI .....	21
20-12.5 mg .....	26	BREO ELLIPTA INH 100-25 .....	77
<i>benazepril &amp; hydrochlorothiazide tab</i>		BREO ELLIPTA INH 200-25 .....	77
20-25 mg .....	26	BREZTRI AERO AER SPHERE .....	73
<i>benazepril &amp; hydrochlorothiazide tab 5-</i>		BREZTRI AERO AER SPHERE	
6.25mg .....	26	(INSTITUTIONAL PACK) .....	73
<i>benazepril hcl</i> .....	27	<i>briellyn</i> .....	52
BENDEKA .....	18	BRILINTA .....	64
BENLYSTA .....	67	<i>brimonidine tartrate</i> .....	72
<i>benzoyl peroxide-erythromycin gel 5-</i>		<i>brinzolamide</i> .....	72
3% .....	77	BRIVIACT .....	34
<i>benztropine mesylate</i> .....	40	<i>bromocriptine mesylate</i> .....	40
BERINERT .....	64	BROMSITE .....	72
BESIVANCE .....	71	BRUKINSA .....	21

<i>budesonide</i> .....	61	<i>carbidopa &amp; levodopa tab er 25-100</i>	
<i>budesonide (inhalation)</i> .....	76	<i>mg</i> .....	40
<i>bumetanide</i> .....	32	<i>carbidopa &amp; levodopa tab er 50-200</i>	
<i>buprenorphine hcl</i> .....	46	<i>mg</i> .....	40
<i>buprenorphine hcl-naloxone hcl sl film</i>		<i>carbidopa-levodopa-entacapone tabs</i>	
<i>12-3 mg (base equiv)</i> .....	46	<i>12.5-50-200 mg</i> .....	40
<i>buprenorphine hcl-naloxone hcl sl film</i>		<i>carbidopa-levodopa-entacapone tabs</i>	
<i>2-0.5 mg (base equiv)</i> .....	46	<i>18.75-75-200 mg</i> .....	40
<i>buprenorphine hcl-naloxone hcl sl film</i>		<i>carbidopa-levodopa-entacapone tabs</i>	
<i>4-1 mg (base equiv)</i> .....	46	<i>25-100-200 mg</i> .....	40
<i>buprenorphine hcl-naloxone hcl sl film</i>		<i>carbidopa-levodopa-entacapone tabs</i>	
<i>8-2 mg (base equiv)</i> .....	46	<i>31.25-125-200 mg</i> .....	40
<i>buprenorphine hcl-naloxone hcl sl tab</i>		<i>carbidopa-levodopa-entacapone tabs</i>	
<i>2-0.5 mg (base equiv)</i> .....	46	<i>37.5-150-200 mg</i> .....	40
<i>buprenorphine hcl-naloxone hcl sl tab</i>		<i>carbidopa-levodopa-entacapone tabs</i>	
<i>8-2 mg (base equiv)</i> .....	46	<i>50-200-200 mg</i> .....	40
<i>bupropion hcl</i> .....	38	<i>carboplatin</i> .....	18
<i>bupropion hcl (smoking deterrent)</i> ...	46	<i>carglumic acid</i> .....	57
<i>bupirone hcl</i> .....	34	<i>carteolol hcl (ophth)</i> .....	72
<i>butorphanol tartrate</i> .....	8	<i>cartia xt</i> .....	31
BYDUREON BCISE .....	47	<i>carvedilol</i> .....	31
BYETTA .....	47	<i>caspofungin acetate</i> .....	11
<b>C</b>		CAYSTON .....	9
<i>cabergoline</i> .....	57	<i>caziant</i> .....	52
CABOMETYX .....	21	<i>cefaclor</i> .....	15
<i>calcipotriene</i> .....	78	CEFACTOR ER .....	15
<i>calcitonin (salmon) spray</i> .....	51	<i>cefadroxil</i> .....	15
<i>calcitrene</i> .....	78	CEFAZOLIN INJ 1GM/50ML .....	15
<i>calcitriol</i> .....	59	<i>cefazolin sodium</i> .....	15
<i>calcium acetate (phosphate binder)</i> ..	58	CEFAZOLIN SOLN 2GM/100ML-4% ...	15
CALQUENCE .....	21	<i>cefdinir</i> .....	15
<i>camila</i> .....	52	<i>cefepime hcl</i> .....	15
<i>candesartan cilexetil</i> .....	28	<i>cefixime</i> .....	15
CAPLYTA .....	41	<i>cefoxitin sodium</i> .....	15
CAPRELSA .....	21	<i>cefpodoxime proxetil</i> .....	15, 16
<i>captopril</i> .....	27	<i>cefprozil</i> .....	16
<i>carb/levo orally disintegrating tab 10-</i>		<i>ceftazidime</i> .....	16
<i>100mg</i> .....	40	CEFTAZIDIME/ SOL D5W 1GM .....	16
<i>carb/levo orally disintegrating tab 25-</i>		CEFTAZIDIME/ SOL D5W 2GM .....	16
<i>100mg</i> .....	40	<i>ceftriaxone sodium</i> .....	16
<i>carb/levo orally disintegrating tab 25-</i>		<i>cefuroxime axetil</i> .....	16
<i>250mg</i> .....	40	<i>cefuroxime sodium</i> .....	16
<i>carbamazepine</i> .....	34	<i>celecoxib</i> .....	7
<i>carbidopa &amp; levodopa tab 10-100 mg</i>	40	CELONTIN .....	34
<i>carbidopa &amp; levodopa tab 25-100 mg</i>	40	<i>cephalexin</i> .....	16
<i>carbidopa &amp; levodopa tab 25-250 mg</i>	40	CERDELGA .....	57
		CEREZYME .....	57

<i>cetirizine hcl</i> .....	74	CLINIMIX INJ 8/14 .....	70
<i>chateal</i> .....	52	<i>clinisol sf 15%</i> .....	70
CHEMET .....	51	CLINOLIPID EMU 20% .....	71
<i>chlorhexidine gluconate (mouth-throat)</i> .....	81	<i>clobazam</i> .....	34
<i>chloroquine phosphate</i> .....	12	<i>clobetasol propionate</i> .....	79
<i>chlorpromazine hcl</i> .....	41	<i>clobetasol propionate e</i> .....	79
CHLORPROMAZINE HYDROCHLOR ....	41	<i>clomipramine hcl</i> .....	38
<i>chlorthalidone</i> .....	32	<i>clonazepam</i> .....	34
<i>cholestyramine</i> .....	30	<i>clonidine</i> .....	33
<i>cholestyramine light</i> .....	30	<i>clonidine hcl</i> .....	33
<i>ciclopirox olamine</i> .....	78	<i>clopidogrel bisulfate</i> .....	64
<i>cilostazol</i> .....	64	<i>clorazepate dipotassium</i> .....	34
CILOXAN .....	71	<i>clotrimazole</i> .....	81
CIMDUO TAB 300-300 .....	13	<i>clotrimazole (topical)</i> .....	78
<i>cinacalcet hcl</i> .....	57	<i>clotrimazole w/ betamethasone cream</i> 1-0.05% .....	78
CIPRO .....	16	<i>clozapine</i> .....	41
<i>ciprofloxacin 200 mg/100ml in d5w</i> ..	16	COARTEM TAB 20-120MG.....	12
<i>ciprofloxacin 400 mg/200ml in d5w</i> ..	16	<i>colchicine</i> .....	7
<i>ciprofloxacin hcl</i> .....	16	<i>colchicine w/ probenecid tab 0.5-500</i> mg .....	7
<i>ciprofloxacin hcl (ophth)</i> .....	71	<i>colesevelam hcl</i> .....	30
<i>ciprofloxacin-dexamethasone otic susp</i> 0.3-0.1%.....	73	<i>colestipol hcl</i> .....	30
<i>cisplatin</i> .....	18	<i>colistimethate sodium</i> .....	9
<i>citalopram hydrobromide</i> .....	38	COMBIGAN SOL 0.2/0.5% .....	72
<i>claravis</i> .....	77	COMBIVENT AER 20-100 .....	73
<i>clarithromycin</i> .....	16	COMETRIQ (60MG DOSE).....	21
<i>clindamycin hcl</i> .....	9	COMETRIQ KIT 100MG.....	21
<i>clindamycin palmitate hydrochloride</i> ..	9	COMETRIQ KIT 140MG.....	21
<i>clindamycin phosphate</i> .....	9	COMPLERA TAB.....	13
<i>clindamycin phosphate (topical)</i> .....	77	<i>compro</i> .....	60
<i>clindamycin phosphate in d5w iv soln</i> 300 mg/50ml .....	9	<i>constulose</i> .....	61
<i>clindamycin phosphate in d5w iv soln</i> 600 mg/50ml .....	9	COPIKTRA .....	21
<i>clindamycin phosphate in d5w iv soln</i> 900 mg/50ml .....	9	CORLANOR.....	33
<i>clindamycin phosphate vaginal</i> .....	63	COTELLIC.....	21
CLINDMYC/NAC INJ 300/50ML .....	9	CREON CAP 12000UNT.....	62
CLINDMYC/NAC INJ 600/50ML .....	9	CREON CAP 24000UNT.....	62
CLINDMYC/NAC INJ 900/50ML .....	9	CREON CAP 3000UNIT .....	62
CLINIMIX INJ 4.25/D10.....	70	CREON CAP 36000UNT.....	62
CLINIMIX INJ 4.25/D5W.....	70	CREON CAP 6000UNIT .....	62
CLINIMIX INJ 5%/D15W .....	70	<i>cromolyn sodium</i> .....	75
CLINIMIX INJ 5%/D20W .....	70	<i>cromolyn sodium (mastocytosis)</i> .....	61
CLINIMIX INJ 6/5 .....	70	<i>cromolyn sodium (ophth)</i> .....	72
CLINIMIX INJ 8/10 .....	70	<i>cryselle-28</i> .....	52
		<i>cyclobenzaprine hcl</i> .....	46
		<i>cyclophosphamide</i> .....	19
		CYCLOPHOSPHAMIDE .....	19



CYCLOPHOSPHAMIDE MONOHYDR....	19	<i>dexamethasone sodium phosphate</i>	
<i>cycloserine</i> .....	14	( <i>ophth</i> ) .....	72
<i>cyclosporine</i> .....	67	<i>dexmethylphenidate hcl</i> .....	43
<i>cyclosporine modified (for</i>		<i>dextrose</i> .....	71
<i>microemulsion)</i> .....	67	<i>dextrose 10% w/ sodium chloride</i>	
<i>cyproheptadine hcl</i> .....	74	0.45% .....	69
<i>cyred eq.</i> .....	52	<i>dextrose 2.5% w/ sodium chloride</i>	
CYSTADROPS.....	73	0.45% .....	69
CYSTAGON .....	57	<i>dextrose 5% in lactated ringers</i> .....	69
CYSTARAN.....	73	<i>dextrose 5% w/ sodium chloride 0.2%</i>	
<i>cytarabine</i> .....	19	.....	69
<b>D</b>		<i>dextrose 5% w/ sodium chloride</i>	
D10W/NAACL INJ 0.2% .....	69	0.225%.....	69
D2.5W/NAACL INJ 0.45%.....	69	<i>dextrose 5% w/ sodium chloride 0.3%</i>	
D5W/LYTES INJ #48 .....	69	.....	69
<i>dabigatran etexilate mesylate</i> .....	63	<i>dextrose 5% w/ sodium chloride 0.45%</i>	
<i>dalfampridine</i> .....	45	.....	69
DALIRESP.....	75	<i>dextrose 5% w/ sodium chloride 0.9%</i>	
<i>danazol</i> .....	56	.....	69
<i>dantrolene sodium</i> .....	46	DIACOMIT .....	35
<i>dapsone</i> .....	9	<i>diazepam</i> .....	35
DAPTACEL INJ.....	67	<i>diazepam (anticonvulsant)</i> .....	35
<i>daptomycin</i> .....	10	<i>diazepam inj</i> .....	35
DAPTOMYCIN.....	10	<i>diazoxide</i> .....	57
<i>dasetta 1/35</i> .....	52	<i>diclofenac potassium</i> .....	7
<i>dasetta 7/7/7</i> .....	52	<i>diclofenac sodium</i> .....	7
DAURISMO .....	21	<i>diclofenac sodium (ophth)</i> .....	72
<i>deblitane</i> .....	52	<i>diclofenac sodium (topical)</i> .....	80
<i>deferasirox</i> .....	52	<i>dicloxacillin sodium</i> .....	17
DELESTROGEN.....	56	<i>dicyclomine hcl</i> .....	60
DELSTRIGO TAB.....	13	DIFICID .....	16
DENGVAZIA SUS .....	67	<i>diflunisal</i> .....	7
DESCOVY TAB 120-15MG .....	13	<i>difluprednate</i> .....	72
DESCOVY TAB 200/25MG .....	13	<i>digox</i> .....	33
<i>desipramine hcl</i> .....	38	<i>digoxin</i> .....	33
<i>desmopressin acetate</i> .....	57	<i>dihydroergotamine mesylate</i> .....	44
<i>desmopressin acetate spray</i> .....	57	DILANTIN.....	35
<i>desmopressin acetate spray</i>		DILANTIN INFATABS.....	35
<i>refrigerated</i> .....	58	DILANTIN-125 .....	35
<i>desogest-eth estrad &amp; eth estrad tab</i>		<i>diltiazem hcl</i> .....	31
0.15-0.02/0.01 mg(21/5).....	52	<i>diltiazem hcl coated beads</i> .....	31
<i>desogestrel &amp; ethinyl estradiol tab 0.15</i>		<i>diltiazem hcl extended release beads</i>	31
<i>mg-30 mcg</i> .....	52	<i>dilt-xr</i> .....	31
<i>desvenlafaxine succinate</i> .....	38	DIP/TET PED INJ 25-5LFU .....	68
<i>dexamethasone</i> .....	56	<i>diphenhydramine hcl</i> .....	74
DEXAMETHASONE INTENSOL.....	56	<i>diphenoxylate w/ atropine liq 2.5-0.025</i>	
<i>dexamethasone sodium phosphate</i> ...	56	<i>mg/5ml</i> .....	61

<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i> .....	61	<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i> .....	13
<i>dipyridamole</i> .....	64	ELIGARD .....	19
<i>disopyramide phosphate</i> .....	29	<i>elinest</i> .....	52
<i>disulfiram</i> .....	46	ELIQUIS .....	63
<i>divalproex sodium</i> .....	35	ELIQUIS STARTER PACK .....	63
<i>docetaxel</i> .....	21	ELLA .....	53
DOCETAXEL .....	21	ELLECE .....	19
<i>dofetilide</i> .....	29	<i>eluryng</i> .....	53
<i>donepezil hydrochloride</i> .....	38	EMCYT .....	19
DOPTELET .....	64	<i>emoquette</i> .....	53
<i>dorzolamide hcl</i> .....	73	EMSAM .....	39
<i>dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml</i> .....	73	<i>emtricitabine</i> .....	12
<i>dotti</i> .....	56	<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i> .....	13
DOVATO TAB 50-300MG .....	13	<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i> .....	13
<i>doxazosin mesylate</i> .....	27	<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i> .....	13
<i>doxepin hcl</i> .....	38	<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i> .....	14
<i>doxepin hcl (sleep)</i> .....	44	EMTRIVA .....	12
<i>doxorubicin hcl</i> .....	19	EMVERM .....	10
<i>doxorubicin hcl liposomal</i> .....	19	<i>enalapril maleate</i> .....	27
<i>doxy 100</i> .....	18	<i>enalapril maleate &amp; hydrochlorothiazide tab 10-25 mg</i> .....	26
<i>doxycycline (monohydrate)</i> .....	18	<i>enalapril maleate &amp; hydrochlorothiazide tab 5-12.5 mg</i> .....	26
<i>doxycycline hyclate</i> .....	18	ENBREL .....	65
DRIZALMA SPRINKLE .....	38	ENBREL MINI .....	65
<i>dronabinol</i> .....	60	ENBREL SURECLICK .....	65
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i> .....	52	ENDARI .....	64
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i> .....	52	<i>endocet tab 10-325mg</i> .....	8
DROXIA .....	64	<i>endocet tab 2.5-325mg</i> .....	8
<i>droxidopa</i> .....	33	<i>endocet tab 5-325mg</i> .....	8
<i>duloxetine hcl</i> .....	39	<i>endocet tab 7.5-325mg</i> .....	8
DUPIXENT .....	65	ENGERIX-B .....	68
<i>dutasteride</i> .....	62	<i>enoxaparin sodium</i> .....	63
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i> .....	62	<i>enpresse-28</i> .....	53
<b>E</b>		<i>enskyce</i> .....	53
<i>e.e.s. 400</i> .....	16	ENSTILAR AER .....	79
<i>ec-naproxen</i> .....	7	<i>entacapone</i> .....	40
EDURANT .....	12	<i>entecavir</i> .....	14
<i>efavirenz</i> .....	12	ENTRESTO TAB 24-26MG .....	28
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i> .....	13	ENTRESTO TAB 49-51MG .....	28
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i> .....	13	ENTRESTO TAB 97-103MG .....	28
		<i>enulose</i> .....	61

EPCLUSA PAK 150-37.5.....	14	<i>etravirine</i> .....	12
EPCLUSA PAK 200-50MG.....	14	<i>euthyrox</i> .....	59
EPCLUSA TAB 200-50MG.....	14	<i>everolimus</i> .....	22
EPCLUSA TAB 400-100.....	14	<i>everolimus (immunosuppressant)</i> ....	67
EPIDIOLEX .....	35	EVOTAZ TAB 300-150.....	14
<i>epinephrine (anaphylaxis)</i> .....	75	<i>exemestane</i> .....	20
<i>epitol</i> .....	35	EXKIVITY .....	22
EPIVIR HBV .....	14	<i>ezetimibe</i> .....	30
<i>eplerenone</i> .....	27	<i>ezetimibe-simvastatin tab 10-10 mg</i> .30	
EPRONTIA .....	35	<i>ezetimibe-simvastatin tab 10-20 mg</i> .30	
<i>ergotamine w/ caffeine tab 1-100 mg</i> .....	44	<i>ezetimibe-simvastatin tab 10-40 mg</i> .30	
ERIVEDGE .....	21	<i>ezetimibe-simvastatin tab 10-80 mg</i> .30	
ERLEADA.....	19	<b>F</b>	
<i>erlotinib hcl</i> .....	21, 22	FABRAZYME.....	58
<i>errin</i> .....	53	<i>falmina</i> .....	53
<i>ertapenem sodium</i> .....	10	<i>famciclovir</i> .....	15
<i>ery</i> .....	77	<i>famotidine</i> .....	60
<i>ery-tab</i> .....	16	<i>famotidine in nacl 0.9% iv soln 20</i> <i>mg/50ml</i> .....	60
ERYTHROCIN LACTOBIONATE .....	16	FANAPT.....	41
<i>erythrocin stearate</i> .....	16	FANAPT PAK .....	41
<i>erythromycin (acne aid)</i> .....	77	FARXIGA .....	47
<i>erythromycin (ophth)</i> .....	71	FASENRA .....	75
<i>erythromycin base</i> .....	16	FASENRA PEN .....	75
<i>erythromycin ethylsuccinate</i> .....	16	<i>felbamate</i> .....	35
<i>erythromycin lactobionate</i> .....	16	<i>felodipine</i> .....	31
ESBRIET .....	75	<i>femynor</i> .....	53
<i>escitalopram oxalate</i> .....	39	<i>fenofibrate</i> .....	29
<i>esomeprazole magnesium</i> .....	62	<i>fenofibrate micronized</i> .....	29
<i>estarylla</i> .....	53	<i>fentanyl</i> .....	7
<i>estradiol</i> .....	56	<i>fentanyl citrate</i> .....	8
<i>estradiol &amp; norethindrone acetate tab</i> <i>0.5-0.1 mg</i> .....	56	<i>fesoterodine fumarate</i> .....	62
<i>estradiol &amp; norethindrone acetate tab</i> <i>1-0.5 mg</i> .....	56	FETZIMA .....	39
<i>estradiol vaginal</i> .....	56	FETZIMA CAP TITRATIO .....	39
<i>estradiol valerate</i> .....	56	FIASP FLEX INJ TOUCH .....	50
<i>ethambutol hcl</i> .....	14	FIASP INJ 100/ML .....	50
<i>ethosuximide</i> .....	35	FIASP PENFIL INJ U-100 .....	50
<i>ethynodiol diacetate &amp; ethinyl estradiol</i> <i>tab 1 mg-35 mcg</i> .....	53	<i>finasteride</i> .....	62
<i>ethynodiol diacetate &amp; ethinyl estradiol</i> <i>tab 1 mg-50 mcg</i> .....	53	FINTEPLA .....	35
<i>etodolac</i> .....	7	<i>flac</i> .....	73
<i>etonogestrel-ethinyl estradiol va ring</i> <i>0.120-0.015 mg/24hr</i> .....	53	FLAREX.....	72
<i>etoposide</i> .....	21	FLEBOGAMMA DIF .....	66
		<i>flecainide acetate</i> .....	29
		FLOVENT DISKUS.....	76
		FLOVENT HFA .....	76
		<i>fluconazole</i> .....	11

<i>fluconazole in nacl 0.9% inj 200 mg/100ml</i> .....	11	GAMUNEX-C .....	66
<i>fluconazole in nacl 0.9% inj 400 mg/200ml</i> .....	11	<i>ganciclovir sodium</i> .....	15
<i>flucytosine</i> .....	11	GARDASIL 9 INJ.....	68
<i>fludrocortisone acetate</i> .....	56	<i>gatifloxacin (ophth)</i> .....	71
<i>flunisolide (nasal)</i> .....	76	GATTEX .....	61
<i>fluocinolone acetonide</i> .....	79	GAUZE PADS 2 .....	50
<i>fluocinolone acetonide (otic)</i> .....	73	<i>gavilyte-c</i> .....	61
<i>fluocinonide</i> .....	79	<i>gavilyte-g</i> .....	61
<i>fluocinonide emulsified base</i> .....	79	GAVRETO .....	22
<i>fluorometholone (ophth)</i> .....	72	<i>gemcitabine hcl</i> .....	19
<i>fluorouracil</i> .....	19	<i>gemfibrozil</i> .....	29
<i>fluorouracil (topical)</i> .....	80	GEMTESA .....	62
<i>fluoxetine hcl</i> .....	39	<i>generlac</i> .....	61
<i>fluphenazine decanoate</i> .....	41	<i>gengraf</i> .....	67
<i>fluphenazine hcl</i> .....	41	GENOTROPIN.....	58
<i>flurbiprofen</i> .....	7	GENOTROPIN MINIQUICK.....	58
<i>flurbiprofen sodium</i> .....	72	<i>gentak</i> .....	71
<i>fluticasone propionate</i> .....	79	<i>gentamicin in saline inj 0.8 mg/ml</i> ....	10
<i>fluticasone propionate (nasal)</i> .....	76	<i>gentamicin in saline inj 1 mg/ml</i> .....	10
<i>fluvoxamine maleate</i> .....	34	<i>gentamicin in saline inj 1.2 mg/ml</i> ....	10
<i>fondaparinux sodium</i> .....	63	<i>gentamicin in saline inj 1.6 mg/ml</i> ....	10
FORTEO .....	51	<i>gentamicin in saline inj 2 mg/ml</i> .....	10
<i>fosamprenavir calcium</i> .....	12	<i>gentamicin sulfate</i> .....	10
<i>fosinopril sodium</i> .....	27	<i>gentamicin sulfate (ophth)</i> .....	71
<i>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</i> .....	26	<i>gentamicin sulfate (topical)</i> .....	77
<i>fosinopril sodium &amp; hydrochlorothiazide tab 20-12.5 mg</i> .....	26	GENVOYA TAB .....	14
FOTIVDA .....	22	GILENYA .....	45
FREAMINE III INJ 10%.....	71	GILOTRIF .....	22
<i>fulvestrant</i> .....	20	<i>glatiramer acetate</i> .....	45
<i>furosemide</i> .....	32	<i>glatopa</i> .....	46
<i>furosemide inj</i> .....	32	<i>glimepiride</i> .....	47
FUZEON .....	12	<i>glipizide</i> .....	47
<i>fyavolv tab 0.5mg-2.5mcg</i> .....	56	<i>glipizide xl</i> .....	47
<i>fyavolv tab 1mg-5mcg</i> .....	56	<i>glipizide-metformin hcl tab 2.5-250 mg</i> .....	47
FYCOMPA .....	35	<i>glipizide-metformin hcl tab 2.5-500 mg</i> .....	48
<b>G</b>		<i>glipizide-metformin hcl tab 5-500 mg</i> .....	48
<i>gabapentin</i> .....	36	<i>glycopyrrolate</i> .....	60
<i>galantamine hydrobromide</i> .....	38	<i>glydo</i> .....	79
GAMASTAN INJ .....	66	GLYXAMBI TAB 10-5 MG .....	48
GAMMAGARD LIQUID.....	66	GLYXAMBI TAB 25-5 MG .....	48
GAMMAGARD S/D IGA LESS TH.....	66	GOLYTELY SOL.....	61
GAMMAKED .....	66	<i>granisetron hcl</i> .....	60
GAMMAPLEX .....	66	<i>griseofulvin microsize</i> .....	11
		<i>griseofulvin ultramicrosize</i> .....	11
		<i>guanfacine hcl</i> .....	33

*guanfacine hcl (adhd)* ..... 43, 44  
 GVOKE HYPOPEN 2-PACK .....57  
 GVOKE KIT .....57  
 GVOKE PFS.....57

**H**

HAEGARDA .....64  
*hailey 1.5/30* .....53  
*halobetasol propionate* .....79  
*haloperidol* .....41  
*haloperidol decanoate* .....41  
*haloperidol lactate* .....42  
 HARVONI PAK 33.75-150MG .....15  
 HARVONI PAK 45-200MG .....15  
 HARVONI TAB 45-200MG .....15  
 HARVONI TAB 90-400MG .....15  
 HAVRIX.....68  
*heather* .....53  
 HEP SOD/D5W INJ 20000UNT .....63  
 HEP SOD/D5W INJ 25000UNT .....63  
 HEP SOD/NACL INJ 25000UNT .....63  
*heparin sodium (porcine)* .....63  
 HEPARIN/NACL INJ 25000UNT .....63  
 HERCEP HYLEC SOL 60-10000 .....22  
 HERCEPTIN.....22  
 HERZUMA.....22  
 HETLIOZ .....44  
 HIBERIX.....68  
 HUMIRA .....65  
 HUMIRA PEDIA INJ CROHNS .....65  
 HUMIRA PEDIATRIC CROHNS D.....65  
 HUMIRA PEN.....65  
 HUMIRA PEN KIT PS/UV .....65  
 HUMIRA PEN-CD/UC/HS START .....65  
 HUMIRA PEN-PEDIATRIC UC S .....65  
 HUMIRA PEN-PS/UV STARTER.....65  
 HUMULIN R U-500 (CONCENTR .....50  
 HUMULIN R U-500 KWIKPEN.....50  
*hydralazine hcl*.....33  
*hydrochlorothiazide* .....32  
*hydrocodone bitartrate*..... 7  
*hydrocodone-acetaminophen soln 7.5-325 mg/15ml* ..... 8  
*hydrocodone-acetaminophen tab 10-325 mg* ..... 8  
*hydrocodone-acetaminophen tab 5-325 mg* ..... 8

*hydrocodone-acetaminophen tab 7.5-325 mg* ..... 8  
*hydrocodone-ibuprofen tab 7.5-200 mg* ..... 8  
*hydrocortisone* .....56  
*hydrocortisone (intrarectal)* .....61  
*hydrocortisone (rectal)* .....80  
*hydrocortisone (topical)* .....79  
*hydromorphone hcl* ..... 8  
*hydroxychloroquine sulfate* .....66  
*hydroxyurea* .....20  
*hydroxyzine hcl*.....74  
*hydroxyzine pamoate* .....74  
 HYSINGLA ER ..... 7

**I**

*ibandronate sodium* .....51  
 IBRANCE .....22  
*ibu* ..... 7  
*ibuprofen* ..... 7  
*icatibant acetate* .....64  
*iclevia* .....53  
 ICLUSIG.....22  
 IDHIFA .....22  
 ILEVRO .....72  
*imatinib mesylate*.....22  
 IMBRUVICA .....22  
*imipenem-cilastatin intravenous for soln 250 mg* .....10  
*imipenem-cilastatin intravenous for soln 500 mg* .....10  
*imipramine hcl*.....39  
*imiquimod* .....80  
 IMOVAX RABIES (H.D.C.V.) .....68  
*incassia*.....53  
 INCRELEX .....58  
 INCRUSE ELLIPTA .....74  
*indapamide* .....32  
 INFANRIX INJ .....68  
 INFLIXIMAB.....65  
 INGREZZA .....45  
 INGREZZA CAP 40-80MG .....45  
 INLYTA .....22  
 INQOVI TAB 35-100MG .....19  
 INREBIC.....22  
 INSULIN PEN NEEDLES: BD/NOVO ...50  
 INSULIN SAFETY NEEDLES .....50  
 INSULIN SYRINGES: BD .....50

INTELENCE.....	12	<i>jinteli</i> .....	56
INTRALIPID.....	71	<i>jolessa</i> .....	53
INTRON A.....	67	<i>juleber</i> .....	53
<i>introvale</i> .....	53	JULUCA TAB 50-25MG.....	14
INVEGA SUSTENNA.....	42	<i>junel 1.5/30</i> .....	53
IPOL INJ INACTIVE.....	68	<i>junel 1/20</i> .....	53
<i>ipratropium bromide</i> .....	74	<i>junel fe 1.5/30</i> .....	53
<i>ipratropium bromide (nasal)</i> .....	74	<i>junel fe 1/20</i> .....	53
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i> .....	74	<b>K</b>	
<i>irbesartan</i> .....	29	KADCYLA.....	22
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i> .....	28	KALYDECO.....	75
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i> .....	28	KANJINTI.....	23
IRESSA.....	22	<i>kariva</i> .....	53
<i>irinotecan hcl</i> .....	20	<i>kcl 10 meq/l (0.075%) in dextrose 5% &amp; nacl 0.45% inj</i> .....	69
ISENTRESS.....	12	<i>kcl 20 meq/l (0.15%) in dextrose 5% &amp; nacl 0.2% inj</i> .....	69
ISENTRESS HD.....	12	<i>kcl 20 meq/l (0.15%) in dextrose 5% &amp; nacl 0.45% inj</i> .....	69
<i>isibloom</i> .....	53	<i>kcl 20 meq/l (0.15%) in dextrose 5% &amp; nacl 0.9% inj</i> .....	69
ISOLYTE-P INJ /D5W.....	69	<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i> .....	69
ISOLYTE-S INJ.....	69	.....	69
ISOLYTE-S INJ PH 7.4.....	69	KCL 20 MEQ/L (0.15%) IN NACL 0.45% INJ.....	69
<i>isoniazid</i> .....	14	<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i> .....	69
ISOPTO ATROPINE.....	73	.....	69
<i>isosorbide dinitrate</i> .....	33	<i>kcl 30 meq/l (0.224%) in dextrose 5% &amp; nacl 0.45% inj</i> .....	69
<i>isosorbide mononitrate</i> .....	33	<i>kcl 40 meq/l (0.3%) in dextrose 5% &amp; nacl 0.45% inj</i> .....	69
<i>isotretinoin</i> .....	77	KCL 40 MEQ/L (0.3%) IN NACL 0.9% INJ.....	69
<i>itraconazole</i> .....	11	.....	69
<i>ivermectin</i> .....	10	KCL/D5W/NACL INJ 0.3/0.9%.....	69
IXIARO INJ.....	68	<i>kelnor 1/35</i> .....	53
<b>J</b>		<i>kelnor 1/50</i> .....	53
JAKAFI.....	22	KERENDIA.....	27
<i>jantoven</i> .....	63	KESIMPTA.....	46
JANUMET TAB 50-1000.....	48	<i>ketoconazole</i> .....	11
JANUMET TAB 50-500MG.....	48	<i>ketoconazole (topical)</i> .....	78
JANUMET XR TAB 100-1000.....	48	<i>ketorolac tromethamine (ophth)</i> .....	72
JANUMET XR TAB 50-1000.....	48	KEVZARA.....	65
JANUMET XR TAB 50-500MG.....	48	KEYTRUDA.....	23
JANUVIA.....	48	KINRIX INJ.....	68
JARDIANCE.....	48	KISQALI 200 DOSE.....	23
<i>jasmiel</i> .....	53	KISQALI 200 PAK FEMARA.....	20
JENTADUETO TAB 2.5-1000.....	48	KISQALI 400 DOSE.....	23
JENTADUETO TAB 2.5-500.....	48		
JENTADUETO TAB 2.5-850.....	48		
JENTADUETO TAB XR 2.5-1000MG.....	48		
JENTADUETO TAB XR 5-1000MG.....	48		

KISQALI 400 PAK FEMARA.....	20	<i>lessina</i> .....	53
KISQALI 600 DOSE.....	23	<i>letrozole</i> .....	20
KISQALI 600 PAK FEMARA.....	20	<i>leucovorin calcium</i> .....	25, 26
<i>klor-con</i> .....	70	LEUKERAN.....	19
<i>klor-con 10</i> .....	70	<i>leuprolide acetate</i> .....	20
<i>klor-con 8</i> .....	70	<i>levabuterol hcl</i> .....	75
<i>klor-con m10</i> .....	70	<i>levabuterol tartrate</i> .....	75
<i>klor-con m15</i> .....	70	LEVEMIR .....	50
<i>klor-con m20</i> .....	70	LEVEMIR FLEXTOUCH .....	50
KORLYM .....	58	<i>levetiracetam</i> .....	36
<i>kurvelo</i> .....	53	<i>levetiracetam in sodium chloride iv soln</i> <i>1000 mg/100ml</i> .....	36
KYNMOBI .....	40	<i>levetiracetam in sodium chloride iv soln</i> <i>1500 mg/100ml</i> .....	36
<b>L</b>		<i>levetiracetam in sodium chloride iv soln</i> <i>500 mg/100ml</i> .....	36
<i>labetalol hcl</i> .....	31	<i>levobunolol hcl</i> .....	73
<i>lacosamide</i> .....	36	<i>levocarnitine (metabolic modifiers)</i> ...	58
<i>lacosamide oral</i> .....	36	<i>levocetirizine dihydrochloride</i> .....	74
<i>lactated ringer's solution</i> .....	69	<i>levofloxacin</i> .....	16
<i>lactic acid (ammonium lactate)</i> .....	80	<i>levofloxacin in d5w iv soln 250</i> <i>mg/50ml</i> .....	16
<i>lactulose</i> .....	61	<i>levofloxacin in d5w iv soln 500</i> <i>mg/100ml</i> .....	17
<i>lactulose (encephalopathy)</i> .....	61	<i>levofloxacin in d5w iv soln 750</i> <i>mg/150ml</i> .....	17
<i>lamivudine</i> .....	12	<i>levonest</i> .....	53
<i>lamivudine (hbv)</i> .....	15	<i>levonorgestrel &amp; ethinyl estradiol (91-</i> <i>day) tab 0.15-0.03 mg</i> .....	53
<i>lamivudine-zidovudine tab 150-300 mg</i> .....	14	<i>levonorgestrel &amp; ethinyl estradiol tab</i> <i>0.1 mg-20 mcg</i> .....	53
<i>lamotrigine</i> .....	36	<i>levonorgestrel &amp; ethinyl estradiol tab</i> <i>0.15 mg-30 mcg</i> .....	54
<i>lansoprazole</i> .....	62	<i>levonorgestrel-eth estra tab 0.05-</i> <i>30/0.075-40/0.125-30mg-mcg</i> .....	54
LANTUS .....	50	<i>levora 0.15/30-28</i> .....	54
LANTUS SOLOSTAR .....	50	<i>levo-t</i> .....	59
<i>lapatinib ditosylate</i> .....	23	<i>levothyroxine sodium</i> .....	59
<i>larin 1.5/30</i> .....	53	<i>levoxyl</i> .....	59
<i>larin 1/20</i> .....	53	LEXIVA .....	12
<i>larin fe 1.5/30</i> .....	53	<i>lidocaine</i> .....	79, 80
<i>larin fe 1/20</i> .....	53	<i>lidocaine hcl</i> .....	80
<i>larissia</i> .....	53	<i>lidocaine hcl (local anesth.)</i> .....	9
<i>latanoprost</i> .....	73	<i>lidocaine hcl (mouth-throat)</i> .....	81
LATUDA .....	42	<i>lidocaine-prilocaine cream 2.5-2.5%</i> .....	80
<i>leena</i> .....	53	<i>lillow</i> .....	54
<i>leflunomide</i> .....	66	<i>linezolid</i> .....	10
<i>lenalidomide</i> .....	20		
LENVIMA 10 MG DAILY DOSE.....	23		
LENVIMA 12MG DAILY DOSE.....	23		
LENVIMA 20 MG DAILY DOSE.....	23		
LENVIMA 4 MG DAILY DOSE .....	23		
LENVIMA 8 MG DAILY DOSE .....	23		
LENVIMA CAP 14 MG .....	23		
LENVIMA CAP 18 MG .....	23		
LENVIMA CAP 24 MG .....	23		

<i>linezolid in sodium chloride iv soln 600 mg/300ml-0.9%</i> .....	10	LUPRON DEPOT-PED (3-MONTH) .....	58
LINZESS .....	61	<i>lutera</i> .....	54
<i>liothyronine sodium</i> .....	59	<i>lyleq</i> .....	54
<i>lisinopril</i> .....	27	<i>lyllana</i> .....	56
<i>lisinopril &amp; hydrochlorothiazide tab 10-12.5 mg</i> .....	26	LYNPARZA .....	23
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5 mg</i> .....	26	LYSODREN .....	20
<i>lisinopril &amp; hydrochlorothiazide tab 20-25 mg</i> .....	26	<i>lyza</i> .....	54
<i>lithium carbonate</i> .....	45	<b>M</b>	
<i>loestrin 1.5/30-21</i> .....	54	<i>magnesium sulfate</i> .....	69
<i>loestrin 1/20-21</i> .....	54	MAGNESIUM SULFATE .....	69
<i>loestrin fe 1.5/30</i> .....	54	<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i> .....	69
<i>loestrin fe 1/20</i> .....	54	<i>malathion</i> .....	80
LOKELMA .....	52	<i>maraviroc</i> .....	12
LONSURF TAB 15-6.14.....	19	<i>marlissa</i> .....	54
LONSURF TAB 20-8.19.....	19	MARPLAN .....	39
<i>loperamide hcl</i> .....	61	MATULANE .....	20
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i> .....	14	MAVYRET PAK 50-20MG .....	15
<i>lopinavir-ritonavir tab 100-25 mg</i> .....	14	MAVYRET TAB 100-40MG .....	15
<i>lopinavir-ritonavir tab 200-50 mg</i> .....	14	<i>meclizine hcl</i> .....	60
<i>lorazepam</i> .....	34	<i>medroxyprogesterone acetate</i> .....	59
<i>lorazepam intensol</i> .....	34	<i>medroxyprogesterone acetate (contraceptive)</i> .....	54
LORBRENA .....	23	<i>mefloquine hcl</i> .....	12
<i>loryna</i> .....	54	<i>megestrol acetate</i> .....	20, 59
<i>losartan potassium</i> .....	29	<i>megestrol acetate (appetite)</i> .....	59
<i>losartan potassium &amp; hydrochlorothiazide tab 100-12.5 mg</i> .....	28	MEKINIST .....	23
<i>losartan potassium &amp; hydrochlorothiazide tab 100-25 mg</i> .....	28	MEKTOVI.....	23
<i>losartan potassium &amp; hydrochlorothiazide tab 50-12.5 mg</i> .....	28	<i>meloxicam</i> .....	7
LOTEMAX .....	72	<i>memantine hcl</i> .....	38
<i>lovastatin</i> .....	30	MENACTRA INJ .....	68
<i>low-ogestrel</i> .....	54	MENQUADFI INJ.....	68
<i>loxapine succinate</i> .....	42	MENVEO INJ .....	68
LUMAKRAS .....	23	<i>mercaptapurine</i> .....	19
LUMIGAN .....	73	<i>meropenem</i> .....	10
LUMIZYME.....	58	<i>mesalamine</i> .....	61
LUPRON DEPOT (1-MONTH).....	20	<i>mesalamine w/ cleanser</i> .....	61
LUPRON DEPOT (3-MONTH).....	20	MESNEX.....	26
LUPRON DEPOT-PED (1-MONTH) .....	58	<i>metadate er</i> .....	44
		<i>metformin hcl</i> .....	48
		<i>methadone hcl</i> .....	8
		<i>methadone hydrochloride i</i> .....	8
		<i>methazolamide</i> .....	32
		<i>methenamine hippurate</i> .....	10
		<i>methimazole</i> .....	59
		<i>methotrexate sodium</i> .....	19, 66
		<i>methylphenidate hcl</i> .....	44



<i>methylprednisolone</i> .....	57	MVASI .....	23
<i>methylprednisolone acetate</i> .....	57	<i>mycophenolate mofetil</i> .....	67
<i>methylprednisolone sod succ</i> .....	57	<i>mycophenolate sodium</i> .....	67
<i>metoclopramide hcl</i> .....	60	<i>myorisan</i> .....	77
<i>metolazone</i> .....	32	MYRBETRIQ.....	63
<i>metoprolol &amp; hydrochlorothiazide tab</i> 100-25 mg .....	31	<b>N</b>	
<i>metoprolol &amp; hydrochlorothiazide tab</i> 100-50 mg .....	31	<i>nabumetone</i> .....	7
<i>metoprolol &amp; hydrochlorothiazide tab</i> 50-25 mg .....	30	<i>nadolol</i> .....	31
<i>metoprolol succinate</i> .....	31	<i>nafcillin sodium</i> .....	17
<i>metoprolol tartrate</i> .....	31	NAGLAZYME .....	58
<i>metronidazole</i> .....	10	<i>nalbuphine hcl</i> .....	8
<i>metronidazole (topical)</i> .....	80	<i>naloxone hcl</i> .....	46
<i>metronidazole vaginal</i> .....	63	<i>naltrexone hcl</i> .....	46
<i>metyrosine</i> .....	33	NAMZARIC CAP 14-10MG .....	38
MG SO4/D5W INJ 10MG/ML.....	69	NAMZARIC CAP 21-10MG .....	38
<i>micafungin sodium</i> .....	11	NAMZARIC CAP 28-10MG .....	38
<i>microgestin 1.5/30</i> .....	54	NAMZARIC CAP 7-10MG.....	38
<i>microgestin 1/20</i> .....	54	NAMZARIC CAP PACK .....	38
<i>microgestin fe 1.5/30</i> .....	54	<i>naproxen</i> .....	7
<i>microgestin fe 1/20</i> .....	54	<i>naproxen sodium</i> .....	7
<i>midodrine hcl</i> .....	33	<i>naratriptan hcl</i> .....	44
<i>miglustat</i> .....	58	NATACYN .....	71
<i>mili</i> .....	54	<i>nateglinide</i> .....	49
<i>mimvey</i> .....	56	NATPARA .....	51
<i>minocycline hcl</i> .....	18	NAYZILAM .....	36
<i>minoxidil</i> .....	33	<i>nebivolol hcl</i> .....	31
<i>mirtazapine</i> .....	39	<i>necon 0.5/35-28</i> .....	54
<i>misoprostol</i> .....	61	<i>nefazodone hcl</i> .....	39
MITIGARE .....	7	<i>neomycin sulfate</i> .....	10
M-M-R II INJ.....	68	<i>neomycin-bacitrac zn-polymyx</i> 5(3.5)mg-400unt-10000unt op oin	71
M-NATAL PLUS TAB .....	70	<i>neomycin-polymy-gramicid op sol</i> 1.75-10000-0.025mg-unt-mg/ml ..	72
<i>moexipril hcl</i> .....	27	<i>neomycin-polymyxin-dexamethasone</i> <i>ophth oint 0.1%</i> .....	71
<i>molindone hcl</i> .....	42	<i>neomycin-polymyxin-dexamethasone</i> <i>ophth susp 0.1%</i> .....	71
<i>mometasone furoate</i> .....	79	<i>neomycin-polymyxin-hc ophth susp</i> ..	71
MONJUVI.....	23	<i>neomycin-polymyxin-hc otic soln 1%</i>	73
<i>mono-lynyah</i> .....	54	<i>neomycin-polymyxin-hc otic susp 3.5</i> <i>mg/ml-10000 unit/ml-1%</i> .....	73
<i>montelukast sodium</i> .....	75	NERLYNX.....	23
<i>morphine sulfate</i> .....	8	NEUPRO .....	40
MORPHINE SULFATE .....	8	<i>nevirapine</i> .....	12
MOVANTIK .....	61	NEXAVAR .....	23
<i>moxifloxacin hcl</i> .....	17	<i>niacin (antihyperlipidemic)</i> .....	30
<i>moxifloxacin hcl (ophth)</i> .....	71	<i>nicardipine hcl</i> .....	32
MULTAQ.....	29		
<i>mupirocin</i> .....	77		

NICOTROL INHALER .....	46	NOVOLOG .....	50
NICOTROL NS .....	47	NOVOLOG FLEXPEN .....	50
<i>nifedipine</i> .....	32	NOVOLOG MIX INJ 70/30 .....	50
<i>nikki</i> .....	54	NOVOLOG MIX INJ FLEXPEN .....	51
<i>nilutamide</i> .....	20	NOVOLOG PENFILL .....	51
<i>nimodipine</i> .....	32	NOXAFIL .....	11
NINLARO .....	23	NUBEQA .....	20
<i>nitazoxanide</i> .....	10	NUEDEXTA CAP 20-10MG .....	45
<i>nitisinone</i> .....	58	NULOJIX .....	67
NITRO-BID .....	33	NUPLAZID .....	42
<i>nitrofurantoin macrocrystal</i> .....	10	NURTEC .....	44
<i>nitrofurantoin monohyd macro</i> .....	10	NUTRILIPID .....	71
<i>nitroglycerin</i> .....	33	NUZYRA .....	18
<i>nizatidine</i> .....	60	<i>nyamyc</i> .....	78
<i>nora-be</i> .....	54	<i>nylia 1/35</i> .....	55
<i>norethindrone (contraceptive)</i> .....	54	<i>nylia 7/7/7</i> .....	55
<i>norethindrone ace &amp; ethinyl estradiol</i> <i>tab 1 mg-20 mcg</i> .....	54	NYMALIZE .....	32
<i>norethindrone ace &amp; ethinyl estradiol</i> <i>tab 1.5 mg-30 mcg</i> .....	54	<i>nymyo</i> .....	55
<i>norethindrone ace &amp; ethinyl estradiol-fe</i> <i>tab 1 mg-20 mcg</i> .....	54	<i>nystatin</i> .....	11
<i>norethindrone acetate</i> .....	59	<i>nystatin (mouth-throat)</i> .....	81
<i>norethindrone acetate-ethinyl estradiol</i> <i>tab 0.5 mg-2.5 mcg</i> .....	56	<i>nystatin (topical)</i> .....	78
<i>norethindrone acetate-ethinyl estradiol</i> <i>tab 1 mg-5 mcg</i> .....	56	<i>nystop</i> .....	78
<i>norgestimate &amp; ethinyl estradiol tab</i> <i>0.25 mg-35 mcg</i> .....	54	<b>o</b>	
<i>norgestimate-eth estrad tab 0.18-</i> <i>25/0.215-25/0.25-25 mg-mcg</i> .....	54	<i>ocella</i> .....	55
<i>norgestimate-eth estrad tab 0.18-</i> <i>35/0.215-35/0.25-35 mg-mcg</i> .....	54	OCTAGAM .....	66
<i>norlyroc</i> .....	54	<i>octreotide acetate</i> .....	58
NORPACE CR .....	29	ODEFSEY TAB .....	14
<i>nortrel 0.5/35 (28)</i> .....	54	ODOMZO .....	23
<i>nortrel 1/35 (21)</i> .....	55	OFEV .....	75
<i>nortrel 1/35 (28)</i> .....	55	<i>ofloxacin (ophth)</i> .....	72
<i>nortrel 7/7/7</i> .....	55	<i>ofloxacin (otic)</i> .....	73
<i>nortriptyline hcl</i> .....	39	OGIVRI .....	23
NORVIR .....	12	OGIVRI INJ 420MG .....	23
NOVOLIN INJ 70/30 .....	50	<i>olanzapine</i> .....	42
NOVOLIN INJ 70/30 FP .....	50	<i>olmesartan medoxomil</i> .....	29
NOVOLIN N .....	50	<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 20-12.5 mg</i> .....	28
NOVOLIN N FLEXPEN .....	50	<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 40-12.5 mg</i> .....	28
NOVOLIN R .....	50	<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 40-25 mg</i> .	28
NOVOLIN R FLEXPEN .....	50	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 20-5-12.5</i> <i>mg</i> .....	28

<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-10-12.5 mg</i> .....	28	OZEMPIC (0.25 OR 0.5MG/DOSE) ....	49
<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-10-25 mg</i> .....	28	OZEMPIC (1MG/DOSE).....	49
<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-5-12.5 mg</i> .....	28	OZEMPIC (2MG/DOSE) SOPN 8MG/3ML .....	49
<i>olmesartan-amlodipine- hydrochlorothiazide tab 40-5-25 mg</i> .....	28	<b>P</b>	
<i>olopatadine hcl</i> .....	72	<i>pacerone</i> .....	29
<i>omeprazole</i> .....	62	<i>paclitaxel</i> .....	21
OMNIPOD 5 G6 KIT INTRO .....	51	<i>paclitaxel protein-bound particles for iv susp 100 mg</i> .....	21
OMNIPOD 5 G6 MIS PODS .....	51	<i>paliperidone</i> .....	42
OMNIPOD DASH KIT INTRO .....	51	<i>pamidronate disodium</i> .....	51
OMNIPOD DASH MIS PODS.....	51	PAMIDRONATE DISODIUM.....	51
OMNIPOD MIS CLASSIC .....	51	PANRETIN .....	80
OMNIPOD PDM KIT CLASSIC.....	51	<i>pantoprazole sodium</i> .....	62
<i>ondansetron</i> .....	60	PANZYGA .....	67
<i>ondansetron hcl</i> .....	60	<i>paraplatin</i> .....	19
ONTRUZANT .....	23	<i>paricalcitol</i> .....	59
ONUREG .....	19	<i>paromomycin sulfate</i> .....	10
OPSUMIT.....	33	<i>paroxetine hcl</i> .....	39
ORGOVYX.....	20	PASER .....	14
ORKAMBI GRA 100-125 .....	75	PEDIARIX INJ 0.5ML .....	68
ORKAMBI GRA 150-188 .....	75	PEDVAX HIB .....	68
ORKAMBI TAB 100-125 .....	75	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i> .....	61
ORKAMBI TAB 200-125 .....	75	<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i> .....	61
<i>oseltamivir phosphate</i> .....	15	PEGASYS.....	15
OTEZLA.....	65	PEMAZYRE.....	23
OTEZLA TAB 10/20/30 .....	65	<i>pemetrexed disodium</i> .....	19
<i>oxacillin sodium</i> .....	17	PEN GK/DEXTR INJ 40000/ML.....	17
<i>oxaliplatin</i> .....	19	PEN GK/DEXTR INJ 60000/ML.....	18
<i>oxandrolone</i> .....	47	<i>penicillamine</i> .....	52
<i>oxcarbazepine</i> .....	36	<i>penicillin g potassium</i> .....	18
<i>oxybutynin chloride</i> .....	63	PENICILLIN G PROCAINE.....	18
<i>oxycodone hcl</i> .....	8, 9	<i>penicillin g sodium</i> .....	18
<i>oxycodone w/ acetaminophen tab 10- 325 mg</i> .....	9	<i>penicillin v potassium</i> .....	18
<i>oxycodone w/ acetaminophen tab 2.5- 325 mg</i> .....	9	PENTACEL INJ.....	68
<i>oxycodone w/ acetaminophen tab 5- 325 mg</i> .....	9	<i>pentamidine isethionate inh</i> .....	10
<i>oxycodone w/ acetaminophen tab 7.5- 325 mg</i> .....	9	<i>pentamidine isethionate inj</i> .....	10
		<i>pentoxifylline</i> .....	64
		<i>perindopril erbumine</i> .....	27
		<i>periogard</i> .....	81
		<i>permethrin</i> .....	80
		<i>perphenazine</i> .....	42
		PERSERIS .....	42
		<i>pfizerpen</i> .....	18
		<i>phenelzine sulfate</i> .....	39

<i>phenobarbital</i> .....	36	<i>potassium citrate (alkalinizer)</i> .....	62
<i>phenobarbital sodium</i> .....	36	PRADAXA .....	63
PHENYTEK .....	36	PRALUENT .....	30
<i>phenytoin</i> .....	36	<i>pramipexole dihydrochloride</i> .....	40
<i>phenytoin sodium</i> .....	36	<i>prasugrel hcl</i> .....	65
<i>phenytoin sodium extended</i> .....	36	<i>pravastatin sodium</i> .....	30
PHESGO SOL .....	23	<i>praziquantel</i> .....	10
<i>philith</i> .....	55	<i>prazosin hcl</i> .....	27
PIFELTRO .....	12	<i>prednisolone</i> .....	57
<i>pilocarpine hcl</i> .....	73	<i>prednisolone acetate (ophth)</i> .....	72
<i>pilocarpine hcl (oral)</i> .....	81	PREDNISOLONE SODIUM PHOSP .....	72
<i>pimozide</i> .....	42	<i>prednisolone sodium phosphate</i> .....	57
<i>pimtrea</i> .....	55	<i>prednisone</i> .....	57
<i>pindolol</i> .....	31	PREDNISONE INTENSOL .....	57
<i>pioglitazone hcl</i> .....	49	<i>pregabalin</i> .....	36, 37
<i>piperacillin sod-tazobactam na for inj</i> 3.375 gm (3-0.375 gm) .....	18	PREHEVBRIO .....	68
<i>piperacillin sod-tazobactam sod for inj</i> 13.5 gm (12-1.5 gm) .....	18	PREMASOL SOL 10% .....	71
<i>piperacillin sod-tazobactam sod for inj</i> 2.25 gm (2-0.25 gm) .....	18	PRENATAL TAB 27-1MG .....	70
<i>piperacillin sod-tazobactam sod for inj</i> 4.5 gm (4-0.5 gm) .....	18	PRENATAL TAB PLUS .....	70
<i>piperacillin sod-tazobactam sod for inj</i> 40.5 gm (36-4.5 gm) .....	18	PRENATAL VIT TAB LOW IRON .....	70
PIQRAY 200MG DAILY DOSE .....	23	<i>prevalite</i> .....	30
PIQRAY 250MG TAB DOSE .....	24	PREVYMIS .....	15
PIQRAY 300MG DAILY DOSE .....	24	PREZCOBIX TAB 800-150 .....	14
<i>pirfenidone</i> .....	75, 76	PREZISTA .....	12, 13
<i>pirmella 1/35</i> .....	55	PRIFTIN .....	14
<i>piroxicam</i> .....	7	<i>primaquine phosphate</i> .....	12
PLASMA-LYTE INJ -148 .....	70	PRIMAQUINE PHOSPHATE .....	12
PLASMA-LYTE INJ -A .....	70	<i>primidone</i> .....	37
<i>plenamine</i> .....	71	PRIORIX INJ .....	68
PLENVU SOL .....	61	PRIVIGEN .....	67
<i>podofilox</i> .....	80	<i>probenecid</i> .....	7
<i>polymyxin b-trimethoprim ophth soln</i> 10000 unit/ml-0.1% .....	72	PROCALAMINE INJ 3% .....	71
POMALYST .....	20	<i>prochlorperazine</i> .....	60
<i>portia-28</i> .....	55	<i>prochlorperazine edisylate</i> .....	60
<i>posaconazole</i> .....	11	<i>prochlorperazine maleate</i> .....	60
<i>potassium chloride</i> .....	70	PROCRIT .....	64
POTASSIUM CHLORIDE .....	70	<i>procto-med hc</i> .....	80
<i>potassium chloride 20 meq/l (0.15%)</i> <i>in dextrose 5% inj</i> .....	70	<i>procto-pak</i> .....	80
<i>potassium chloride microencapsulated</i> <i>crystals er</i> .....	70	<i>proctosol hc</i> .....	80
		<i>proctozone-hc</i> .....	80
		PROGRAF .....	67
		PROLASTIN-C .....	76
		PROLENSA .....	72
		PROLIA .....	51
		PROMACTA .....	64
		<i>promethazine hcl</i> .....	60
		<i>propafenone hcl</i> .....	29

<i>proparacaine hcl</i> .....	73	REZUROCK .....	67
<i>propranolol hcl</i> .....	31	RHOPRESSA .....	73
<i>propylthiouracil</i> .....	59	<i>ribavirin (hepatitis c)</i> .....	15
PROQUAD INJ .....	68	<i>rifabutin</i> .....	14
PROSOL INJ 20% .....	71	<i>rifampin</i> .....	14
<i>protriptyline hcl</i> .....	39	<i>riluzole</i> .....	45
PULMICORT FLEXHALER .....	76	<i>rimantadine hydrochloride</i> .....	15
PULMOZYME .....	76	RINVOQ .....	66
PURIXAN .....	19	<i>risperidone</i> .....	42
<i>pyrazinamide</i> .....	14	<i>ritonavir</i> .....	13
<i>pyridostigmine bromide</i> .....	45	<i>rivastigmine</i> .....	38
<b>Q</b>		<i>rivastigmine tartrate</i> .....	38
QINLOCK.....	24	<i>rizatriptan benzoate</i> .....	45
QUADRACEL INJ.....	68	<i>ropinirole hydrochloride</i> .....	40
QUADRACEL INJ 0.5ML .....	68	<i>rosadan</i> .....	80
<i>quetiapine fumarate</i> .....	42	<i>rosuvastatin calcium</i> .....	30
<i>quinapril hcl</i> .....	27	ROTARIX SUS .....	68
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i> .....	26	ROTATEQ SOL.....	68
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i> .....	26	<i>roweepra</i> .....	37
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i> .....	26	ROZLYTREK.....	24
<i>quinidine sulfate</i> .....	29	RUBRACA .....	24
<i>quinine sulfate</i> .....	12	<i>rufinamide</i> .....	37
<b>R</b>		RUKOBIA .....	13
RABAVERT INJ .....	68	RYBELSUS .....	49
<i>raloxifene hcl</i> .....	58	RYDAPT .....	24
<i>ramipril</i> .....	27	<b>S</b>	
<i>ranolazine</i> .....	33	<i>sajazir</i> .....	64
<i>rasagiline mesylate</i> .....	40	SANDIMMUNE.....	67
RAYALDEE .....	59	SANTYL.....	80
<i>reclipsen</i> .....	55	<i>sapropterin dihydrochloride</i> .....	58
RECOMBIVAX HB.....	68	SCSEMBLIX .....	24
RECTIV .....	80	<i>scopolamine</i> .....	60
REGRANEX .....	80	SECUADO.....	42
RELENZA DISKHALER .....	15	<i>selegiline hcl</i> .....	40
RELISTOR .....	61	<i>selenium sulfide</i> .....	78
REMICADE.....	65	SELZENTRY .....	13
RENFLEXIS .....	65	SEREVENT DISKUS.....	75
<i>repaglinide</i> .....	49	<i>sertraline hcl</i> .....	39
RESTASIS .....	73	<i>setlakin</i> .....	55
RESTASIS MULTIDOSE.....	73	<i>sevelamer carbonate</i> .....	58, 59
RETEVMO .....	24	<i>sharobel</i> .....	55
REVLIMID.....	20	SHINGRIX .....	68
REXULTI.....	42	SIGNIFOR .....	58
REYATAZ.....	13	<i>sildenafil citrate (pulmonary hypertension)</i> .....	33
		<i>silver sulfadiazine</i> .....	77
		SIMBRINZA SUS 1-0.2%.....	73

<i>simliya</i> .....	55	<i>sulfamethoxazole-trimethoprim susp</i>	
<i>simvastatin</i> .....	30	200-40 mg/5ml .....	10
<i>sirolimus</i> .....	67	<i>sulfamethoxazole-trimethoprim tab</i>	
SIRTURO .....	14	400-80 mg .....	11
SIVEXTRO .....	10	<i>sulfamethoxazole-trimethoprim tab</i>	
SKYRIZI .....	66	800-160 mg .....	11
SKYRIZI PEN .....	66	SULFAMYLON .....	78
<i>sodium chloride</i> .....	70	<i>sulfasalazine</i> .....	61
<i>sodium chloride (gu irrigant)</i> .....	80	<i>sulindac</i> .....	7
<i>sodium fluoride chew; tab; 1.1 (0.5 f)</i>		<i>sumatriptan</i> .....	45
mg/ml soln .....	70	<i>sumatriptan succinate</i> .....	45
<i>sodium phenylbutyrate</i> .....	58	<i>sunitinib malate</i> .....	24
<i>sodium polystyrene sulfonate powder</i>		SUPREP BOWEL SOL PREP KIT .....	61
.....	52	<i>syeda</i> .....	55
<i>solifenacin succinate</i> .....	63	SYMBICORT AER 160-4.5 .....	77
SOLIQUA INJ 100/33 .....	51	SYMBICORT AER 80-4.5 .....	77
SOLTAMOX .....	20	SYMDEKO TAB 100-150 .....	76
SOLU-CORTEF .....	57	SYMDEKO TAB 50-75MG .....	76
SOMATULINE DEPOT .....	58	SYMJEPI .....	76
SOMAVERT .....	58	SYMPAZAN .....	37
<i>sorafenib tosylate</i> .....	24	SYMTUZA TAB .....	14
<i>sorine</i> .....	29	SYNAREL .....	56
<i>sotalol hcl</i> .....	29	SYNERCID INJ 500MG .....	11
<i>sotalol hcl (afib/afl)</i> .....	29	SYNJARDY TAB 12.5-1000MG .....	49
<i>spironolactone</i> .....	27	SYNJARDY TAB 12.5-500 .....	49
<i>spironolactone &amp; hydrochlorothiazide</i>		SYNJARDY TAB 5-1000MG .....	49
<i>tab 25-25 mg</i> .....	32	SYNJARDY TAB 5-500MG .....	49
<i>sprintec 28</i> .....	55	SYNJARDY XR TAB 10-1000 .....	49
SPRITAM .....	37	SYNJARDY XR TAB 12.5-1000MG ....	49
SPRYCEL .....	24	SYNJARDY XR TAB 25-1000 .....	49
<i>sps</i> .....	52	SYNJARDY XR TAB 5-1000MG .....	49
<i>sronyx</i> .....	55	SYNRIBO .....	20
<i>ssd</i> .....	77	SYNTHROID .....	59
<i>stavudine</i> .....	13	<b>T</b>	
STIVARGA .....	24	TABLOID .....	19
<i>streptomycin sulfate</i> .....	10	TABRECTA .....	24
STRIBILD TAB .....	14	<i>tacrolimus</i> .....	67
<i>subvenite</i> .....	37	<i>tacrolimus (topical)</i> .....	80
<i>sucrafate</i> .....	62	TAFINLAR .....	24
<i>sulfacetamide sodium (acne)</i> .....	77	TAGRISSO .....	24
<i>sulfacetamide sodium (ophth)</i> .....	72	TALTZ .....	66
<i>sulfacetamide sodium-prednisolone</i>		TALZENNA .....	24
<i>ophth soln 10-0.23(0.25)%</i> .....	71	<i>tamoxifen citrate</i> .....	20
<i>sulfadiazine</i> .....	10	<i>tamsulosin hcl</i> .....	62
<i>sulfamethoxazole-trimethoprim iv soln</i>		<i>tarina fe 1/20 eq</i> .....	55
400-80 mg/5ml .....	10	TASIGNA .....	24
		<i>tazarotene</i> .....	78

<i>tazicef</i> .....	16	<i>topiramate</i> .....	37
TAZORAC .....	78	<i>toposar</i> .....	21
<i>taztia xt</i> .....	32	<i>toremifene citrate</i> .....	20
TAZVERIK .....	24	<i>torseamide</i> .....	32
TDVAX INJ 2-2 LF.....	68	TOUJEO MAX SOLOSTAR.....	51
TECENTRIQ .....	24	TOUJEO SOLOSTAR .....	51
TEFLARO .....	16	TPN ELECTROL INJ .....	70
<i>telmisartan</i> .....	29	TRADJENTA .....	49
<i>temazepam</i> .....	44	<i>tramadol hcl</i> .....	9
TENIVAC INJ 5-2LF.....	68	<i>tramadol-acetaminophen tab 37.5-325</i> <i>mg</i> .....	9
<i>tenofovir disoproxil fumarate</i> .....	13	<i>trandolapril</i> .....	27
TEPMETKO.....	24	<i>tranexamic acid</i> .....	64
<i>terazosin hcl</i> .....	27	<i>tranylcypromine sulfate</i> .....	39
<i>terbinafine hcl</i> .....	11	TRAVASOL INJ 10%.....	71
<i>terbutaline sulfate</i> .....	75	TRAZIMERA .....	24
<i>terconazole vaginal</i> .....	63	<i>trazodone hcl</i> .....	39
TERIPARATIDE.....	51	TRECATOR .....	14
<i>testosterone</i> .....	47	TRELEGY AER ELLIPTA 100-62.5-25 MCG .....	74
<i>testosterone cypionate</i> .....	47	TRELEGY AER ELLIPTA 200-62.5-25 MCG .....	74
<i>testosterone enanthate</i> .....	47	<i>treprostinil</i> .....	34
<i>tetrabenazine</i> .....	45	TRESIBA .....	51
<i>tetracycline hcl</i> .....	18	TRESIBA FLEXTOUCH.....	51
THALOMID.....	20	<i>tretinoin</i> .....	77
THEO-24 .....	76	<i>tretinoin (chemotherapy)</i> .....	21
<i>theophylline</i> .....	76	<i>triamcinolone acetonide (mouth)</i> .....	81
<i>thioridazine hcl</i> .....	42	<i>triamcinolone acetonide (topical)</i> .....	79
<i>thiothixene</i> .....	43	<i>triamterene &amp; hydrochlorothiazide cap</i> <i>37.5-25 mg</i> .....	32
<i>tiadylt er</i> .....	32	<i>triamterene &amp; hydrochlorothiazide tab</i> <i>37.5-25 mg</i> .....	32
<i>tiagabine hcl</i> .....	37	<i>triamterene &amp; hydrochlorothiazide tab</i> <i>75-50 mg</i> .....	32
TIBSOVO.....	24	TRICARE TAB PRENATAL .....	70
TICOVAC .....	68	<i>trientine hcl</i> .....	52
<i>tigecycline</i> .....	18	<i>tri-estarylla</i> .....	55
TIGECYCLINE.....	18	<i>trifluoperazine hcl</i> .....	43
<i>tilia fe</i> .....	55	<i>trifluridine</i> .....	72
<i>timolol maleate</i> .....	31	<i>trihexyphenidyl hcl</i> .....	41
<i>timolol maleate (ophth)</i> .....	73	TRIJARDY XR TAB ER 24HR 10-5- 1000MG .....	49
TIVICAY .....	13	TRIJARDY XR TAB ER 24HR 12.5-2.5- 1000MG .....	49
TIVICAY PD .....	13	TRIJARDY XR TAB ER 24HR 25-5- 1000MG .....	49
<i>tizanidine hcl</i> .....	46		
TOBRADEX OIN 0.3-0.1% .....	71		
TOBRADEX ST SUS 0.3-0.05.....	71		
<i>tobramycin</i> .....	11		
<i>tobramycin (ophth)</i> .....	72		
<i>tobramycin sulfate</i> .....	11		
<i>tobramycin-dexamethasone ophth susp</i> <i>0.3-0.1%</i> .....	71		
<i>tolterodine tartrate</i> .....	63		

TRIJARDY XR TAB ER 24HR 5-2.5-1000MG .....	49	<i>valproic acid</i> .....	37
TRIKAFTA TAB 100-50-75MG & 150MG .....	76	<i>valsartan</i> .....	29
TRIKAFTA TAB 50-25-37.5MG & 75MG .....	76	<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i> .....	28
<i>tri-legest fe</i> .....	55	<i>valsartan-hydrochlorothiazide tab 160-25 mg</i> .....	28
<i>tri-linyah</i> .....	55	<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i> .....	28
<i>tri-lo-estarylla</i> .....	55	<i>valsartan-hydrochlorothiazide tab 320-25 mg</i> .....	28
<i>tri-lo-marzia</i> .....	55	<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i> .....	28
<i>tri-lo-mili</i> .....	55	VALTOCO .....	37
<i>tri-lo-sprintec</i> .....	55	<i>vancomycin hcl</i> .....	11
TRIMETHOPRIM .....	11	VANCOMYCIN INJ 1 GM .....	11
<i>tri-mili</i> .....	55	VANCOMYCIN INJ 500MG .....	11
<i>trimipramine maleate</i> .....	39	VANCOMYCIN INJ 750MG .....	11
TRINTELLIX .....	39	VAQTA .....	68
<i>tri-nymyo</i> .....	55	<i>varenicline tartrate</i> .....	47
<i>tri-sprintec</i> .....	55	<i>varenicline tartrate tab 0.5 mg x 11 &amp; tab 1 mg x 42 pack</i> .....	47
TRIUMEQ PD TAB .....	14	VARIVAX .....	68
TRIUMEQ TAB .....	14	VASCEPA .....	30
<i>trivora-28</i> .....	55	<i>velivet</i> .....	55
<i>tri-vylibra</i> .....	55	VELPHORO .....	59
<i>tri-vylibra lo</i> .....	55	VELTASSA .....	52
TRIZIVIR TAB .....	14	VEMLIDY .....	15
TROGARZO .....	13	VENCLEXTA .....	25
TROPHAMINE INJ 10% .....	71	VENCLEXTA TAB START PK .....	25
<i>trospium chloride</i> .....	63	<i>venlafaxine hcl</i> .....	39
TRULICITY .....	49	VENTAVIS .....	34
TRUMENBA INJ .....	68	VENTOLIN HFA .....	75
TRUSELTIQ 100 MG DAILY DOSE .....	24	VENTOLIN HFA (INSTITUTIONAL PACK) .....	75
TRUSELTIQ 125 MG DAILY DOSE .....	24	<i>verapamil hcl</i> .....	32
TRUSELTIQ 50 MG DAILY DOSE .....	24	VERQUVO .....	33
TRUSELTIQ 75 MG DAILY DOSE .....	24	VERSACLOZ .....	43
TRUXIMA .....	24	VERZENIO .....	25
TUKYSA .....	24	<i>vestura</i> .....	55
TURALIO .....	24	V-GO 20 KIT .....	51
TWINRIX INJ .....	68	V-GO 30 KIT .....	51
TYBOST .....	13	V-GO 40 KIT .....	51
TYPHIM VI .....	68	VICTOZA .....	49
<b>U</b>		<i>vienna</i> .....	55
<i>unithroid</i> .....	59	<i>vigabatrin</i> .....	37
<i>ursodiol</i> .....	62	<i>vigadrone</i> .....	37
<b>V</b>		VIIBRYD KIT STARTER .....	39
<i>valacyclovir hcl</i> .....	15		
VALCHLOR .....	80		
<i>valganciclovir hcl</i> .....	15		
<i>valproate sodium</i> .....	37		



<i>vilazodone hcl</i> .....	39	XIGDUO XR TAB 5-1000MG .....	50
VIMPAT .....	37	XIGDUO XR TAB 5-500MG .....	50
<i>vincristine sulfate</i> .....	21	XIIDRA .....	73
<i>vinorelbine tartrate</i> .....	21	XOLAIR.....	76
<i>viorele</i> .....	55	XOSPATA .....	25
VIRACEPT.....	13	XPOVIO 100 MG ONCE WEEKLY .....	25
VIREAD .....	13	XPOVIO 40 MG ONCE WEEKLY .....	25
VITRAKVI .....	25	XPOVIO 40 MG TWICE WEEKLY .....	25
VIVITROL .....	47	XPOVIO 60 MG ONCE WEEKLY .....	25
VIZIMPRO .....	25	XPOVIO 60 MG TWICE WEEKLY .....	25
VONJO .....	25	XPOVIO 80 MG ONCE WEEKLY .....	25
<i>voriconazole</i> .....	11, 12	XPOVIO 80 MG TWICE WEEKLY .....	25
VOSEVI TAB .....	15	XTANDI.....	20
VOTRIENT .....	25	<i>xulane</i> .....	55
VRAYLAR.....	43	XULTOPHY INJ 100/3.6 .....	51
VRAYLAR CAP 1.5-3MG .....	43	XYREM.....	46
<i>vyfemla</i> .....	55	<b>Y</b>	
<i>vylibra</i> .....	55	YF-VAX INJ.....	68
VYZULTA.....	73	<i>yuvafem</i> .....	56
<b>W</b>		<b>Z</b>	
<i>warfarin sodium</i> .....	63	<i>zafemy</i> .....	55
<i>water for irrigation, sterile irrigation</i>		<i>zafirlukast</i> .....	75
<i>soln</i> .....	80	ZARXIO.....	64
WELIREG.....	21	ZEJULA .....	25
<i>wera</i> .....	55	ZELBORAF.....	25
<b>X</b>		ZEMAIRA.....	76
XALKORI .....	25	<i>zenatane</i> .....	77
XARELTO.....	63, 64	ZENPEP CAP 10000UNT.....	62
XARELTO STAR TAB 15/20MG.....	64	ZENPEP CAP 15000UNT.....	62
XATMEP .....	66	ZENPEP CAP 20000UNT.....	62
XCOPRI.....	37	ZENPEP CAP 25000 .....	62
XCOPRI PAK 100-150 .....	37	ZENPEP CAP 3000UNIT .....	62
XCOPRI PAK 12.5-25 .....	37	ZENPEP CAP 40000 .....	62
XCOPRI PAK 150-200MG		ZENPEP CAP 5000UNIT .....	62
(MAINTENANCE).....	37	ZERVIAE .....	72
XCOPRI PAK 150-200MG (TITRATION)		<i>zidovudine</i> .....	13
.....	37	ZIEXTENZO .....	64
XCOPRI PAK 50-100MG .....	37	<i>ziprasidone hcl</i> .....	43
XELJANZ .....	66	<i>ziprasidone mesylate</i> .....	43
XELJANZ XR .....	66	ZIRABEV .....	25
XERMELO .....	62	ZIRGAN .....	72
XGEVA .....	51	<i>zoledronic acid</i> .....	51
XHANCE .....	76	ZOLINZA.....	25
XIFAXAN .....	62	<i>zolmitriptan</i> .....	45
XIGDUO XR TAB 10-1000 .....	50	<i>zolpidem tartrate</i> .....	44
XIGDUO XR TAB 10-500MG .....	50	<i>zonisamide</i> .....	38
XIGDUO XR TAB 2.5-1000 .....	49	<i>zovia 1/35</i> .....	55

*zumandimine* .....56  
ZYDELIG .....25  
ZYKADIA .....25

ZYLET SUS 0.5-0.3% .....71  
ZYPREXA RELPREVV .....43

This formulary was updated on 09/01/2022. For more recent information or other questions, please contact Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit [www.GlobalHealth.com](http://www.GlobalHealth.com).

Esta lista se actualizó el 09/01/2022. Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio de Atención al Cliente al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite [www.GlobalHealth.com](http://www.GlobalHealth.com).

# Important Plan Materials

GlobalHealth provides important plan materials that explain how to use your health plan benefits.

## Evidence of Coverage

The Evidence of Coverage (EOC) is essentially your Member Handbook. It contains detailed information on your benefits, cost-shares, and coverage rules for your plan. For example, if you are unsure whether a service requires prior authorization or not, you can find that information in your plan's EOC. You can find your health plan's EOC online at [www.GlobalHealth.com](http://www.GlobalHealth.com). For the upcoming plan year, EOC information is available no later than October 15th.

## Provider Directory

In most cases, you must receive care from an in-network provider. You can find a network provider in the Provider Directory at [www.GlobalHealth.com](http://www.GlobalHealth.com).

## Drug Formulary\*

The Drug Formulary (List of Covered Drugs) provides you information about the prescription drugs covered under your plan, including tier placement, availability of mail order and certain drugs covered in the coverage gap phase. Additionally, if a prescription drug has prior authorization, step therapy or quantity limits, this information is provided in the Drug Formulary. You can locate the Drug Formulary for your plan online at [www.GlobalHealth.com](http://www.GlobalHealth.com).

## Pharmacy Directory\*

In most cases, your prescriptions are covered only if they are filled at a network pharmacy. Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost-sharing may be less at pharmacies with preferred cost-sharing. You can find a network pharmacy in the Pharmacy Directory at [www.GlobalHealth.com](http://www.GlobalHealth.com).



**GlobalHealth**

Generations Medicare  
Advantage Plans

If you would like a hard copy of any plan materials, please contact Customer Care.

## Customer Care

**Toll Free:**

**1-844-280-5555**

**Local:**

**405-280-5555**

**TTY: 711**

8am to 8pm,  
seven days a week  
(Oct 1 – Mar 31)  
8am to 8pm,  
Monday through Friday  
(Apr 1 - Sept 30)

\*Only applicable to plans with prescription drug coverage.

GlobalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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).

H3706\_ELECTRONICNOTICE\_2023\_C



**GlobalHealth**  
Medicare Advantage Plans

# NOTICE OF **PRIVACY PRACTICES**



**THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION ("PHI") MAYBE USED AND/OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.**

GlobalHealth is committed to protecting the privacy and confidentiality of our Members' Protected Health Information ("PHI") in compliance with applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

## **How GlobalHealth May Use or Disclose Your Health Information**

For Treatment. We may use and/or disclose your PHI to a healthcare provider, hospital, or other healthcare facility in order to arrange for or facilitate treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, hospitals, and other healthcare providers for services delivered to you that are covered by your health plan; to determine your eligibility for benefits; to coordinate benefits; to review for medical necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.

For Health Plan Operations. We may use and/or disclose PHI about you for health plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc.

Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, providers, or care settings.

Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information:

- To a regulatory agency for activities including, but not limited to, licensure, certification, accreditation, audits, investigations, inspections, and medical device reporting;
- To law enforcement upon receipt of a court order, warrant, summons, or other similar process;
- In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute or other lawful process;
- To public health agencies or legal authorities charged with preventing or controlling disease, injury or disability;
- For health oversight activities conducted by agencies such as the Centers for Medicare and Medicaid Services ("CMS"), State Department of Health, Insurance Department, etc.;
- For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations;
- In order to comply with laws and regulations related to Workers' Compensation;
- For coordination of insurance or Medicare benefits, if applicable;
- When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat); and
- In the course of any administrative or judicial proceeding, where required by law.

Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Personal/Authorized Representative. We may use and/or disclose PHI to your authorized representative.

Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Emergencies. We may use and/or disclose your PHI if necessary in an emergency if the use or disclosure is necessary for your emergency treatment.

Military/Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities.

Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclosure your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.

Limited Data Set. If we use your PHI to make a "limited data set," we may give that information to others for purposes of research, public health action or health care operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information.

Any Other Uses. We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI require your written authorization.

NOTE: The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

## **Your Health Information Rights**

### Right to Inspect and Copy

You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by State and Federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may appeal to our Privacy Officer.

### Right to Confidential Communication

You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with.

### Right to Accounting of Disclosures

You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or health care or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.

### Right to Request Restrictions on Uses or Disclosures

You have the right to request restrictions or limitations on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If we do agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf.

### Right to Request Amendment of PHI

You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer.

#### Right to Be Notified of a Breach

You have the right to receive notification of any breaches of your unsecured PHI.

#### Right to Revoke Authorization

You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required.

#### Right to Receive a Copy of this Notice

You have the right to receive a paper copy of this Notice upon request.

#### Changes to this Notice

GlobalHealth reserves the right to change this notice and make the new provisions effective for all PHI that we maintain.

### **To Report a Privacy Violation**

If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at:

**ATTN: Privacy OfficerGlobalHealth  
210 Park Avenue  
Suite 2800  
Oklahoma City, OK 73102**

**Toll-free 1-877-280-5852 (leave message) or  
Email [privacy@globalhealth.com](mailto:privacy@globalhealth.com)**

You may also file a complaint with the U.S. Department of Health and Human Services 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, D.C. 20201. You will not be penalized or retaliated against for filing a complaint.

**Effective Date: 08/01/2021**

Original Notice: 04/01/2003  
Revised: 04/01/2011  
04/01/2013  
08/01/2021



## Multi-Language Insert

### Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول . سيقوم شخص ما يتحدث العربية 1-844-280-5555 على مترجم فوري، ليس عليك سوى الاتصال بنا على . بمساعدتك. هذه خدمة مجانية.

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

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

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

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

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

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-844-280-5555にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

# Non-Discrimination Notice

---

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

GlobalHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o Information written in other languages

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

If you believe that GlobalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **ATTN: Director, Compliance & Legal Services**, 210 Park Ave, Suite 2800, Oklahoma City, OK 73102 or Email: [compliance@globalhealth.com](mailto:compliance@globalhealth.com). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

GlobalHealth:

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

Si necesita recibir estos servicios, comuníquese con GlobalHealth Customer Care en 1-844-280-5555 (toll-free) (TTY:711).

Si considera que GlobalHealth no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: ATTN: **Director, Compliance & Legal Services**, 210 Park Ave, Suite 2800, Oklahoma City, OK 73102 o Email: [compliance@globalhealth.com](mailto:compliance@globalhealth.com). Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Customer Care está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Puede obtener los formularios de reclamo en el sitio web <http://www.hhs.gov/ocr/office/file/index.html>