Aetna Better Health® of Illinois

Preferred Drug List

April 2025

This Formulary is up to date through the date of publication. Please notify Aetna Better Health of Illinois at ABHILPharmacy@AETNA.com or **1-866-329-4701 TTY: 711** with any mistakes in the formulary.

Pharmacy Program

Aetna Better Health® of Illinois is committed to providing high quality drug coverage to our members. We work with the Department of Healthcare and Family Services to include medications that treat many conditions and diseases. Aetna Better Health covers prescription and certain over-the-counter (OTC) medications when ordered by a network provider. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and maximum quantities.

Filling a Prescription

You can have your prescriptions filled at a network pharmacy. At the pharmacy, you will need to give the pharmacist your prescription and your ID card. You can find a pharmacy that is in the Aetna Better Health network by using the Find a Provider tool on **AetnaBetterHealth.com/Illinois-Medicaid**. If you need help finding a pharmacy near you or if you have any questions about drug coverage, call us at **1-866-329-4701 TTY: 711**.

There is no cost for covered drugs.

If your medication is not on the preferred drug list or is on the preferred drug list but has limitations, you can:

1. Speak with your doctor about switching to a similar medication that is on the preferred drug list.
2. Request a prior authorization or speak to your doctor about submitting a prior authorization for you. You or your doctor may do this by submitting the medication prior authorization form, found on **AetnaBetterHealth.com/Illinois-Medicaid.**

Generic Drugs

Generic drugs have the same active ingredient and work the same as brand name drugs. When preferred generic drugs are available, the brand name drug will not be covered without prior authorization.

Specialty Drugs

Specialty drugs are usually not available at retail pharmacies and require additional review and monitoring. These drugs are only covered when supplied by an Aetna Better Health network specialty pharmacy.

Pharmacy Benefit Exclusions

The following drug categories are not part of the Aetna Better Health pharmacy benefit:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Durable Medical Equipment (DME) products and medical supplies (unless listed on the PDL)
- Drugs and other agents used for cosmetic purposes or for hair growth

- Erectile dysfunction drugs prescribed to treat impotence
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- OTC products (unless listed on the PDL)
- Drugs not included in the Medicaid Drug Rebate Program, drug product data file (unless listed on the PDL)

Legend

P	Preferred Drug	Drugs preferred by Aetna Better Health
NP	Non-Preferred	Drugs not preferred by Aetna Better Health
AL	Age Limit	Drug is limited to specific age
PA	Prior Authorization	Prior Authorization required before prescription can be filled.
-	Smart Edit	Prior Authorization required before prescription can be filled. Criteria may be met automatically
QLL	Quantity Level Limit	There is a limit on the amount of drug covered per prescription or within a specific time frame.
ST	Step Therapy	Requires trial and failure of one or more preferred products prior to coverage.
OTC	Over-the-Counter	Over-the-Counter (OTC) products eligible for coverage with a valid prescription written by a licensed physician/clinician.

Aetna Better Health of Illinois Formulary Guide

Table of Contents

lowercase italics = Generic drugs **UPPERCASE BOLD** = Brand name drugs	**Drug Tier** **Non – Preferred** = Non – Preferred **Preferred** = Preferred	**Coverage Requirements and Limits** = Diagnosis Required **AL** = Age Restrictions **OTC** = OTC Medications **PA** = Prior Authorization Applies **QL** = Quantity Limits **ST** = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexiants* - Drugs For The Nervous System**		
****Adhd Agent - Selective Alpha Adrenergic Agonists*** - Drugs For Attention Deficit Disorder***		
clonidine hcl er	Preferred	QL (120 EA per 30 days); AL (Min 6 Years)
guanfacine hcl er	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
INTUNIV	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
****Adhd Agent - Selective Norepinephrine Reuptake Inhibitor*** - Drugs For Attention Deficit Disorder***		
atomoxetine hcl	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
QELBREE	Non – Preferred	
STRATTERA	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
****Amphetamine Mixtures*** - Drugs For Attention Deficit Disorder***		
amphetamine-dextroamphet er capsule extended release 24 hour 10 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
amphetamine-dextroamphet er capsule extended release 24 hour 15 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 20 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 25 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 30 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 10 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 12.5 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 15 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 20 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 30 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 5 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphetamine-dextroamphetamine tablet 7.5 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
amphet-dextroamphet 3-bead er	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 10 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 12.5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 15 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADDERALL TABLET 20 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL TABLET 7.5 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
MYDAYIS	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
Amphetamines - Drugs For Attention Deficit Disorder***		
amphetamine sulfate	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dextroamphetamine sulfate oral solution	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 10 mg oral	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 15 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 2.5 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 20 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 30 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 5 mg oral	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
dextroamphetamine sulfate tablet 7.5 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 10 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 10 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 20 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 20 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 30 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 30 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 40 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 40 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lisdexamfetamine dimesylate capsule 50 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 50 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 60 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 60 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 70 mg oral	Non – Preferred	AL (Min 6 Years)
lisdexamfetamine dimesylate capsule 70 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
lisdexamfetamine dimesylate oral tablet chewable	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methamphetamine hcl	Non – Preferred	QL (5 EA per 1 day); AL (Min 6 Years)
ADZENYS XR-ODT	Non – Preferred	AL (Min 6 Years)
DEXEDRINE	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE	Preferred	PA; AL (Min 6 Years)
DYANAVEL XR ORAL TABLET EXTENDED RELEASE	Non – Preferred	PA; AL (Min 6 Years)
EVEKEO	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
PROCENTRA	Non – Preferred	QL (60 ML per 1 day); AL (Min 6 Years)
VYVANSE	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
XELSTRYM	Non – Preferred	
ZENZEDI TABLET 10 MG ORAL	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZENZEDI TABLET 15 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 2.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 20 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 5 MG ORAL	Non – Preferred	QL (6 EA per 1 day); AL (Min 6 Years)
ZENZEDI TABLET 7.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
Analeptics - Drugs For The Nervous System***		
caffeine citrate	Preferred	AL (Min 18 Years)
Dopamine And Norepinephrine Reuptake Inhibitors (Dnris) - Drugs For Sleep Disorder***		
SUNOSI	Non – Preferred	AL (Min 6 Years)
Histamine H3-Receptor Antagonist/Inverse Agonists - Drugs For Sleep Disorder***		
WAKIX	Non – Preferred	AL (Min 18 Years)
Stimulant Combinations - Drugs For Attention Deficit Disorder***		
AZSTARYS	Non – Preferred	
Stimulants - Misc. - Drugs For Attention Deficit Disorder***		
armodafinil tablet 150 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
armodafinil tablet 200 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
armodafinil tablet 250 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
armodafinil tablet 50 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
dexmethylphenidate hcl	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
dexmethylphenidate hcl er	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate	Non – Preferred	PA; QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (cd)	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl er (la) capsule extended release 24 hour 10 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (la) capsule extended release 24 hour 30 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (la) capsule extended release 24 hour 40 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (la) capsule extended release 24 hour 60 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 18 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 27 mg oral	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 27 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 36 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
methylphenidate hcl er (osm) tablet extended release 45 mg oral	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 54 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 63 mg oral	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl er (osm) tablet extended release 72 mg oral	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl er (xr)	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl er oral tablet extended release 24 hour	Non – Preferred	AL (Min 6 Years)
methylphenidate hcl oral solution	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
methylphenidate hcl oral tablet	Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
methylphenidate hcl oral tablet chewable	Non – Preferred	QL (4 EA per 1 day); AL (Min 6 Years)
modafinil	Preferred	AL (Min 17 Years)
APTENSIO XR	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 18 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 27 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 36 MG ORAL	Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
CONCERTA TABLET EXTENDED RELEASE 54 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
COTEMPLA XR-ODT	Non – Preferred	AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAYTRANA	Preferred	PA; QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Preferred	AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL	Preferred	AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 35 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL	Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
JORNAY PM	Preferred	PA; AL (Min 6 Years)
METHYLIN	Non – Preferred	QL (30 ML per 1 day); AL (Min 6 Years)
NUVIGIL TABLET 150 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 200 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)
NUVIGIL TABLET 250 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 17 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUVIGIL TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 17 Years)
PROVIGIL	Non – Preferred	AL (Min 17 Years)
QUILLICHEW ER	Non – Preferred	AL (Min 6 Years)
QUILLIVANT XR	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 18 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 27 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 36 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 45 MG ORAL	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 54 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 63 MG ORAL	Non – Preferred	AL (Min 6 Years)
RELEXXII TABLET EXTENDED RELEASE 72 MG ORAL	Non – Preferred	AL (Min 6 Years)
RITALIN	Non – Preferred	QL (3 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 6 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 6 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Amebicides* - Drugs For Infections**		
****Amebicides*** - Drugs For Parasites***		
SOLOSEC	Non – Preferred	
***Aminoglycosides* - Drugs For Infections**		
****Aminoglycosides*** - Antibiotics***		
amikacin sulfate	Preferred	
gentamicin in saline	Preferred	
gentamicin sulfate	Preferred	
neomycin sulfate	Preferred	
tobramycin nebulization solution 300 mg/4ml inhalation	Non – Preferred	
tobramycin nebulization solution 300 mg/5ml inhalation	Non – Preferred	
tobramycin nebulization solution 300 mg/5ml inhalation	Non – Preferred	QL (10 ML per 1 day)
tobramycin sulfate	Preferred	
ARIKAYCE	Non – Preferred	
BETHKIS	Non – Preferred	
KITABIS PAK (W/ NEBULIZER)	Preferred	QL (10 ML per 1 day)
TOBI	Non – Preferred	QL (10 ML per 1 day)
TOBI PODHALER	Non – Preferred	
***Analgesics - Anti-Inflammatory* - Drugs For Pain And Fever**		
****Antirheumatic - Janus Kinase (Jak) Inhibitors*** - Arthritis And Pain Drugs***		
OLUMIANT	Non – Preferred	
RINVOQ	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XELJANZ	Preferred	PA
XELJANZ XR	Preferred	PA
Antirheumatic Antimetabolites - Arthritis And Pain Drugs**		
OTREXUP	Non – Preferred	
RASUVO	Non – Preferred	
Anti-Tnf-Alpha - Monoclonal Antibodies - Arthritis And Pain Drugs**		
adalimumab-aacf (2 pen)	Non – Preferred	
adalimumab-adaz	Non – Preferred	
adalimumab-adbm (2 pen) auto-injector kit 40 mg/0.4ml subcutaneous	Preferred	PA
adalimumab-adbm (2 pen) auto-injector kit 40 mg/0.8ml subcutaneous	Non – Preferred	
adalimumab-adbm (2 syringe) prefilled syringe kit 10 mg/0.2ml subcutaneous	Preferred	PA
adalimumab-adbm (2 syringe) prefilled syringe kit 20 mg/0.4ml subcutaneous	Preferred	PA
adalimumab-adbm (2 syringe) prefilled syringe kit 40 mg/0.4ml subcutaneous	Preferred	PA
adalimumab-adbm (2 syringe) prefilled syringe kit 40 mg/0.8ml subcutaneous	Non – Preferred	
adalimumab-adbm(cd/uc/hs strt) auto-injector kit 40 mg/0.4ml subcutaneous	Preferred	PA
adalimumab-adbm(cd/uc/hs strt) auto-injector kit 40 mg/0.8ml subcutaneous	Non – Preferred	
adalimumab-adbm(ps/uv starter) auto-injector kit 40 mg/0.4ml subcutaneous	Preferred	PA
adalimumab-adbm(ps/uv starter) auto-injector kit 40 mg/0.8ml subcutaneous	Non – Preferred	
adalimumab-fkjp (2 pen)	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
adalimumab-fkjp (2 syringe)	Non – Preferred	
adalimumab-ryvk (2 pen)	Non – Preferred	PA
adalimumab-ryvk (2 syringe)	Non – Preferred	PA
ABRILADA (1 PEN)	Non – Preferred	
ABRILADA (2 PEN)	Non – Preferred	
ABRILADA (2 SYRINGE)	Non – Preferred	
AMJEVITA	Non – Preferred	
AMJEVITA-PED 10KG TO <15KG	Non – Preferred	
AMJEVITA-PED 15KG TO <30KG	Non – Preferred	
CYLTEZO (2 PEN)	Non – Preferred	
CYLTEZO (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.2ML SUBCUTANEOUS	Non – Preferred	PA
CYLTEZO (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.4ML SUBCUTANEOUS	Non – Preferred	PA
CYLTEZO (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS	Non – Preferred	
CYLTEZO-CD/UC/HS STARTER	Non – Preferred	
CYLTEZO-PSORIASIS/UV STARTER	Non – Preferred	
HADLIMA	Non – Preferred	
HADLIMA PUSHTOUCH	Non – Preferred	
HULIO (2 PEN)	Non – Preferred	
HULIO (2 SYRINGE)	Non – Preferred	
HUMIRA (1 PEN)	Non – Preferred	QL (3 EA per 180 days)
HUMIRA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS	Non – Preferred	
HUMIRA (2 PEN) AUTO-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS	Non – Preferred	QL (6 EA per 28 days)
HUMIRA (2 PEN) AUTO-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS	Non – Preferred	QL (3 EA per 180 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS	Non – Preferred	QL (2 EA per 28 days)
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS	Non – Preferred	QL (2 EA per 28 days)
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS	Non – Preferred	
HUMIRA (2 SYRINGE) PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS	Non – Preferred	QL (2 EA per 28 days)
HUMIRA-CD/UC/HS STARTER	Non – Preferred	QL (3 EA per 180 days)
HUMIRA-PSORIASIS/UVEIT STARTER	Non – Preferred	QL (3 EA per 180 days)
HYRIMOZ	Non – Preferred	
HYRIMOZ-CROHNS/UC STARTER	Non – Preferred	
HYRIMOZ-PED<40KG CROHN STARTER	Non – Preferred	
HYRIMOZ-PED>/=40KG CROHN START	Non – Preferred	
HYRIMOZ-PLAQ PSOR/UVEIT START	Non – Preferred	
IDACIO (2 PEN)	Non – Preferred	
IDACIO (2 SYRINGE)	Non – Preferred	
IDACIO-CROHNS/UC STARTER	Non – Preferred	
IDACIO-PSORIASIS STARTER	Non – Preferred	
SIMLANDI (1 PEN)	Preferred	PA
SIMLANDI (1 SYRINGE)	Preferred	PA
SIMLANDI (2 PEN)	Preferred	PA
SIMLANDI (2 SYRINGE)	Preferred	PA
SIMPONI	Non – Preferred	
SIMPONI ARIA	Non – Preferred	
YUFLYMA (1 PEN)	Non – Preferred	
YUFLYMA (2 PEN)	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
YUFLYMA (2 SYRINGE)	Non – Preferred	
YUFLYMA-CD/UC/HS STARTER	Non – Preferred	
YUSIMRY	Non – Preferred	
Cyclooxygenase 2 (Cox-2) Inhibitors - Arthritis And Pain Drugs**		
celecoxib	Preferred	QL (1 EA per 1 day)
CELEBREX	Non – Preferred	QL (1 EA per 1 day)
Gold Compounds - Arthritis And Pain Drugs**		
auranofin	Non – Preferred	
RIDAURA	Non – Preferred	
Interleukin-1 Blockers - Arthritis And Pain Drugs**		
ARCALYST	Non – Preferred	
Interleukin-1 Receptor Antagonist (Il-1Ra) - Arthritis And Pain Drugs**		
KINERET	Non – Preferred	
Interleukin-1Beta Blockers - Arthritis And Pain Drugs**		
ILARIS	Non – Preferred	
Interleukin-6 Receptor Inhibitors - Arthritis And Pain Drugs**		
ACTEMRA	Non – Preferred	
ACTEMRA ACTPEN	Non – Preferred	
KEVZARA	Non – Preferred	
TOFIDENCE	Non – Preferred	
TYENNE	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nonsteroidal Anti-Inflammatory Agent Combinations - Arthritis And Pain Drugs***		
diclofenac-misoprostol	Non – Preferred	
ibuprofen-famotidine	Non – Preferred	QL (4 EA per 1 day)
naproxen-esomeprazole mg	Non – Preferred	
ARTHROTEC	Non – Preferred	
VIMOVO	Non – Preferred	
Nonsteroidal Anti-Inflammatory Agents (Nsaids) - Arthritis And Pain Drugs***		
cvs ibuprofen infants	Preferred	OTC
diclofenac potassium oral capsule	Non – Preferred	
diclofenac potassium tablet 25 mg oral	Non – Preferred	
diclofenac potassium tablet 50 mg oral	Preferred	
diclofenac sodium	Preferred	
diclofenac sodium er	Preferred	
ec-naproxen	Preferred	
etodolac	Preferred	
etodolac er	Preferred	
fenoprofen calcium	Non – Preferred	
flurbiprofen	Preferred	
ibuprofen oral capsule	Preferred	OTC; QL (6 EA per 1 day)
ibuprofen oral suspension	Non – Preferred	
ibuprofen oral tablet 200 mg	Preferred	OTC; QL (6 EA per 1 day)
ibuprofen tablet 400 mg oral	Preferred	
ibuprofen tablet 600 mg oral	Preferred	
ibuprofen tablet 800 mg oral	Preferred	
indomethacin	Preferred	
indomethacin er	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ketoprofen er	Non – Preferred	
ketorolac tromethamine	Preferred	QL (20 EA per 30 days)
meclofenamate sodium	Non – Preferred	
mefenamic acid	Non – Preferred	
meloxicam oral capsule	Non – Preferred	
meloxicam oral tablet	Preferred	QL (1 EA per 1 day)
nabumetone tablet 500 mg oral	Preferred	
nabumetone tablet 500 mg oral	Preferred	QL (4 EA per 1 day)
nabumetone tablet 750 mg oral	Preferred	
nabumetone tablet 750 mg oral	Preferred	QL (4 EA per 1 day)
naproxen	Preferred	
naproxen dr	Preferred	
naproxen sodium	Preferred	
naproxen sodium er	Non – Preferred	
oxaprozin	Non – Preferred	
piroxicam	Non – Preferred	
sulindac	Preferred	
tolmetin sodium	Non – Preferred	
DAYPRO	Non – Preferred	
IBU	Preferred	
LOFENA	Non – Preferred	
MEDI-FIRST IBUPROFEN	Preferred	OTC; QL (6 EA per 1 day)
NALFON	Non – Preferred	
NAPRELAN	Non – Preferred	
RELAFEN DS	Non – Preferred	
Phosphodiesterase 4 (Pde4) Inhibitors - Arthritis And Pain Drugs***		
OTEZLA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pyrimidine Synthesis Inhibitors - Arthritis And Pain Drugs***		
leflunomide	Preferred	QL (1 EA per 1 day)
ARAVA	Non – Preferred	QL (1 EA per 1 day)
Selective Costimulation Modulators - Arthritis And Pain Drugs***		
ORENCIA	Non – Preferred	
ORENCIA CLICKJECT	Non – Preferred	
Soluble Tumor Necrosis Factor Receptor Agents - Arthritis And Pain Drugs***		
ENBREL MINI	Preferred	PA; QL (4 PEN per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	Preferred	PA
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	Preferred	PA; QL (4 ML per 28 days)
ENBREL SURECLICK	Preferred	PA; QL (4 ML per 28 days)
***Analgesics - Nonnarcotic* - Drugs For Pain And Fever**		
Analgesics - Selective Nav1.8 Sodium Channel Inhibitors - Drugs For Pain And Fever***		
JOURNAVX	Non – Preferred	
Analgesics Other - Arthritis And Pain Drugs***		
acetaminophen	Preferred	OTC
acetaminophen childrens	Preferred	OTC
acetaminophen extra strength	Preferred	OTC
pain relief extra strength	Preferred	OTC
pain reliever	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHILDRENS MEDI-TABS	Preferred	OTC
Analgesics-Sedatives - Arthritis And Pain Drugs**		
butalbital-acetaminophen oral capsule	Non – Preferred	
butalbital-acetaminophen tablet 50-300 mg oral	Preferred	
butalbital-acetaminophen tablet 50-325 mg oral	Preferred	QL (6 EA per 1 day)
butalbital-apap-caffeine capsule 50-300-40 mg oral	Preferred	
butalbital-apap-caffeine capsule 50-325-40 mg oral	Preferred	QL (6 EA per 1 day)
butalbital-apap-caffeine oral tablet	Preferred	QL (6 EA per 1 day)
butalbital-aspirin-caffeine	Preferred	QL (6 EA per 1 day)
BAC (BUTALBITAL-ACETAMIN-CAFF)	Preferred	QL (6 EA per 1 day)
ESGIC	Non – Preferred	QL (6 EA per 1 day)
FIORICET	Non – Preferred	
Salicylate Combinations - Arthritis And Pain Drugs**		
aspirin buf(cacarb-mgcarb-mgo)	Preferred	OTC
Salicylates - Arthritis And Pain Drugs**		
aspirin 81	Preferred	OTC
diflunisal	Preferred	
salsalate	Preferred	
DOLOBID	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Analgesics - Opioid* - Drugs For Pain And Fever**		
****Codeine Combinations*** - Arthritis And Pain Drugs***		
acetaminophen-codeine oral solution	Preferred	QL (20 ML per 1 day); AL (Min 18 Years)
acetaminophen-codeine oral tablet	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
butalbital-apap-caff-cod	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
butalbital-asa-caff-codeine	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
ASCOMP-CODEINE	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
FIORICET/CODEINE	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
****Dihydrocodeine Combinations*** - Arthritis And Pain Drugs***		
apap-caff-dihydrocodeine	Non – Preferred	
****Hydrocodone Combinations*** - Arthritis And Pain Drugs***		
hydrocodone-acetaminophen solution 10-325 mg/15ml oral	Preferred	
hydrocodone-acetaminophen solution 2.5-108 mg/5ml oral	Preferred	QL (40 ML per 1 day)
hydrocodone-acetaminophen solution 5-217 mg/10ml oral	Preferred	QL (40 ML per 1 day)
hydrocodone-acetaminophen solution 7.5-325 mg/15ml oral	Preferred	QL (40 ML per 1 day)
hydrocodone-acetaminophen tablet 10-300 mg oral	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrocodone-acetaminophen tablet 10-325 mg oral	Preferred	QL (4 EA per 1 day)
hydrocodone-acetaminophen tablet 10-325 mg oral	Preferred	
hydrocodone-acetaminophen tablet 2.5-325 mg oral	Preferred	
hydrocodone-acetaminophen tablet 5-300 mg oral	Preferred	
hydrocodone-acetaminophen tablet 5-325 mg oral	Preferred	QL (4 EA per 1 day)
hydrocodone-acetaminophen tablet 5-325 mg oral	Preferred	
hydrocodone-acetaminophen tablet 7.5-300 mg oral	Preferred	
hydrocodone-acetaminophen tablet 7.5-325 mg oral	Preferred	QL (4 EA per 1 day)
hydrocodone-acetaminophen tablet 7.5-325 mg oral	Preferred	
hydrocodone-ibuprofen tablet 10-200 mg oral	Preferred	
hydrocodone-ibuprofen tablet 5-200 mg oral	Preferred	
hydrocodone-ibuprofen tablet 7.5-200 mg oral	Preferred	QL (4 EA per 1 day)
Opioid Agonists - Arthritis And Pain Drugs**		
codeine sulfate	Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
fentanyl	Non – Preferred	
hydrocodone bitartrate er	Non – Preferred	
hydromorphone hcl er	Non – Preferred	
hydromorphone hcl oral liquid	Preferred	
hydromorphone hcl rectal	Preferred	QL (4 EA per 1 day)
hydromorphone hcl tablet 2 mg oral	Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydromorphone hcl tablet 4 mg oral	Preferred	QL (4 EA per 1 day)
hydromorphone hcl tablet 8 mg oral	Preferred	QL (2 EA per 1 day)
levorphanol tartrate	Non – Preferred	
meperidine hcl	Non – Preferred	
methadone hcl oral concentrate	Non – Preferred	QL (3 EA per 1 day)
methadone hcl oral tablet soluble	Non – Preferred	
methadone hcl solution 10 mg/5ml oral	Non – Preferred	QL (15 ML per 1 day)
methadone hcl solution 5 mg/5ml oral	Non – Preferred	
methadone hcl solution 5 mg/5ml oral	Non – Preferred	QL (30 ML per 1 day)
methadone hcl tablet 10 mg oral	Non – Preferred	QL (3 EA per 1 day)
methadone hcl tablet 5 mg oral	Non – Preferred	QL (6 EA per 1 day)
morphine sulfate (concentrate) solution 100 mg/5ml oral	Preferred	QL (4.5 ML per 1 day)
morphine sulfate (concentrate) solution 20 mg/ml oral	Preferred	
morphine sulfate er beads	Non – Preferred	
morphine sulfate er oral capsule extended release 24 hour	Non – Preferred	
morphine sulfate er tablet extended release 100 mg oral	Preferred	PA; QL (1 EA per 1 day)
morphine sulfate er tablet extended release 15 mg oral	Preferred	PA; QL (6 EA per 1 day)
morphine sulfate er tablet extended release 200 mg oral	Preferred	PA; QL (1 EA per 1 day)
morphine sulfate er tablet extended release 30 mg oral	Preferred	PA
morphine sulfate er tablet extended release 60 mg oral	Preferred	PA; QL (1 EA per 1 day)
morphine sulfate oral solution	Preferred	QL (45 ML per 1 day)
morphine sulfate suppository 10 mg rectal	Preferred	QL (4 EA per 1 day)
morphine sulfate suppository 20 mg rectal	Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
morphine sulfate suppository 30 mg rectal	Preferred	QL (3 EA per 1 day)
morphine sulfate suppository 5 mg rectal	Preferred	QL (4 EA per 1 day)
morphine sulfate tablet 15 mg oral	Preferred	QL (4 EA per 1 day)
morphine sulfate tablet 30 mg oral	Preferred	QL (3 EA per 1 day)
oxycodone hcl concentrate 100 mg/5ml oral	Preferred	
oxycodone hcl concentrate 100 mg/5ml oral	Preferred	QL (6 ML per 1 day)
oxycodone hcl oral capsule	Preferred	QL (4 EA per 1 day)
oxycodone hcl solution 5 mg/5ml oral	Preferred	
oxycodone hcl solution 5 mg/5ml oral	Preferred	QL (60 ML per 1 day)
oxycodone hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
oxycodone hcl tablet 15 mg oral	Preferred	QL (4 EA per 1 day)
oxycodone hcl tablet 20 mg oral	Preferred	QL (3 EA per 1 day)
oxycodone hcl tablet 30 mg oral	Preferred	QL (4 EA per 1 day)
oxycodone hcl tablet 5 mg oral	Preferred	QL (4 EA per 1 day)
oxymorphone hcl	Non – Preferred	
oxymorphone hcl er	Non – Preferred	QL (2 EA per 1 day)
tramadol hcl (er biphasic)	Non – Preferred	AL (Min 18 Years)
tramadol hcl er	Non – Preferred	AL (Min 18 Years)
tramadol hcl oral solution	Non – Preferred	AL (Min 18 Years)
tramadol hcl tablet 100 mg oral	Non – Preferred	AL (Min 18 Years)
tramadol hcl tablet 100 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 18 Years)
tramadol hcl tablet 25 mg oral	Non – Preferred	AL (Min 18 Years)
tramadol hcl tablet 50 mg oral	Preferred	
tramadol hcl tablet 50 mg oral	Preferred	QL (8 EA per 1 day); AL (Min 18 Years)
tramadol hcl tablet 75 mg oral	Preferred	AL (Min 18 Years)
CONZIP	Non – Preferred	AL (Min 18 Years)
DILAUDID ORAL LIQUID	Non – Preferred	
DILAUDID TABLET 2 MG ORAL	Non – Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DILAUDID TABLET 4 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
DILAUDID TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
HYSINGLA ER	Non – Preferred	
METHADONE HCL INTENSOL	Non – Preferred	QL (3 ML per 1 day)
METHADOSE ORAL CONCENTRATE	Non – Preferred	QL (3 ML per 1 day)
METHADOSE ORAL TABLET SOLUBLE	Non – Preferred	
METHADOSE SUGAR-FREE	Non – Preferred	QL (3 ML per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 100 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 15 MG ORAL	Non – Preferred	PA; QL (6 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 200 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 30 MG ORAL	Non – Preferred	PA
MS CONTIN TABLET EXTENDED RELEASE 60 MG ORAL	Non – Preferred	PA; QL (1 EA per 1 day)
NUCYNTA ER	Non – Preferred	
OXYCONTIN	Non – Preferred	
ROXICODONE	Non – Preferred	QL (4 EA per 1 day)
ROXYBOND	Non – Preferred	
Opioid Combinations - Arthritis And Pain Drugs**		
benzhydrocodone-acetaminophen	Non – Preferred	
nalocet	Non – Preferred	
oxycodone-acetaminophen oral solution	Preferred	
oxycodone-acetaminophen oral tablet	Preferred	QL (4 EA per 1 day)
APADAZ	Non – Preferred	
ENDOCET	Preferred	QL (4 EA per 1 day)
PERCOCET	Non – Preferred	QL (4 EA per 1 day)
PROLATE	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Opioid Partial Agonists - Arthritis And Pain Drugs**		
buprenorphine hcl	Preferred	
buprenorphine hcl-naloxone hcl	Preferred	
buprenorphine patch weekly 10 mcg/hr transdermal	Non – Preferred	QL (4 EA per 28 days)
buprenorphine patch weekly 15 mcg/hr transdermal	Non – Preferred	QL (4 EA per 28 days)
buprenorphine patch weekly 20 mcg/hr transdermal	Non – Preferred	QL (4 EA per 28 days)
buprenorphine patch weekly 5 mcg/hr transdermal	Non – Preferred	QL (4 EA per 28 days)
buprenorphine patch weekly 7.5 mcg/hr transdermal	Non – Preferred	QL (4 EA per 28 days)
butorphanol tartrate	Non – Preferred	QL (2.5 ML per 30 days)
pentazocine-naloxone hcl	Non – Preferred	QL (4 EA per 1 day)
BELBUCA	Non – Preferred	
BRIXADI	Preferred	
BRIXADI (WEEKLY)	Preferred	
BUTRANS	Non – Preferred	QL (4 EA per 28 days)
SUBLOCADE	Preferred	
SUBOXONE	Preferred	
ZUBSOLV	Preferred	
Tramadol Combinations - Arthritis And Pain Drugs**		
tramadol-acetaminophen	Non – Preferred	AL (Min 18 Years)
***Androgens-Anabolic* - Hormones**		
Androgens - Drugs For Men**		
testosterone cypionate	Preferred	PA; QL (10 ML per 90 days)
testosterone enanthate	Preferred	PA; QL (5 ML per 60 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
testosterone transdermal gel	Preferred	PA; QL (5 GM per 1 day)
testosterone transdermal solution	Preferred	PA; QL (6 ML per 1 day)
***Anorectal And Related Products* - Rectal Preparations**		
****Intrarectal Steroids*** - Rectal Preparations***		
budesonide	Non – Preferred	
hydrocortisone	Preferred	
CORTENEMA	Non – Preferred	
CORTIFOAM	Non – Preferred	
UCERIS	Non – Preferred	
****Nitrate Vasodilating Agents*** - Rectal Preparations***		
RECTIV	Non – Preferred	
****Rectal Anesthetic/Steroids*** - Rectal Preparations***		
lidocaine-hydrocort (perianal)	Non – Preferred	
lidocaine-hydrocortisone ace	Non – Preferred	
ANA-LEX	Non – Preferred	
LIDOCORT	Non – Preferred	
PROCTOFOAM HC	Non – Preferred	
****Rectal Combinations - Misc.*** - Rectal Preparations***		
hemorrhoidal	Preferred	OTC
PREPARATION H	Preferred	OTC
****Rectal Local Anesthetics*** - Rectal Preparations***		
pramoxine hcl (perianal)	Preferred	OTC
PROCTOFOAM	Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Rectal Steroids - Rectal Preparations***		
hydrocortisone (perianal)	Preferred	
hydrocortisone acetate	Non – Preferred	
ANUSOL-HC	Non – Preferred	
PROCTO-MED HC	Preferred	
PROCTOSOL HC	Preferred	
PROCTOZONE-HC	Preferred	
***Antacids* - Drugs For The Stomach**		
Antacids - Aluminum Salts - Drugs For Ulcers And Stomach Acid***		
aluminum hydroxide gel	Preferred	OTC
Antacids - Bicarbonate - Drugs For Ulcers And Stomach Acid***		
sodium bicarbonate	Preferred	OTC
Antacids - Calcium Salts - Drugs For Ulcers And Stomach Acid***		
calcium carbonate antacid	Preferred	OTC
Antacids - Magnesium Salts - Drugs For Ulcers And Stomach Acid***		
magnesium oxide	Preferred	OTC
***Anthelmintics* - Drugs For Infections**		
Anthelmintics - Drugs For Parasites***		
albendazole	Non – Preferred	
benznidazole	Non – Preferred	
ivermectin	Non – Preferred	
praziquantel	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BILTRICIDE	Non – Preferred	
EGATEN	Non – Preferred	
EMVERM	Non – Preferred	
STROMECTOL	Non – Preferred	
***Antianginal Agents* - Drugs For The Heart**		
****Antianginals-Other*** - Drugs For Angina***		
ranolazine er	Non – Preferred	
ASPRUZYO SPRINKLE	Non – Preferred	
****Nitrates*** - Drugs For Angina***		
isosorbide dinitrate	Preferred	
isosorbide mononitrate	Preferred	
isosorbide mononitrate er tablet extended release 24 hour 120 mg oral	Preferred	QL (2 EA per 1 day)
isosorbide mononitrate er tablet extended release 24 hour 30 mg oral	Preferred	
isosorbide mononitrate er tablet extended release 24 hour 30 mg oral	Preferred	QL (1 EA per 1 day)
isosorbide mononitrate er tablet extended release 24 hour 60 mg oral	Preferred	QL (1 EA per 1 day)
nitroglycerin sublingual	Preferred	
nitroglycerin transdermal	Preferred	
nitroglycerin translingual	Non – Preferred	
ISORDIL TITRADOSE	Non – Preferred	
NITRO-BID	Preferred	
NITRO-DUR	Non – Preferred	
NITROLINGUAL	Non – Preferred	
NITROSTAT	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antianxiety Agents* - Drugs For The Nervous System**		
****Antianxiety Agents - Misc.*** - Drugs For Anxiety***		
buspirone hcl tablet 10 mg oral	Preferred	
buspirone hcl tablet 10 mg oral	Preferred	QL (6 EA per 1 day)
buspirone hcl tablet 15 mg oral	Preferred	QL (4 EA per 1 day)
buspirone hcl tablet 30 mg oral	Preferred	
buspirone hcl tablet 5 mg oral	Preferred	QL (12 EA per 1 day)
buspirone hcl tablet 7.5 mg oral	Preferred	QL (8 EA per 1 day)
hydroxyzine hcl oral syrup	Preferred	
hydroxyzine hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
hydroxyzine hcl tablet 25 mg oral	Preferred	
hydroxyzine hcl tablet 25 mg oral	Preferred	QL (4 EA per 1 day)
hydroxyzine hcl tablet 50 mg oral	Preferred	QL (8 EA per 1 day)
hydroxyzine pamoate	Preferred	QL (4 EA per 1 day)
meprobamate	Non – Preferred	
****Benzodiazepines*** - Drugs For Seizures /Personality Disorder/Nerve Pain***		
alprazolam er	Non – Preferred	QL (2 EA per 1 day)
alprazolam oral tablet dispersible	Non – Preferred	
alprazolam tablet 0.25 mg oral	Preferred	QL (4 EA per 1 day)
alprazolam tablet 0.5 mg oral	Preferred	QL (4 EA per 1 day)
alprazolam tablet 1 mg oral	Preferred	QL (6 EA per 1 day)
alprazolam tablet 2 mg oral	Preferred	QL (5 EA per 1 day)
alprazolam xr	Non – Preferred	QL (2 EA per 1 day)
chlordiazepoxide hcl capsule 10 mg oral	Preferred	QL (4 EA per 1 day)
chlordiazepoxide hcl capsule 25 mg oral	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
chlordiazepoxide hcl capsule 25 mg oral	Preferred	QL (12 EA per 1 day)
chlordiazepoxide hcl capsule 5 mg oral	Preferred	QL (4 EA per 1 day)
clorazepate dipotassium tablet 15 mg oral	Preferred	QL (3 EA per 1 day)
clorazepate dipotassium tablet 3.75 mg oral	Preferred	QL (2 EA per 1 day)
clorazepate dipotassium tablet 7.5 mg oral	Preferred	QL (3 EA per 1 day)
diazepam oral concentrate	Preferred	QL (10 ML per 1 day)
diazepam oral solution	Preferred	QL (10 ML per 1 day)
diazepam oral tablet	Preferred	QL (4 EA per 1 day)
lorazepam oral concentrate	Preferred	QL (2 ML per 1 day)
lorazepam tablet 0.5 mg oral	Preferred	
lorazepam tablet 0.5 mg oral	Preferred	QL (4 EA per 1 day)
lorazepam tablet 1 mg oral	Preferred	
lorazepam tablet 1 mg oral	Preferred	QL (6 EA per 1 day)
lorazepam tablet 2 mg oral	Preferred	
lorazepam tablet 2 mg oral	Preferred	QL (5 EA per 1 day)
oxazepam	Preferred	QL (4 EA per 1 day)
ALPRAZOLAM INTENSOL	Preferred	
ATIVAN TABLET 0.5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
ATIVAN TABLET 1 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
ATIVAN TABLET 2 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
DIAZEPAM INTENSOL	Preferred	QL (10 ML per 1 day)
LORAZEPAM INTENSOL	Preferred	QL (2 ML per 1 day)
LOREEV XR	Non – Preferred	
XANAX TABLET 0.25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
XANAX TABLET 0.5 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
XANAX TABLET 1 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
XANAX TABLET 2 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
XANAX XR	Non – Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antiarrhythmics* - Drugs For The Heart**		
****Antiarrhythmics Type I-A*** - Drugs For Abnormal Heart Rhythms***		
disopyramide phosphate	Preferred	
quinidine gluconate er	Preferred	
quinidine sulfate	Preferred	
NORPACE	Non – Preferred	
NORPACE CR	Preferred	
****Antiarrhythmics Type I-B*** - Drugs For Abnormal Heart Rhythms***		
mexiletine hcl	Preferred	
****Antiarrhythmics Type I-C*** - Drugs For Abnormal Heart Rhythms***		
flecainide acetate	Preferred	
propafenone hcl	Preferred	
propafenone hcl er	Non – Preferred	
****Antiarrhythmics Type Iii*** - Drugs For Abnormal Heart Rhythms***		
amiodarone hcl	Preferred	
dofetilide	Preferred	
MULTAQ	Non – Preferred	QL (2 EA per 1 day)
PACERONE	Preferred	
TIKOSYN	Non – Preferred	
***Antiasthmatic And Bronchodilator Agents* - Drugs For The Lungs**		
****5-Lipoxygenase Inhibitors*** - Drugs For Asthma/Copd***		
zileuton er	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYFLO	Non – Preferred	
Adrenergic Combinations - Drugs For Asthma/Copd**		
budesonide-formoterol fumarate	Non – Preferred	QL (10.3 GM per 20 days)
fluticasone furoate-vilanterol aerosol powder breath activated 100-25 mcg/act inhalation	Non – Preferred	
fluticasone furoate-vilanterol aerosol powder breath activated 200-25 mcg/act inhalation	Non – Preferred	QL (1 Pack per 30 days)
fluticasone-salmeterol aerosol powder breath activated 100-50 mcg/act inhalation	Non – Preferred	QL (2 EA per 1 day)
fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation	Non – Preferred	
fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation	Non – Preferred	
fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/act inhalation	Non – Preferred	QL (2 EA per 1 day)
fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/act inhalation	Non – Preferred	QL (2 EA per 1 day)
fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation	Non – Preferred	
fluticasone-salmeterol inhalation aerosol	Non – Preferred	
ipratropium-albuterol	Preferred	QL (18 ML per 1 day)
ADVAIR DISKUS	Preferred	QL (2 EA per 1 day)
ADVAIR HFA	Preferred	
AIRDUO RESPICLICK 113/14	Preferred	
AIRDUO RESPICLICK 232/14	Preferred	
AIRDUO RESPICLICK 55/14	Preferred	
AIRSUPRA	Preferred	
ANORO ELLIPTA	Preferred	
BEVESPI AEROSPHERE	Non – Preferred	QL (10.7 GM per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT INHALATION	Non – Preferred	QL (60 GM per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT INHALATION	Non – Preferred	QL (1 Pack per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH INHALATION	Non – Preferred	
BREYNA	Non – Preferred	QL (10.3 GM per 20 days)
BREZTRI AEROSPHERE	Non – Preferred	
COMBIVENT RESPIMAT	Non – Preferred	QL (8 GM per 28 days)
DUAKLIR PRESSAIR	Non – Preferred	
DULERA AEROSOL 100-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 200-5 MCG/ACT INHALATION	Preferred	QL (13 GM Max Qty Per Fill Retail)
DULERA AEROSOL 50-5 MCG/ACT INHALATION	Preferred	
STIOLTO RESPIMAT	Non – Preferred	QL (1 CANISTER per 28 days)
SYMBICORT	Preferred	QL (10.3 GM per 20 days)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT INHALATION	Non – Preferred	
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT INHALATION	Non – Preferred	
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIXELA INHUB AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/ACT INHALATION	Non – Preferred	QL (2 EA per 1 day)
Anti-Ige Monoclonal Antibodies - Drugs For Asthma/Copd***		
XOLAIR	Preferred	PA
Anti-Inflammatory Agents - Drugs For Asthma/Copd***		
cromolyn sodium	Preferred	
Beta Adrenergics - Drugs For Asthma/Copd***		
albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation	Preferred	QL (36 GM per 30 days)
albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution 0.63 mg/3ml inhalation	Preferred	
albuterol sulfate nebulization solution 0.63 mg/3ml inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution 1.25 mg/3ml inhalation	Preferred	
albuterol sulfate nebulization solution 1.25 mg/3ml inhalation	Preferred	QL (12 ML per 1 day)
albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation	Preferred	QL (2 ML per 1 day)
albuterol sulfate oral	Non – Preferred	
arformoterol tartrate	Non – Preferred	
formoterol fumarate	Non – Preferred	
levalbuterol hcl	Non – Preferred	
levalbuterol tartrate	Non – Preferred	QL (30 GM per 30 days)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
terbutaline sulfate	Preferred	
BROVANA	Non – Preferred	
PERFOROMIST	Non – Preferred	
PROAIR RESPICLICK	Non – Preferred	
SEREVENT DISKUS	Preferred	QL (2 EA per 1 day)
STRIVERDI RESPIMAT	Non – Preferred	QL (4 GM per 28 days)
VENTOLIN HFA	Non – Preferred	QL (36 GM per 30 days)
XOPENEX HFA AEROSOL 45 MCG/ACT INHALATION	Non – Preferred	QL (30 GM per 30 days)
Bronchodilators - Anticholinergics - Drugs For Asthma/Copd**		
ipratropium bromide	Preferred	
tiotropium bromide monohydrate	Preferred	
ATROVENT HFA	Preferred	QL (26 GM per 30 days)
INCRUSE ELLIPTA	Preferred	
SPIRIVA HANDIHALER	Preferred	
SPIRIVA RESPIMAT	Preferred	
TUDORZA PRESSAIR	Non – Preferred	
YUPELRI	Non – Preferred	
Interleukin-5 Antagonists (Igg1 Kappa) - Drugs For Asthma/Copd**		
FASENRA	Preferred	PA
FASENRA PEN	Preferred	PA
NUCALA	Preferred	PA
Interleukin-5 Antagonists (Igg4 Kappa) - Drugs For Asthma/Copd**		
CINQAIR SOLUTION 100 MG/10ML INTRAVENOUS	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CINQAIR SOLUTION 100 MG/10ML INTRAVENOUS	Preferred	PA
Leukotriene Receptor Antagonists - Drugs For Asthma/Copd**		
montelukast sodium	Preferred	QL (1 EA per 1 day)
zafirlukast	Preferred	QL (2 EA per 1 day)
ACCOLATE	Non – Preferred	QL (2 EA per 1 day)
SINGULAIR	Non – Preferred	QL (1 EA per 1 day)
Selective Phosphodiesterase 4 (Pde4) Inhibitors - Drugs For Asthma/Copd**		
roflumilast	Non – Preferred	
DALIRESP	Non – Preferred	
Steroid Inhalants - Drugs For Asthma/Copd**		
budesonide suspension 0.25 mg/2ml inhalation	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
budesonide suspension 0.5 mg/2ml inhalation	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
budesonide suspension 1 mg/2ml inhalation	Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
fluticasone propionate diskus	Preferred	
fluticasone propionate hfa aerosol 110 mcg/act inhalation	Preferred	QL (0.4 GM per 1 day)
fluticasone propionate hfa aerosol 220 mcg/act inhalation	Preferred	QL (0.4 GM per 1 day)
fluticasone propionate hfa aerosol 44 mcg/act inhalation	Preferred	QL (0.3534 GM per 1 day)
ALVESCO	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION	Preferred	
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200 MCG/ACT INHALATION	Preferred	
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION	Preferred	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	Non – Preferred	QL (1 EA per 1 day)
ASMANEX (120 METERED DOSES)	Preferred	
ASMANEX (14 METERED DOSES)	Preferred	
ASMANEX (30 METERED DOSES)	Preferred	
ASMANEX (60 METERED DOSES)	Preferred	
ASMANEX HFA	Non – Preferred	
PULMICORT	Non – Preferred	QL (120 ML per 30 days); AL (Max 7 Years)
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT INHALATION	Preferred	
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 90 MCG/ACT INHALATION	Non – Preferred	
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 90 MCG/ACT INHALATION	Preferred	
QVAR REDIHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION	Non – Preferred	QL (0.3533 GM per 1 day)
QVAR REDIHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Thymic Stromal Lymphopoietin (Tslp) Antagonists - Drugs For Asthma/Copd***		
TEZSPIRE	Preferred	PA
Xanthines - Drugs For Asthma/Copd***		
theophylline	Preferred	
theophylline er	Preferred	
THEO-24	Preferred	
***Anticoagulants* - Drugs For The Blood**		
Coumarin Anticoagulants - Drugs To Prevent Blood Clots***		
warfarin sodium	Preferred	
JANTOVEN	Preferred	
Direct Factor Xa Inhibitors - Drugs To Prevent Blood Clots***		
ELIQUIS	Preferred	QL (2 EA per 1 day)
ELIQUIS DVT/PE STARTER PACK	Preferred	QL (74 EA per 30 days)
SAVAYSA	Non – Preferred	
XARELTO ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
XARELTO STARTER PACK	Preferred	QL (51 EA per 30 days)
XARELTO TABLET 10 MG ORAL	Preferred	
XARELTO TABLET 15 MG ORAL	Preferred	QL (1 EA per 1 day)
XARELTO TABLET 2.5 MG ORAL	Preferred	
XARELTO TABLET 20 MG ORAL	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Heparins And Heparinoid-Like Agents - Drugs To Prevent Blood Clots***		
heparin na (pork) lock flsh pf	Preferred	
heparin sod (pork) lock flush	Preferred	
heparin sodium (porcine)	Preferred	
heparin sodium (porcine) pf	Preferred	
Low Molecular Weight Heparins - Drugs To Prevent Blood Clots***		
enoxaparin sodium	Preferred	
FRAGMIN	Preferred	
LOVENOX	Non – Preferred	
Synthetic Heparinoid-Like Agents - Drugs To Prevent Blood Clots***		
fondaparinux sodium	Preferred	
ARIXTRA	Non – Preferred	
Thrombin Inhibitors - Selective Direct & Reversible - Drugs To Prevent Blood Clots***		
dabigatran etexilate mesylate	Non – Preferred	
PRADAXA	Non – Preferred	
***Anticonvulsants* - Drugs For The Nervous System**		
Ampa Glutamate Receptor Antagonists - Drugs For Seizures /Personality Disorder/Nerve Pain***		
FYCOMPA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticonvulsants - Benzodiazepines - Drugs For Seizures /Personality Disorder/Nerve Pain***		
clobazam	Non – Preferred	
clonazepam oral tablet	Preferred	
clonazepam oral tablet dispersible	Non – Preferred	
diazepam	Preferred	QL (2 EA Max Qty Per Fill Retail)
KLONOPIN	Non – Preferred	
NAYZILAM	Non – Preferred	
ONFI	Non – Preferred	
SYMPAZAN	Non – Preferred	
VALTOCO 10 MG DOSE	Non – Preferred	
VALTOCO 15 MG DOSE	Non – Preferred	
VALTOCO 20 MG DOSE	Non – Preferred	
VALTOCO 5 MG DOSE	Non – Preferred	
Anticonvulsants - Misc. - Drugs For Seizures /Personality Disorder/Nerve Pain***		
carbamazepine	Preferred	
carbamazepine er oral capsule extended release 12 hour	Non – Preferred	QL (4 EA per 1 day)
carbamazepine er tablet extended release 12 hour 100 mg oral	Preferred	
carbamazepine er tablet extended release 12 hour 100 mg oral	Preferred	QL (10 EA per 1 day)
carbamazepine er tablet extended release 12 hour 200 mg oral	Preferred	
carbamazepine er tablet extended release 12 hour 200 mg oral	Preferred	QL (5 EA per 1 day)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
carbamazepine er tablet extended release 12 hour 400 mg oral	Preferred	
carbamazepine er tablet extended release 12 hour 400 mg oral	Preferred	QL (2 EA per 1 day)
gabapentin oral capsule	Preferred	QL (6 EA per 1 day)
gabapentin oral solution	Preferred	
gabapentin tablet 600 mg oral	Preferred	
gabapentin tablet 600 mg oral	Preferred	QL (6 EA per 1 day)
gabapentin tablet 800 mg oral	Preferred	QL (4.5 EA per 1 day)
lacosamide	Non – Preferred	
lamotrigine er	Non – Preferred	
lamotrigine oral kit	Non – Preferred	
lamotrigine oral tablet dispersible	Non – Preferred	
lamotrigine starter kit-blue	Non – Preferred	
lamotrigine starter kit-green	Non – Preferred	
lamotrigine starter kit-orange	Non – Preferred	
lamotrigine tablet 100 mg oral	Preferred	
lamotrigine tablet 150 mg oral	Preferred	
lamotrigine tablet 200 mg oral	Preferred	QL (2 EA per 1 day)
lamotrigine tablet 25 mg oral	Preferred	QL (6 EA per 1 day)
lamotrigine tablet chewable 25 mg oral	Preferred	QL (6 EA per 1 day)
lamotrigine tablet chewable 5 mg oral	Preferred	QL (8 EA per 1 day)
levetiracetam er tablet extended release 24 hour 500 mg oral	Preferred	QL (6 EA per 1 day)
levetiracetam er tablet extended release 24 hour 750 mg oral	Preferred	QL (4 EA per 1 day)
levetiracetam oral solution	Preferred	
levetiracetam tablet 1000 mg oral	Preferred	QL (3 EA per 1 day)
levetiracetam tablet 250 mg oral	Preferred	QL (4 EA per 1 day)
levetiracetam tablet 500 mg oral	Preferred	QL (6 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levetiracetam tablet 750 mg oral	Preferred	QL (4 EA per 1 day)
oxcarbazepine	Preferred	
oxcarbazepine er	Preferred	
pregabalin	Preferred	
primidone	Preferred	
rufinamide	Non – Preferred	
topiramate capsule sprinkle 15 mg oral	Preferred	QL (4 EA per 1 day)
topiramate capsule sprinkle 25 mg oral	Preferred	QL (4 EA per 1 day)
topiramate capsule sprinkle 50 mg oral	Preferred	
topiramate er	Non – Preferred	
topiramate tablet 100 mg oral	Preferred	QL (4 EA per 1 day)
topiramate tablet 200 mg oral	Preferred	QL (2 EA per 1 day)
topiramate tablet 25 mg oral	Preferred	QL (4 EA per 1 day)
topiramate tablet 50 mg oral	Preferred	QL (4 EA per 1 day)
zonisamide	Preferred	QL (6 EA per 1 day)
APTIOM	Non – Preferred	
BANZEL	Non – Preferred	
BRIVIACT	Non – Preferred	
CARBATROL	Non – Preferred	QL (4 EA per 1 day)
DIACOMIT	Non – Preferred	
ELEPSIA XR	Non – Preferred	
EPIDIOLEX	Non – Preferred	
EPITOL	Preferred	
EPRONTIA	Non – Preferred	
FINTEPLA	Non – Preferred	
KEPPRA ORAL SOLUTION	Non – Preferred	
KEPPRA TABLET 1000 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
KEPPRA TABLET 250 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
KEPPRA TABLET 500 MG ORAL	Non – Preferred	QL (6 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KEPPRA TABLET 750 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
LAMICTAL ODT	Non – Preferred	
LAMICTAL STARTER	Non – Preferred	
LAMICTAL TABLET 100 MG ORAL	Non – Preferred	
LAMICTAL TABLET 150 MG ORAL	Non – Preferred	
LAMICTAL TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
LAMICTAL TABLET 25 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
LAMICTAL TABLET CHEWABLE 25 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
LAMICTAL TABLET CHEWABLE 5 MG ORAL	Non – Preferred	QL (8 EA per 1 day)
LAMICTAL XR	Non – Preferred	
LYRICA	Non – Preferred	
MOTPOLY XR	Non – Preferred	
MYSOLINE	Non – Preferred	
NEURONTIN ORAL CAPSULE	Non – Preferred	QL (6 EA per 1 day)
NEURONTIN ORAL SOLUTION	Non – Preferred	
NEURONTIN TABLET 600 MG ORAL	Non – Preferred	QL (6 EA per 1 day)
NEURONTIN TABLET 800 MG ORAL	Non – Preferred	QL (4.5 EA per 1 day)
OXTELLAR XR	Non – Preferred	
QUDEXY XR	Non – Preferred	
ROWEEPRA	Preferred	QL (6 EA per 1 day)
SPRITAM	Non – Preferred	
SUBVENITE STARTER KIT-BLUE	Non – Preferred	
SUBVENITE STARTER KIT-GREEN	Non – Preferred	
SUBVENITE STARTER KIT-ORANGE	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUBVENITE TABLET 100 MG ORAL	Preferred	
SUBVENITE TABLET 150 MG ORAL	Preferred	
SUBVENITE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
SUBVENITE TABLET 25 MG ORAL	Preferred	QL (6 EA per 1 day)
TEGRETOL	Non – Preferred	
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL	Non – Preferred	QL (10 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (5 EA per 1 day)
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX SPRINKLE	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 100 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPAMAX TABLET 25 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TOPAMAX TABLET 50 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
TRILEPTAL	Non – Preferred	
TROKENDI XR	Non – Preferred	
VIMPAT	Non – Preferred	
ZONISADE	Non – Preferred	
ZTALMY	Non – Preferred	
****Carbamates*** - Drugs For Seizures /Personality Disorder/Nerve Pain***		
felbamate	Non – Preferred	
FELBATOL	Non – Preferred	
XCOPRI	Preferred	
XCOPRI (250 MG DAILY DOSE)	Preferred	
XCOPRI (350 MG DAILY DOSE)	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gaba Modulators - Drugs For Seizures /Personality Disorder/Nerve Pain***		
tiagabine hcl tablet 12 mg oral	Non – Preferred	QL (4 EA per 1 day)
tiagabine hcl tablet 16 mg oral	Non – Preferred	QL (3 EA per 1 day)
tiagabine hcl tablet 2 mg oral	Non – Preferred	QL (1 EA per 1 day)
tiagabine hcl tablet 4 mg oral	Non – Preferred	QL (4 EA per 1 day)
vigabatrin	Non – Preferred	
SABRIL	Non – Preferred	
VIGADRONE	Non – Preferred	
Hydantoins - Drugs For Seizures /Personality Disorder/Nerve Pain***		
phenytoin	Preferred	
phenytoin sodium extended	Preferred	
DILANTIN	Non – Preferred	
DILANTIN INFATABS	Non – Preferred	
PHENYTEK	Preferred	
PHENYTOIN INFATABS	Preferred	
Succinimides - Drugs For Seizures /Personality Disorder/Nerve Pain***		
ethosuximide	Preferred	
methsuximide	Non – Preferred	
CELONTIN	Non – Preferred	
ZARONTIN	Non – Preferred	
Valproic Acid - Drugs For Seizures /Personality Disorder/Nerve Pain***		
divalproex sodium	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
divalproex sodium er	Preferred	
valproic acid	Preferred	
DEPAKOTE	Non – Preferred	
DEPAKOTE ER	Non – Preferred	
DEPAKOTE SPRINKLES	Non – Preferred	
***Antidepressants* - Drugs For The Nervous System**		
****Alpha-2 Receptor Antagonists (Tetracyclics)*** - Drugs For Depression***		
mirtazapine	Preferred	QL (1 EA per 1 day)
REMERON	Non – Preferred	QL (1 EA per 1 day)
REMERON SOLTAB	Non – Preferred	QL (1 EA per 1 day)
****Antidepressant - Miscellaneous Combinations*** - Drugs For Depression***		
AUVELITY	Non – Preferred	
****Antidepressants - Misc.*** - Drugs For Depression***		
bupropion hcl	Preferred	QL (3 EA per 1 day)
bupropion hcl er (sr) tablet extended release 12 hour 100 mg oral	Preferred	
bupropion hcl er (sr) tablet extended release 12 hour 100 mg oral	Preferred	QL (2 EA per 1 day)
bupropion hcl er (sr) tablet extended release 12 hour 150 mg oral	Preferred	QL (2 EA per 1 day)
bupropion hcl er (sr) tablet extended release 12 hour 200 mg oral	Preferred	QL (2 EA per 1 day)
bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral	Preferred	QL (1 EA per 1 day)
bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral	Preferred	
bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral	Preferred	QL (1 EA per 1 day)
bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral	Preferred	
APLENZIN	Non – Preferred	
FORFIVO XL	Non – Preferred	
WELLBUTRIN SR	Non – Preferred	QL (2 EA per 1 day)
WELLBUTRIN XL	Non – Preferred	QL (1 EA per 1 day)
Gaba Receptor Modulator - Neuroactive Steroid - Drugs For Depression***		
ZURZUVAE	Preferred	
Monoamine Oxidase Inhibitors (Maois) - Drugs For Depression***		
phenelzine sulfate	Preferred	
tranylcypromine sulfate	Preferred	
EMSAM	Non – Preferred	
MARPLAN	Non – Preferred	
NARDIL	Non – Preferred	
N-Methyl-D-Aspartic Acid (Nmda) Receptor Antagonists - Drugs For Depression***		
SPRAVATO (56 MG DOSE)	Non – Preferred	
SPRAVATO (84 MG DOSE)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Selective Serotonin Reuptake Inhibitors (Ssris) - Drugs For Depression***		
citalopram hydrobromide oral capsule	Non – Preferred	
citalopram hydrobromide oral solution	Preferred	QL (30 ML per 1 day)
citalopram hydrobromide tablet 10 mg oral	Preferred	QL (2 EA per 1 day)
citalopram hydrobromide tablet 20 mg oral	Preferred	QL (2 EA per 1 day)
citalopram hydrobromide tablet 40 mg oral	Preferred	QL (1 EA per 1 day)
escitalopram oxalate oral solution	Preferred	QL (30 ML per 1 day)
escitalopram oxalate tablet 10 mg oral	Preferred	
escitalopram oxalate tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
escitalopram oxalate tablet 20 mg oral	Preferred	
escitalopram oxalate tablet 20 mg oral	Preferred	QL (1 EA per 1 day)
escitalopram oxalate tablet 5 mg oral	Preferred	
escitalopram oxalate tablet 5 mg oral	Preferred	QL (1 EA per 1 day)
fluoxetine hcl capsule 10 mg oral	Preferred	QL (1 EA per 1 day)
fluoxetine hcl capsule 20 mg oral	Preferred	QL (2 EA per 1 day)
fluoxetine hcl capsule 40 mg oral	Preferred	QL (2 EA per 1 day)
fluoxetine hcl oral capsule delayed release	Non – Preferred	
fluoxetine hcl oral tablet	Preferred	
fluoxetine hcl solution 20 mg/5ml oral	Preferred	
fluoxetine hcl solution 20 mg/5ml oral	Preferred	QL (150 ML per 30 days)
fluvoxamine maleate er	Non – Preferred	
fluvoxamine maleate tablet 100 mg oral	Preferred	QL (3 EA per 1 day)
fluvoxamine maleate tablet 25 mg oral	Preferred	QL (1 EA per 1 day)
fluvoxamine maleate tablet 50 mg oral	Preferred	QL (1 EA per 1 day)
paroxetine hcl er	Non – Preferred	
paroxetine hcl oral suspension	Preferred	
paroxetine hcl tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
paroxetine hcl tablet 20 mg oral	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
paroxetine hcl tablet 30 mg oral	Preferred	QL (2 EA per 1 day)
paroxetine hcl tablet 40 mg oral	Preferred	QL (1.5 EA per 1 day)
sertraline hcl concentrate 20 mg/ml oral	Preferred	QL (120 ML per 30 days)
sertraline hcl oral capsule	Non – Preferred	
sertraline hcl tablet 100 mg oral	Preferred	
sertraline hcl tablet 100 mg oral	Preferred	QL (2 EA per 1 day)
sertraline hcl tablet 25 mg oral	Preferred	
sertraline hcl tablet 25 mg oral	Preferred	QL (2 EA per 1 day)
sertraline hcl tablet 50 mg oral	Preferred	
sertraline hcl tablet 50 mg oral	Preferred	QL (2 EA per 1 day)
CELEXA TABLET 10 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CELEXA TABLET 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CELEXA TABLET 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
LEXAPRO	Non – Preferred	QL (1 EA per 1 day)
PAXIL CR	Non – Preferred	
PAXIL ORAL SUSPENSION	Non – Preferred	
PAXIL TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PAXIL TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PAXIL TABLET 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PAXIL TABLET 40 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
PROZAC CAPSULE 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROZAC CAPSULE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
PROZAC CAPSULE 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ZOLOFT ORAL CONCENTRATE	Non – Preferred	QL (120 ML per 30 days)
ZOLOFT ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
Serotonin Modulators - Drugs For Depression***		
nefazodone hcl	Non – Preferred	
trazodone hcl	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
vilazodone hcl	Non – Preferred	
TRINTELLIX	Non – Preferred	
VIIBRYD	Non – Preferred	
Serotonin-Norepinephrine Reuptake Inhibitors (Snris) - Drugs For Depression***		
desvenlafaxine er	Non – Preferred	
desvenlafaxine succinate er	Non – Preferred	
duloxetine hcl capsule delayed release particles 20 mg oral	Preferred	QL (1 EA per 1 day)
duloxetine hcl capsule delayed release particles 30 mg oral	Preferred	QL (1 EA per 1 day)
duloxetine hcl capsule delayed release particles 40 mg oral	Preferred	QL (1 EA per 1 day)
duloxetine hcl capsule delayed release particles 60 mg oral	Preferred	QL (2 EA per 1 day)
venlafaxine besylate er	Preferred	
venlafaxine hcl	Preferred	
venlafaxine hcl er capsule extended release 24 hour 150 mg oral	Preferred	
venlafaxine hcl er capsule extended release 24 hour 150 mg oral	Preferred	QL (1 EA per 1 day)
venlafaxine hcl er capsule extended release 24 hour 37.5 mg oral	Preferred	
venlafaxine hcl er capsule extended release 24 hour 37.5 mg oral	Preferred	QL (1 EA per 1 day)
venlafaxine hcl er capsule extended release 24 hour 75 mg oral	Preferred	
venlafaxine hcl er capsule extended release 24 hour 75 mg oral	Preferred	QL (1 EA per 1 day)
venlafaxine hcl er oral tablet extended release 24 hour	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 60 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DRIZALMA SPRINKLE	Non – Preferred	
EFFEXOR XR	Non – Preferred	QL (1 EA per 1 day)
FETZIMA	Non – Preferred	
FETZIMA TITRATION	Non – Preferred	
PRISTIQ	Non – Preferred	
Tricyclic Agents - Drugs For Depression**		
amitriptyline hcl	Preferred	
amoxapine	Non – Preferred	
clomipramine hcl	Preferred	
desipramine hcl tablet 10 mg oral	Preferred	
desipramine hcl tablet 100 mg oral	Preferred	
desipramine hcl tablet 150 mg oral	Preferred	
desipramine hcl tablet 25 mg oral	Preferred	QL (2 EA per 1 day)
desipramine hcl tablet 50 mg oral	Preferred	
desipramine hcl tablet 75 mg oral	Preferred	
doxepin hcl	Preferred	
imipramine hcl	Preferred	
imipramine pamoate	Non – Preferred	
nortriptyline hcl	Preferred	
protriptyline hcl	Preferred	
trimipramine maleate	Preferred	
ANAFRANIL	Non – Preferred	
PAMELOR	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antidiabetics* - Hormones**		
****Alpha-Glucosidase Inhibitors*** - Drugs For Diabetes***		
acarbose	Preferred	QL (3 EA per 1 day)
miglitol	Preferred	
****Antidiabetic - Amylin Analogs*** - Drugs For Diabetes***		
SYMLINPEN 120	Non – Preferred	
SYMLINPEN 60	Non – Preferred	
****Biguanides*** - Drugs For Diabetes***		
metformin hcl er (mod)	Non – Preferred	
metformin hcl er (osm)	Non – Preferred	
metformin hcl er tablet extended release 24 hour 500 mg oral	Preferred	
metformin hcl er tablet extended release 24 hour 500 mg oral	Preferred	QL (4 EA per 1 day)
metformin hcl er tablet extended release 24 hour 750 mg oral	Preferred	QL (2 EA per 1 day)
metformin hcl oral solution	Non – Preferred	
metformin hcl tablet 1000 mg oral	Preferred	
metformin hcl tablet 500 mg oral	Preferred	
metformin hcl tablet 625 mg oral	Non – Preferred	
metformin hcl tablet 750 mg oral	Preferred	
metformin hcl tablet 850 mg oral	Preferred	
****Diabetic Other*** - Drugs For Diabetes***		
diazoxide	Preferred	
glucagon emergency	Preferred	
BAQSIMI ONE PACK	Preferred	
BAQSIMI TWO PACK	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GVOKE HYPOPEN 1-PACK	Preferred	
GVOKE HYPOPEN 2-PACK	Preferred	
GVOKE KIT	Preferred	
GVOKE PFS	Preferred	
PROGLYCEM	Preferred	
ZEGALOGUE	Preferred	
Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors - Drugs For Diabetes**		
alogliptin benzoate	Non – Preferred	QL (1 EA per 1 day)
saxagliptin hcl	Non – Preferred	
JANUVIA	Preferred	QL (1 EA per 1 day)
ONGLYZA	Non – Preferred	
TRADJENTA	Preferred	QL (1 EA per 1 day)
ZITUVIO	Non – Preferred	
Dipeptidyl Peptidase-4 Inhibitor-Biguanide Combinations - Drugs For Diabetes**		
alogliptin-metformin hcl	Non – Preferred	
saxagliptin-metformin er	Non – Preferred	
sitagliptin base-metformin hcl	Preferred	
JANUMET	Non – Preferred	QL (2 EA per 1 day)
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL	Non – Preferred	
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
JENTADUETO	Non – Preferred	
JENTADUETO XR	Non – Preferred	
ZITUVIMET	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZITUVIMET XR	Non – Preferred	
Dopamine Receptor Agonists - Ergot Derivatives - Drugs For Diabetes***		
CYCLOSET	Non – Preferred	
Dpp-4 Inhibitor-Thiazolidinedione Combinations - Drugs For Diabetes***		
alogliptin-pioglitazone	Non – Preferred	QL (1 EA per 1 day)
Human Insulin - Drugs For Diabetes***		
insulin asp prot & asp flexpen	Non – Preferred	
insulin aspart	Non – Preferred	
insulin aspart flexpen	Non – Preferred	
insulin aspart penfill	Non – Preferred	
insulin aspart prot & aspart	Non – Preferred	
insulin degludec	Preferred	
insulin degludec flextouch	Preferred	
insulin glargine	Non – Preferred	
insulin glargine max solostar	Non – Preferred	
insulin glargine solostar	Non – Preferred	
insulin glargine-yfgn	Non – Preferred	
insulin lispro	Preferred	
insulin lispro (1 unit dial)	Preferred	
insulin lispro junior kwikpen	Preferred	QL (1 ML per 1 day)
insulin lispro prot & lispro	Preferred	
ADMELOG	Non – Preferred	
ADMELOG SOLOSTAR	Non – Preferred	
AFREZZA	Non – Preferred	
APIDRA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
APIDRA SOLOSTAR	Non – Preferred	
BASAGLAR KWIKPEN	Non – Preferred	
BASAGLAR TEMPO PEN	Non – Preferred	
FIASP	Non – Preferred	
FIASP FLEXTOUCH	Non – Preferred	
FIASP PENFILL	Non – Preferred	
FIASP PUMPCART	Non – Preferred	
HUMALOG	Preferred	
HUMALOG JUNIOR KWIKPEN	Preferred	QL (1 ML per 1 day)
HUMALOG KWIKPEN	Preferred	
HUMALOG MIX 50/50 KWIKPEN	Preferred	
HUMALOG MIX 75/25	Preferred	
HUMALOG MIX 75/25 KWIKPEN	Preferred	
HUMALOG TEMPO PEN	Non – Preferred	
HUMULIN 70/30	Preferred	OTC
HUMULIN 70/30 KWIKPEN	Preferred	OTC
HUMULIN N	Preferred	OTC
HUMULIN N KWIKPEN	Preferred	OTC
HUMULIN R	Preferred	OTC
HUMULIN R U-500 (CONCENTRATED)	Preferred	
HUMULIN R U-500 KWIKPEN	Preferred	
LANTUS	Preferred	
LANTUS SOLOSTAR	Preferred	
LYUMJEV	Non – Preferred	
LYUMJEV KWIKPEN	Non – Preferred	
LYUMJEV TEMPO PEN	Non – Preferred	
NOVOLIN 70/30	Non – Preferred	OTC
NOVOLIN 70/30 FLEXPEN	Non – Preferred	OTC
NOVOLIN 70/30 FLEXPEN RELION	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN 70/30 RELION	Non – Preferred	OTC
NOVOLIN N	Non – Preferred	OTC
NOVOLIN N FLEXPEN	Non – Preferred	
NOVOLIN N FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN N RELION	Non – Preferred	OTC
NOVOLIN R	Non – Preferred	OTC
NOVOLIN R FLEXPEN	Non – Preferred	OTC
NOVOLIN R FLEXPEN RELION	Non – Preferred	OTC
NOVOLIN R RELION	Non – Preferred	OTC
NOVOLOG	Non – Preferred	
NOVOLOG 70/30 FLEXPEN RELION	Non – Preferred	
NOVOLOG FLEXPEN	Non – Preferred	
NOVOLOG FLEXPEN RELION	Non – Preferred	
NOVOLOG MIX 70/30	Non – Preferred	
NOVOLOG MIX 70/30 FLEXPEN	Non – Preferred	
NOVOLOG MIX 70/30 RELION	Non – Preferred	
NOVOLOG PENFILL	Non – Preferred	
NOVOLOG RELION	Non – Preferred	
REZVOGLAR KWIKPEN	Non – Preferred	
SEMGLEE (YFGN)	Non – Preferred	
TOUJEO MAX SOLOSTAR	Non – Preferred	
TOUJEO SOLOSTAR	Non – Preferred	
TRESIBA	Non – Preferred	
TRESIBA FLEXTOUCH	Non – Preferred	
Incretin Mimetic Agents (Gip & Glp-1 Receptor Agonists) - Drugs For Diabetes***		
MOUNJARO	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Incretin Mimetic Agents (Glp-1 Receptor Agonists) - Drugs For Diabetes***		
liraglutide	Preferred	Diagnosis Required; QL (6 ML per 1 day)
BYDUREON BCISE	Non – Preferred	
OZEMPIC (0.25 OR 0.5 MG/DOSE)	Non – Preferred	
OZEMPIC (1 MG/DOSE)	Non – Preferred	
OZEMPIC (2 MG/DOSE)	Non – Preferred	
RYBELSUS	Preferred	PA
RYBELSUS (FORMULATION R2) TABLET 1.5 MG ORAL	Preferred	PA
RYBELSUS (FORMULATION R2) TABLET 4 MG ORAL	Preferred	
RYBELSUS (FORMULATION R2) TABLET 9 MG ORAL	Preferred	PA
TRULICITY	Preferred	Diagnosis Required
VICTOZA	Preferred	Diagnosis Required; QL (0.6 ML per 1 day)
Insulin-Incretin Mimetic Combinations - Drugs For Diabetes***		
SOLIQUA	Non – Preferred	
XULTOPHY	Non – Preferred	
Meglitinide Analogues - Drugs For Diabetes***		
nateglinide	Preferred	QL (3 EA per 1 day)
repaglinide tablet 0.5 mg oral	Non – Preferred	QL (4 EA per 1 day)
repaglinide tablet 1 mg oral	Non – Preferred	QL (4 EA per 1 day)
repaglinide tablet 2 mg oral	Non – Preferred	QL (8 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Progesterone Receptor Antagonists - Drugs For Diabetes***		
mifepristone	Non – Preferred	
KORLYM	Non – Preferred	
Sglt2 Inhibitor - Dpp-4 Inhibitor - Biguanide Comb - Drugs For Diabetes***		
TRIJARDY XR	Non – Preferred	
Sglt2 Inhibitor - Dpp-4 Inhibitor Combinations - Drugs For Diabetes***		
GLYXAMBI	Non – Preferred	
QTERN	Non – Preferred	
STEGLUJAN	Non – Preferred	
Sodium-Glucose Co-Transporter 2 (Sglt2) Inhibitors - Drugs For Diabetes***		
dapagliflozin propanediol	Non – Preferred	
FARXIGA	Preferred	
INVOKANA	Preferred	
JARDIANCE	Preferred	QL (1 EA per 1 day)
STEGLATRO	Non – Preferred	
Sodium-Glucose Co-Transporter 2 Inhibitor-Biguanide Comb - Drugs For Diabetes***		
dapagliflozin pro-metformin er	Non – Preferred	
INVOKAMET	Non – Preferred	
INVOKAMET XR	Non – Preferred	
SEGLUROMET	Non – Preferred	
SYNJARDY	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYNJARDY XR	Non – Preferred	
XIGDUO XR	Non – Preferred	
Sulfonylurea-Biguanide Combinations - Drugs For Diabetes**		
glipizide-metformin hcl tablet 2.5-250 mg oral	Preferred	QL (2 EA per 1 day)
glipizide-metformin hcl tablet 2.5-500 mg oral	Preferred	QL (2 EA per 1 day)
glipizide-metformin hcl tablet 5-500 mg oral	Preferred	QL (4 EA per 1 day)
glyburide-metformin tablet 1.25-250 mg oral	Preferred	QL (2 EA per 1 day)
glyburide-metformin tablet 2.5-500 mg oral	Preferred	QL (2 EA per 1 day)
glyburide-metformin tablet 5-500 mg oral	Preferred	QL (4 EA per 1 day)
Sulfonylureas - Drugs For Diabetes**		
glimepiride tablet 1 mg oral	Preferred	QL (1 EA per 1 day)
glimepiride tablet 2 mg oral	Preferred	QL (1 EA per 1 day)
glimepiride tablet 3 mg oral	Preferred	
glimepiride tablet 4 mg oral	Preferred	QL (2 EA per 1 day)
glipizide	Preferred	
glipizide er tablet extended release 24 hour 10 mg oral	Preferred	QL (2 EA per 1 day)
glipizide er tablet extended release 24 hour 2.5 mg oral	Preferred	QL (1 EA per 1 day)
glipizide er tablet extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day)
glyburide	Preferred	
glyburide micronized tablet 1.5 mg oral	Preferred	QL (1 EA per 1 day)
glyburide micronized tablet 3 mg oral	Preferred	QL (1 EA per 1 day)
glyburide micronized tablet 6 mg oral	Preferred	
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL	Non – Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
Sulfonylurea-Thiazolidinedione Combinations - Drugs For Diabetes**		
pioglitazone hcl-glimepiride	Non – Preferred	
DUETACT	Non – Preferred	
Thiazolidinedione-Biguanide Combinations - Drugs For Diabetes**		
pioglitazone hcl-metformin hcl	Non – Preferred	
ACTOPLUS MET	Non – Preferred	
Thiazolidinediones - Drugs For Diabetes**		
pioglitazone hcl	Preferred	QL (1 EA per 1 day)
ACTOS	Non – Preferred	QL (1 EA per 1 day)
***Antidiarrheal/Probiotic Agents* - Drugs For The Stomach**		
Antidiarrheal/Probiotic Agents - Misc. - Drugs For Diarrhea**		
bismuth subsalicylate	Preferred	OTC
stomach relief extra strength	Preferred	OTC
Antiperistaltic Agents - Drugs For Diarrhea**		
diphenoxylate-atropine	Preferred	
loperamide hcl oral capsule	Preferred	
loperamide hcl oral tablet	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antidotes And Specific Antagonists* - Drugs For Overdose Or Poisoning**		
****Antidotes - Chelating Agents*** - Drugs For Overdose Or Poisoning***		
deferasirox	Non – Preferred	
deferasirox granules	Non – Preferred	
deferiprone	Non – Preferred	
CHEMET	Preferred	
EXJADE	Non – Preferred	
FERRIPROX	Non – Preferred	
FERRIPROX TWICE-A-DAY	Non – Preferred	
JADENU	Non – Preferred	
JADENU SPRINKLE	Non – Preferred	
****Opioid Antagonists*** - Drugs For Overdose Or Poisoning***		
nalmefene hcl	Preferred	
naloxone hcl	Preferred	
naltrexone hcl	Preferred	
KLOXXADO	Preferred	
NARCAN	Preferred	
OPVEE	Preferred	
REXTOVY	Preferred	
VIVITROL	Preferred	
ZIMHI	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antiemetics* - Drugs For The Stomach**		
****5-Ht3 Receptor Antagonists*** - Drugs For Vomiting And Nausea***		
granisetron hcl tablet 1 mg oral	Non – Preferred	QL (8 EA per 28 days)
ondansetron hcl oral solution	Preferred	QL (50 ML Max Qty Per Fill Retail)
ondansetron hcl oral tablet	Preferred	QL (3 EA per 1 day)
ondansetron tablet dispersible 16 mg oral	Preferred	
ondansetron tablet dispersible 4 mg oral	Preferred	QL (3 EA per 1 day)
ondansetron tablet dispersible 8 mg oral	Preferred	QL (3 EA per 1 day)
ANZEMET	Non – Preferred	
SANCUSO	Non – Preferred	
****Antiemetic Combinations*** - Drugs For Vomiting And Nausea***		
doxylamine-pyridoxine	Non – Preferred	
AKYNZEO	Non – Preferred	
BONJESTA	Non – Preferred	
DICLEGIS	Non – Preferred	
****Antiemetics - Anticholinergic*** - Drugs For Vomiting And Nausea***		
meclizine hcl	Preferred	
scopolamine	Preferred	
trimethobenzamide hcl	Non – Preferred	
****Antiemetics - Miscellaneous*** - Drugs For Vomiting And Nausea***		
dronabinol	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Substance P/Neurokinin 1 (Nk1) Receptor Antagonists - Drugs For Vomiting And Nausea***		
aprepitant capsule 125 mg oral	Preferred	QL (3 EA per 30 days)
aprepitant capsule 40 mg oral	Preferred	QL (3 EA per 30 days)
aprepitant capsule 80 & 125 mg oral	Preferred	QL (3 EA per 30 days)
aprepitant capsule 80 mg oral	Preferred	QL (3 EA per 30 days)
aprepitant oral	Preferred	QL (3 EA per 30 days)
EMEND	Non – Preferred	
EMEND BIPACK	Non – Preferred	QL (3 EA per 30 days)
EMEND TRIPACK	Non – Preferred	QL (3 EA per 30 days)
***Antifungals* - Drugs For Infections**		
Antifungal - Glucan Synthesis Inhibitors (Echinocandins) - Drugs For Fungus***		
micafungin sodium	Preferred	
Antifungal - Glucan Synthesis Inhibitors (Triterpenoids) - Antibiotics***		
BREXAFEMME	Non – Preferred	
Antifungals - Drugs For Fungus***		
flucytosine	Non – Preferred	
griseofulvin microsize	Preferred	
griseofulvin ultramicrosize	Preferred	
nystatin	Preferred	QL (6 EA per 1 day)
terbinafine hcl	Preferred	QL (1 EA per 1 day)
ANCOBON	Non – Preferred	
Imidazoles - Drugs For Fungus***		
ketoconazole	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Tetrazoles - Drugs For Fungus***		
VIVJOA	Non – Preferred	
Triazoles - Drugs For Fungus***		
fluconazole in sodium chloride	Preferred	
fluconazole oral suspension reconstituted	Preferred	
fluconazole tablet 100 mg oral	Preferred	QL (2 EA per 1 day)
fluconazole tablet 150 mg oral	Preferred	QL (14 EA per 28 days)
fluconazole tablet 200 mg oral	Preferred	QL (2 EA per 1 day)
fluconazole tablet 50 mg oral	Preferred	QL (2 EA per 1 day)
itraconazole capsule 100 mg oral	Preferred	
itraconazole capsule 100 mg oral	Preferred	QL (4 EA per 1 day)
itraconazole oral solution	Non – Preferred	
posaconazole	Non – Preferred	
tolsura	Non – Preferred	
voriconazole	Non – Preferred	
CRESEMBA	Non – Preferred	
DIFLUCAN ORAL SUSPENSION RECONSTITUTED	Non – Preferred	
DIFLUCAN ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
NOXAFIL	Non – Preferred	
SPORANOX ORAL CAPSULE	Non – Preferred	QL (4 EA per 1 day)
SPORANOX ORAL SOLUTION	Non – Preferred	
VFEND	Non – Preferred	
***Antihistamines* - Drugs For The Lungs**		
Antihistamines - Alkylamines - Drugs For Allergies***		
aller-chlor	Preferred	OTC
allergy	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
allergy relief	Preferred	OTC
chlorpheniramine maleate	Preferred	OTC
WAL-FINATE	Preferred	OTC
Antihistamines - Ethanolamines - Drugs For Allergies**		
diphenhydramine hcl oral capsule	Preferred	
diphenhydramine hcl oral liquid	Preferred	OTC; QL (20 ML per 1 day)
diphenhydramine hcl oral tablet	Preferred	OTC
Antihistamines - Non-Sedating - Drugs For Allergies**		
cetirizine hcl oral solution	Preferred	
cetirizine hcl oral tablet	Preferred	OTC; QL (1 EA per 1 day)
cetirizine hcl oral tablet chewable	Preferred	OTC
fexofenadine hcl oral tablet 180 mg	Preferred	OTC; QL (1 EA per 1 day)
fexofenadine hcl oral tablet 60 mg	Preferred	OTC; QL (2 EA per 1 day)
levocetirizine dihydrochloride	Preferred	QL (1 EA per 1 day)
loratadine oral solution	Preferred	OTC; QL (240 ML Max Qty Per Fill Retail)
loratadine oral tablet	Preferred	OTC; QL (1 EA per 1 day)
Antihistamines - Phenothiazines - Drugs For Allergies**		
promethazine hcl oral solution	Preferred	QL (80 ML per 1 day); AL (Min 2 Years)
promethazine hcl oral tablet	Preferred	AL (Min 2 Years)
promethazine hcl rectal	Preferred	AL (Min 2 Years)
Antihistamines - Piperidines - Drugs For Allergies**		
cyproheptadine hcl	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antihyperlipidemics* - Drugs For The Heart**		
****Acl Inhib-Intestinal Cholesterol Absorption Inhib Comb*** - Drugs For Cholesterol***		
NEXLIZET	Non – Preferred	
****Adenosine Triphosphate-Citrate Lyase (Acl) Inhibitors*** - Drugs For Cholesterol***		
NEXLETOL	Non – Preferred	
****Antihyperlipidemics - Misc.*** - Drugs For Cholesterol***		
icosapent ethyl	Non – Preferred	
omega-3-acid ethyl esters capsule 1 gm oral	Non – Preferred	
omega-3-acid ethyl esters capsule 1 gm oral	Non – Preferred	QL (4 EA per 1 day)
LOVAZA	Non – Preferred	QL (4 EA per 1 day)
****Bile Acid Sequestrants*** - Drugs For Cholesterol***		
cholestyramine	Preferred	
cholestyramine light	Preferred	
colesevelam hcl	Non – Preferred	
colestipol hcl	Non – Preferred	
COLESTID	Non – Preferred	
PREVALITE	Preferred	
QUESTRAN	Non – Preferred	
QUESTRAN LIGHT	Non – Preferred	
WELCHOL	Non – Preferred	
****Fibric Acid Derivatives*** - Drugs For Cholesterol***		
fenofibrate	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fenofibrate micronized	Preferred	
fenofibric acid	Preferred	
gemfibrozil	Preferred	QL (2 EA per 1 day)
LIPOFEN	Non – Preferred	
LOPID	Non – Preferred	QL (2 EA per 1 day)
TRICOR	Non – Preferred	
TRILIPIX	Non – Preferred	
Hmg Coa Reductase Inhibitors - Drugs For Cholesterol***		
atorvastatin calcium tablet 10 mg oral	Preferred	
atorvastatin calcium tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
atorvastatin calcium tablet 20 mg oral	Preferred	
atorvastatin calcium tablet 20 mg oral	Preferred	QL (1 EA per 1 day)
atorvastatin calcium tablet 40 mg oral	Preferred	
atorvastatin calcium tablet 40 mg oral	Preferred	QL (1 EA per 1 day)
atorvastatin calcium tablet 80 mg oral	Preferred	
atorvastatin calcium tablet 80 mg oral	Preferred	QL (1 EA per 1 day)
fluvastatin sodium	Non – Preferred	QL (1 EA per 1 day)
fluvastatin sodium er	Non – Preferred	QL (1 EA per 1 day)
lovastatin tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
lovastatin tablet 20 mg oral	Preferred	QL (1 EA per 1 day)
lovastatin tablet 40 mg oral	Preferred	QL (2 EA per 1 day)
pitavastatin calcium	Non – Preferred	
pravastatin sodium tablet 10 mg oral	Preferred	
pravastatin sodium tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
pravastatin sodium tablet 20 mg oral	Preferred	
pravastatin sodium tablet 20 mg oral	Preferred	QL (1 EA per 1 day)
pravastatin sodium tablet 40 mg oral	Preferred	
pravastatin sodium tablet 40 mg oral	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
pravastatin sodium tablet 80 mg oral	Preferred	QL (1 EA per 1 day)
rosuvastatin calcium	Preferred	QL (1 EA per 1 day)
simvastatin	Preferred	QL (1 EA per 1 day)
ALTOPREV	Non – Preferred	
ATORVALIQ	Non – Preferred	
CRESTOR TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CRESTOR TABLET 40 MG ORAL	Non – Preferred	
EZALLOR SPRINKLE	Non – Preferred	
LIPITOR	Non – Preferred	QL (1 EA per 1 day)
LIVALO	Non – Preferred	
ZOCOR	Non – Preferred	QL (1 EA per 1 day)
ZYPITAMAG	Non – Preferred	
Intest Cholest Absorp Inhib-Hmg Coa Reductase Inhib Comb - Drugs For Cholesterol***		
ezetimibe-simvastatin	Non – Preferred	
VYTORIN	Non – Preferred	
Intestinal Cholesterol Absorption Inhibitors - Drugs For Cholesterol***		
ezetimibe	Preferred	QL (1 EA per 1 day)
ZETIA	Non – Preferred	QL (1 EA per 1 day)
Microsomal Triglyceride Transfer Protein Inhibitors - Drugs For Cholesterol***		
JUXTAPID	Non – Preferred	
Nicotinic Acid Derivatives - Drugs For Cholesterol***		
niacin er (antihyperlipidemic)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pcsk9 Inhibitors - Drugs For Cholesterol***		
PRALUENT	Non – Preferred	
REPATHA	Non – Preferred	
REPATHA PUSHTRONEX SYSTEM	Non – Preferred	
REPATHA SURECLICK	Non – Preferred	
Small Interfering Rna (Sirna) Pcsk9 Inhibitors - Drugs For Cholesterol***		
LEQVIO	Non – Preferred	
***Antihypertensives* - Drugs For The Heart**		
Ace Inhibitor & Calcium Channel Blocker Combinations - Drugs For High Blood Pressure***		
amlodipine besy-benazepril hcl	Preferred	QL (1 EA per 1 day)
trandolapril-verapamil hcl er	Preferred	
LOTREL	Non – Preferred	QL (1 EA per 1 day)
Ace Inhibitors & Thiazide/Thiazide-Like - Drugs For High Blood Pressure***		
benazepril-hydrochlorothiazide	Preferred	QL (1 EA per 1 day)
captopril-hydrochlorothiazide	Preferred	
enalapril-hydrochlorothiazide tablet 10-25 mg oral	Preferred	QL (2 EA per 1 day)
enalapril-hydrochlorothiazide tablet 5-12.5 mg oral	Preferred	QL (1 EA per 1 day)
fosinopril sodium-hctz	Preferred	
lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral	Preferred	QL (1 EA per 1 day)
lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lisinopril-hydrochlorothiazide tablet 20-25 mg oral	Preferred	QL (2 EA per 1 day)
quinapril-hydrochlorothiazide	Preferred	QL (1 EA per 1 day)
ACCURETIC	Non – Preferred	QL (1 EA per 1 day)
LOTENSIN HCT	Non – Preferred	QL (1 EA per 1 day)
VASERETIC	Non – Preferred	QL (2 EA per 1 day)
ZESTORETIC TABLET 10-12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZESTORETIC TABLET 20-12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ZESTORETIC TABLET 20-25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
Ace Inhibitors - Drugs For High Blood Pressure***		
benazepril hcl	Preferred	QL (2 EA per 1 day)
captopril	Preferred	QL (3 EA per 1 day)
enalapril maleate oral solution	Non – Preferred	
enalapril maleate tablet 10 mg oral	Preferred	
enalapril maleate tablet 10 mg oral	Preferred	QL (2 EA per 1 day)
enalapril maleate tablet 2.5 mg oral	Preferred	
enalapril maleate tablet 2.5 mg oral	Preferred	QL (2 EA per 1 day)
enalapril maleate tablet 20 mg oral	Preferred	
enalapril maleate tablet 20 mg oral	Preferred	QL (2 EA per 1 day)
enalapril maleate tablet 5 mg oral	Preferred	
enalapril maleate tablet 5 mg oral	Preferred	QL (2 EA per 1 day)
fosinopril sodium	Preferred	QL (2 EA per 1 day)
lisinopril	Preferred	QL (2 EA per 1 day)
moexipril hcl	Preferred	
perindopril erbumine tablet 2 mg oral	Non – Preferred	QL (1 EA per 1 day)
perindopril erbumine tablet 4 mg oral	Non – Preferred	QL (1 EA per 1 day)
perindopril erbumine tablet 8 mg oral	Non – Preferred	QL (2 EA per 1 day)
quinapril hcl	Preferred	QL (2 EA per 1 day)
ramipril capsule 1.25 mg oral	Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ramipril capsule 10 mg oral	Preferred	
ramipril capsule 10 mg oral	Preferred	QL (2 EA per 1 day)
ramipril capsule 2.5 mg oral	Preferred	
ramipril capsule 2.5 mg oral	Preferred	QL (2 EA per 1 day)
ramipril capsule 5 mg oral	Preferred	
ramipril capsule 5 mg oral	Preferred	QL (2 EA per 1 day)
trandolapril tablet 1 mg oral	Preferred	QL (1 EA per 1 day)
trandolapril tablet 2 mg oral	Preferred	QL (1 EA per 1 day)
trandolapril tablet 4 mg oral	Preferred	QL (2 EA per 1 day)
ACCUPRIL	Non – Preferred	QL (2 EA per 1 day)
ALTACE	Non – Preferred	QL (2 EA per 1 day)
EPANED	Non – Preferred	
LOTENSIN	Non – Preferred	QL (2 EA per 1 day)
QBRELIS	Non – Preferred	
VASOTEC	Non – Preferred	QL (2 EA per 1 day)
ZESTRIL	Non – Preferred	QL (2 EA per 1 day)
Agents For Pheochromocytoma - Drugs For High Blood Pressure**		
metyrosine	Preferred	
phenoxybenzamine hcl	Non – Preferred	
DEMSER	Preferred	
Angiotensin Ii Receptor Antag & Ca Channel Blocker Comb - Drugs For High Blood Pressure**		
amlodipine besylate-valsartan	Non – Preferred	QL (1 EA per 1 day)
amlodipine-olmesartan	Non – Preferred	
telmisartan-amlodipine	Non – Preferred	
AZOR	Non – Preferred	
EXFORGE	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Angiotensin Ii Receptor Antag & Thiazide/Thiazide-Like - Drugs For High Blood Pressure***		
candesartan cilexetil-hctz	Non – Preferred	QL (1 EA per 1 day)
irbesartan-hydrochlorothiazide	Preferred	QL (1 EA per 1 day)
losartan potassium-hctz	Preferred	QL (1 EA per 1 day)
olmesartan medoxomil-hctz	Non – Preferred	
telmisartan-hctz	Non – Preferred	
valsartan-hydrochlorothiazide	Preferred	QL (1 EA per 1 day)
ATACAND HCT	Non – Preferred	QL (1 EA per 1 day)
AVALIDE	Non – Preferred	QL (1 EA per 1 day)
BENICAR HCT	Non – Preferred	
DIOVAN HCT	Non – Preferred	QL (1 EA per 1 day)
EDARBYCLOR	Non – Preferred	
HYZAAR	Non – Preferred	QL (1 EA per 1 day)
MICARDIS HCT	Non – Preferred	
Angiotensin Ii Receptor Antagonists - Drugs For High Blood Pressure***		
candesartan cilexetil	Non – Preferred	QL (1 EA per 1 day)
irbesartan tablet 150 mg oral	Preferred	
irbesartan tablet 150 mg oral	Preferred	QL (1 EA per 1 day)
irbesartan tablet 300 mg oral	Preferred	QL (1 EA per 1 day)
irbesartan tablet 300 mg oral	Preferred	
irbesartan tablet 75 mg oral	Preferred	QL (1 EA per 1 day)
irbesartan tablet 75 mg oral	Preferred	
losartan potassium tablet 100 mg oral	Preferred	QL (1 EA per 1 day)
losartan potassium tablet 25 mg oral	Preferred	QL (2 EA per 1 day)
losartan potassium tablet 50 mg oral	Preferred	QL (2 EA per 1 day)
olmesartan medoxomil	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
telmisartan	Non – Preferred	
valsartan oral solution	Preferred	
valsartan oral tablet	Preferred	QL (1 EA per 1 day)
ATACAND	Non – Preferred	QL (1 EA per 1 day)
AVAPRO	Non – Preferred	QL (1 EA per 1 day)
BENICAR	Non – Preferred	
COZAAR TABLET 100 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
COZAAR TABLET 25 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
COZAAR TABLET 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
DIOVAN	Non – Preferred	QL (1 EA per 1 day)
EDARBI	Non – Preferred	
MICARDIS	Non – Preferred	
Angiotensin Ii Receptor Ant-Ca Channel Blocker-Thiazides - Drugs For High Blood Pressure**		
amlodipine-valsartan-hctz	Non – Preferred	
olmesartan-amlodipine-hctz	Non – Preferred	
EXFORGE HCT	Non – Preferred	
TRIBENZOR	Non – Preferred	
Antiadrenergics - Centrally Acting - Drugs For High Blood Pressure**		
clonidine	Preferred	
clonidine er	Non – Preferred	
clonidine hcl	Preferred	
guanfacine hcl tablet 1 mg oral	Preferred	QL (8 EA per 1 day)
guanfacine hcl tablet 2 mg oral	Preferred	QL (4 EA per 1 day)
methyldopa	Preferred	
NEXICLON XR	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiadrenergics - Peripherally Acting - Drugs For High Blood Pressure***		
doxazosin mesylate tablet 1 mg oral	Preferred	QL (1 EA per 1 day)
doxazosin mesylate tablet 2 mg oral	Preferred	QL (1 EA per 1 day)
doxazosin mesylate tablet 4 mg oral	Preferred	QL (1 EA per 1 day)
doxazosin mesylate tablet 8 mg oral	Preferred	QL (2 EA per 1 day)
prazosin hcl	Preferred	QL (4 EA per 1 day)
terazosin hcl capsule 1 mg oral	Preferred	QL (1 EA per 1 day)
terazosin hcl capsule 10 mg oral	Preferred	QL (2 EA per 1 day)
terazosin hcl capsule 2 mg oral	Preferred	QL (2 EA per 1 day)
terazosin hcl capsule 5 mg oral	Preferred	QL (1 EA per 1 day)
CARDURA TABLET 1 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 2 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 4 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDURA TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
Beta Blocker & Diuretic Combinations - Drugs For High Blood Pressure***		
atenolol-chlorthalidone	Preferred	
bisoprolol-hydrochlorothiazide	Preferred	
metoprolol-hydrochlorothiazide	Preferred	
TENORETIC 100	Non – Preferred	
TENORETIC 50	Non – Preferred	
Direct Renin Inhibitors - Drugs For High Blood Pressure***		
aliskiren fumarate	Non – Preferred	
TEKTURNA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Selective Aldosterone Receptor Antagonists (Saras) - Drugs For High Blood Pressure***		
eplerenone	Non – Preferred	
INSPRA	Non – Preferred	
Vasodilators - Drugs For High Blood Pressure***		
hydralazine hcl	Preferred	
minoxidil	Preferred	
***Anti-Infective Agents - Misc.* - Drugs For Infections**		
Anti-Infective Agents - Misc. - Drugs For Infections***		
metronidazole intravenous	Preferred	
metronidazole oral capsule	Non – Preferred	
metronidazole oral tablet	Preferred	
pentamidine isethionate	Preferred	
tinidazole	Non – Preferred	
trimethoprim	Preferred	
LIKMEZ	Non – Preferred	
NEBUPENT	Preferred	
XIFAXAN	Non – Preferred	
Anti-Infective Misc. - Combinations - Antibiotics***		
sulfamethoxazole-trimethoprim	Preferred	
BACTRIM	Non – Preferred	
BACTRIM DS	Non – Preferred	
SULFATRIM PEDIATRIC	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiprotozoal Agents - Drugs For Parasites***		
atovaquone	Preferred	
nitazoxanide	Non – Preferred	
LAMPIT	Non – Preferred	
MEPRON	Non – Preferred	
Carbapenem Combinations - Antibiotics***		
imipenem-cilastatin	Preferred	
Carbapenems - Antibiotics***		
ertapenem sodium	Preferred	
meropenem	Preferred	
meropenem-sodium chloride	Preferred	
Glycopeptides - Antibiotics***		
vancomycin hcl capsule 125 mg oral	Preferred	
vancomycin hcl capsule 125 mg oral	Preferred	QL (4 EA per 1 day)
vancomycin hcl capsule 250 mg oral	Preferred	QL (8 EA per 1 day)
vancomycin hcl in dextrose	Preferred	
vancomycin hcl in nacl	Preferred	
vancomycin hcl intravenous	Preferred	
vancomycin hcl oral solution reconstituted	Preferred	
FIRVANQ	Non – Preferred	
VANCOCIN CAPSULE 125 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
VANCOCIN CAPSULE 250 MG ORAL	Non – Preferred	QL (8 EA per 1 day)
Leprostatics - Antibiotics***		
dapsone	Preferred	
Lincosamides - Antibiotics***		
clindamycin hcl	Preferred	
clindamycin palmitate hcl	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clindamycin phosphate	Preferred	
clindamycin phosphate in d5w	Preferred	
clindamycin phosphate in nacl	Preferred	
CLEOCIN	Non – Preferred	
Monobactams - Antibiotics**		
aztreonam	Preferred	
CAYSTON	Non – Preferred	
Oxazolidinones - Antibiotics**		
linezolid	Non – Preferred	
SIVEXTRO	Non – Preferred	
ZYVOX	Non – Preferred	
Urinary Anti-Infectives - Antibiotics**		
fosfomycin tromethamine	Preferred	
methenamine hippurate	Preferred	
methenamine mandelate	Preferred	
nitrofurantoin macrocrystal	Preferred	
nitrofurantoin monohyd macro	Preferred	
nitrofurantoin suspension 25 mg/5ml oral	Preferred	
nitrofurantoin suspension 50 mg/5ml oral	Preferred	QL (1 ML per 1 day)
MACROBID	Non – Preferred	
Urinary Antiseptic-Antispasmodic &/Or Analgesics - Drugs For Infections**		
mb caps	Non – Preferred	
me/naphos/mb/hyo1	Non – Preferred	
uro-mp	Non – Preferred	
URIMAR-T	Non – Preferred	
UROGESIC-BLUE	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antimalarials* - Drugs For Infections**		
****Antimalarial Combinations*** - Drugs For Parasites***		
atovaquone-proguanil hcl tablet 250-100 mg oral	Preferred	QL (12 EA Max Qty Per Fill Retail)
atovaquone-proguanil hcl tablet 62.5-25 mg oral	Preferred	QL (9 EA Max Qty Per Fill Retail)
COARTEM	Non – Preferred	
MALARONE TABLET 250-100 MG ORAL	Non – Preferred	QL (12 EA Max Qty Per Fill Retail)
MALARONE TABLET 62.5-25 MG ORAL	Non – Preferred	QL (9 EA Max Qty Per Fill Retail)
****Antimalarials*** - Drugs For Parasites***		
chloroquine phosphate	Preferred	
hydroxychloroquine sulfate	Preferred	
mefloquine hcl	Preferred	
primaquine phosphate	Preferred	QL (28 EA Max Qty Per Fill Retail)
pyrimethamine	Non – Preferred	
quinine sulfate	Non – Preferred	
KRINTAFEL	Non – Preferred	
QUALAQUIN	Non – Preferred	
SOVUNA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antimyasthenic/Cholinergic Agents* - Drugs For Nerves And Muscles**		
****Antimyasthenic/Cholinergic Agents*** - Drugs For Nerves And Muscles***		
pyridostigmine bromide	Preferred	
pyridostigmine bromide er	Preferred	
FIRDAPSE	Non – Preferred	
MESTINON	Non – Preferred	
***Antimycobacterial Agents* - Drugs For Infections**		
****Antimycobacterial Agents*** - Antibiotics***		
cycloserine	Preferred	
ethambutol hcl	Preferred	
isoniazid	Preferred	
pretomanid	Non – Preferred	
pyrazinamide	Preferred	
rifabutin	Preferred	
rifampin	Preferred	
PRIFTIN	Preferred	
SIRTURO	Non – Preferred	
TRECATOR	Preferred	
***Antineoplastics And Adjunctive Therapies* - Drugs For Cancer**		
****Androgen Biosynthesis Inhibitors*** - Drugs For Cancer***		
abiraterone acetate	Preferred	
YONSA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYTIGA	Non – Preferred	
Antiadrenals - Drugs For Cancer**		
LYSODREN	Preferred	
Antiandrogens - Drugs For Cancer**		
bicalutamide	Preferred	QL (1 EA per 1 day)
nilutamide	Preferred	
CASODEX	Non – Preferred	QL (1 EA per 1 day)
ERLEADA	Non – Preferred	
NUBEQA	Non – Preferred	
XTANDI	Non – Preferred	
Antiestrogens - Drugs For Cancer**		
tamoxifen citrate	Preferred	
toremifene citrate	Preferred	
FARESTON	Non – Preferred	
SOLTAMOX	Preferred	
Antimetabolites - Drugs For Cancer**		
capecitabine tablet 150 mg oral	Non – Preferred	QL (140 EA per 21 days)
capecitabine tablet 500 mg oral	Non – Preferred	QL (154 EA per 21 days)
mercaptopurine	Preferred	
methotrexate sodium (pf)	Preferred	
methotrexate sodium oral	Preferred	
methotrexate sodium solution 250 mg/10ml injection	Preferred	QL (10 VIAL per 28 days)
methotrexate sodium solution 50 mg/2ml injection	Preferred	QL (4 VIAL per 28 days)
JYLAMVO	Non – Preferred	
ONUREG	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PURIXAN	Non – Preferred	
TABLOID	Preferred	
TREXALL	Preferred	
XATMEP	Non – Preferred	
XELODA TABLET 150 MG ORAL	Non – Preferred	QL (140 EA per 21 days)
XELODA TABLET 500 MG ORAL	Non – Preferred	QL (154 EA per 21 days)
Antineoplastic - Akt Inhibitors - Drugs For Cancer***		
TRUQAP	Non – Preferred	
Antineoplastic - Alk Inhibitors - Drugs For Cancer***		
ALECENSA	Non – Preferred	
ALUNBRIG	Non – Preferred	
LORBRENA	Non – Preferred	
XALKORI	Non – Preferred	
ZYKADIA	Non – Preferred	
Antineoplastic - Anti-Her2 Agents - Drugs For Cancer***		
TUKYSA	Non – Preferred	
Antineoplastic - Bcl-2 Inhibitors - Drugs For Cancer***		
VENCLEXTA	Non – Preferred	
VENCLEXTA STARTING PACK	Non – Preferred	
Antineoplastic - Bcr-Abl Kinase Inhibitors - Drugs For Cancer***		
imatinib mesylate tablet 100 mg oral	Non – Preferred	
imatinib mesylate tablet 100 mg oral	Non – Preferred	QL (3 EA per 1 day)
imatinib mesylate tablet 400 mg oral	Non – Preferred	QL (2 EA per 1 day)
BOSULIF	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DANZITEN	Non – Preferred	
GLEEVEC TABLET 100 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
GLEEVEC TABLET 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ICLUSIG	Non – Preferred	
SCEMBLIX	Non – Preferred	
SPRYCEL	Non – Preferred	QL (1 EA per 1 day)
TASIGNA	Non – Preferred	QL (4 EA per 1 day)
Antineoplastic - Braf Kinase Inhibitors - Drugs For Cancer***		
BRAFTOVI	Non – Preferred	
OJEMDA	Non – Preferred	
TAFINLAR	Non – Preferred	
ZELBORAF	Non – Preferred	
Antineoplastic - Btk Inhibitors - Drugs For Cancer***		
BRUKINSA	Non – Preferred	
CALQUENCE	Non – Preferred	
IMBRUVICA CAPSULE 140 MG ORAL	Non – Preferred	
IMBRUVICA CAPSULE 70 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
IMBRUVICA ORAL SUSPENSION	Non – Preferred	
IMBRUVICA TABLET 140 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
IMBRUVICA TABLET 280 MG ORAL	Non – Preferred	
IMBRUVICA TABLET 420 MG ORAL	Non – Preferred	
JAYPIRCA	Non – Preferred	
Antineoplastic - Egfr Inhibitors - Drugs For Cancer***		
erlotinib hcl	Preferred	QL (1 EA per 1 day)
gefitinib	Preferred	
GILOTRIF	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRESSA	Preferred	
LAZCLUZE	Non – Preferred	
TAGRISSO	Non – Preferred	
TARCEVA	Non – Preferred	QL (1 EA per 1 day)
VIZIMPRO	Non – Preferred	
Antineoplastic - Fgfr Kinase Inhibitors - Drugs For Cancer***		
BALVERSA	Non – Preferred	
LYTGOBI (12 MG DAILY DOSE)	Non – Preferred	
LYTGOBI (16 MG DAILY DOSE)	Non – Preferred	
LYTGOBI (20 MG DAILY DOSE)	Non – Preferred	
PEMAZYRE	Non – Preferred	
Antineoplastic - Gamma Secretase Inhibitors - Drugs For Cancer***		
OGSIVEO	Non – Preferred	
Antineoplastic - Hedgehog Pathway Inhibitors - Drugs For Cancer***		
DAURISMO	Non – Preferred	
ERIVEDGE	Preferred	
ODOMZO	Non – Preferred	
Antineoplastic - Histone Deacetylase Inhibitors - Drugs For Cancer***		
ZOLINZA	Non – Preferred	
Antineoplastic - Hormonal And Related Agent Combinations - Drugs For Cancer***		
AKEEGA	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Immunomodulators - Drugs For Cancer***		
POMALYST	Non – Preferred	
Antineoplastic - Kras Inhibitors - Drugs For Cancer***		
KRAZATI	Non – Preferred	
LUMAKRAS	Non – Preferred	
Antineoplastic - Mek Inhibitors - Drugs For Cancer***		
COTELLIC	Non – Preferred	
GOMEKLI	Non – Preferred	
KOSELUGO	Non – Preferred	
MEKINIST	Non – Preferred	
MEKTOVI	Non – Preferred	
Antineoplastic - Met Inhibitors - Drugs For Cancer***		
TABRECTA	Non – Preferred	
TEPMETKO	Non – Preferred	
Antineoplastic - Methyltransferase Inhibitors - Drugs For Cancer***		
TAZVERIK	Non – Preferred	
Antineoplastic - Mtor Kinase Inhibitors - Drugs For Cancer***		
everolimus oral tablet	Non – Preferred	QL (1 EA per 1 day)
everolimus oral tablet soluble	Non – Preferred	
AFINITOR	Non – Preferred	QL (1 EA per 1 day)
AFINITOR DISPERZ	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Multikinase Inhibitors - Drugs For Cancer**		
lapatinib ditosylate	Non – Preferred	
pazopanib hcl	Preferred	QL (4 EA per 1 day)
sorafenib tosylate	Preferred	QL (4 EA per 1 day)
sunitinib malate capsule 12.5 mg oral	Preferred	
sunitinib malate capsule 12.5 mg oral	Preferred	QL (1 EA per 1 day)
sunitinib malate capsule 25 mg oral	Preferred	
sunitinib malate capsule 25 mg oral	Preferred	QL (1 EA per 1 day)
sunitinib malate capsule 37.5 mg oral	Preferred	
sunitinib malate capsule 37.5 mg oral	Preferred	QL (1 EA per 1 day)
sunitinib malate capsule 50 mg oral	Preferred	
sunitinib malate capsule 50 mg oral	Preferred	QL (28 EA per 42 days)
CABOMETYX	Non – Preferred	QL (1 EA per 1 day)
CAPRELSA	Preferred	
COMETRIQ (100 MG DAILY DOSE)	Non – Preferred	
COMETRIQ (140 MG DAILY DOSE)	Non – Preferred	
COMETRIQ (60 MG DAILY DOSE)	Non – Preferred	
FOTIVDA	Non – Preferred	
NERLYNX	Non – Preferred	
NEXAVAR	Preferred	QL (4 EA per 1 day)
QINLOCK	Non – Preferred	
RYDAPT	Non – Preferred	
STIVARGA	Non – Preferred	
SUTENT CAPSULE 12.5 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 25 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 37.5 MG ORAL	Preferred	QL (1 EA per 1 day)
SUTENT CAPSULE 50 MG ORAL	Preferred	QL (28 EA per 42 days)
TURALIO	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TYKERB	Non – Preferred	QL (6 EA per 1 day)
VANFLYTA	Non – Preferred	
VOTRIENT	Preferred	QL (4 EA per 1 day)
XOSPATA	Non – Preferred	
Antineoplastic - Pdgfr-Alpha Inhibitors - Drugs For Cancer**		
AYVAKIT	Non – Preferred	
Antineoplastic - Proteasome Inhibitors - Drugs For Cancer**		
NINLARO	Non – Preferred	
Antineoplastic - Ret Inhibitors - Drugs For Cancer**		
GAVRETO	Non – Preferred	
Antineoplastic - Tropomyosin Receptor Kinase Inhibitors - Drugs For Cancer**		
AUGTYRO	Non – Preferred	
ROZLYTREK	Non – Preferred	
VITRAKVI	Non – Preferred	
Antineoplastic - Xpo1 Inhibitors - Drugs For Cancer**		
XPOVIO (100 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (40 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (60 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (60 MG TWICE WEEKLY)	Non – Preferred	
XPOVIO (80 MG ONCE WEEKLY)	Non – Preferred	
XPOVIO (80 MG TWICE WEEKLY)	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic Combinations - Drugs For Cancer***		
INQOVI	Non – Preferred	
LONSURF	Non – Preferred	
Antineoplastics Misc. - Drugs For Cancer***		
hydroxyurea	Preferred	
HYDREA	Non – Preferred	
MATULANE	Preferred	
Aromatase Inhibitors - Drugs For Cancer***		
anastrozole	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
exemestane tablet 25 mg oral	Preferred	AL (Min 40 Years)
exemestane tablet 25 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
letrozole tablet 2.5 mg oral	Preferred	AL (Min 40 Years)
letrozole tablet 2.5 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
ARIMIDEX	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
AROMASIN	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
FEMARA	Non – Preferred	QL (1 EA per 1 day); AL (Min 40 Years)
Cyclin-Dependent Kinases (Cdk) Inhibitors - Drugs For Cancer***		
IBRANCE ORAL CAPSULE	Non – Preferred	QL (1 EA per 1 day)
IBRANCE ORAL TABLET	Non – Preferred	
KISQALI (200 MG DOSE)	Non – Preferred	
KISQALI (400 MG DOSE)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KISQALI (600 MG DOSE)	Non – Preferred	
VERZENIO	Non – Preferred	QL (2 EA per 1 day)
Folic Acid Antagonists Rescue Agents - Drugs For Cancer**		
leucovorin calcium	Preferred	
Gonadotropin Releasing Hormone (Gnrh) Antagonists - Drugs For Cancer**		
ORGOVYX	Non – Preferred	
Imidazotetrazines - Drugs For Cancer**		
temozolomide	Preferred	
Isocitrate Dehydrogenase 1 & 2 (Idh1 & Idh2) Inhibitors - Drugs For Cancer**		
VORANIGO	Non – Preferred	
Isocitrate Dehydrogenase-1 (Idh1) Inhibitors - Drugs For Cancer**		
REZLIDHIA	Non – Preferred	
TIBSOVO	Non – Preferred	
Isocitrate Dehydrogenase-2 (Idh2) Inhibitors - Drugs For Cancer**		
IDHIFA	Non – Preferred	
Janus Associated Kinase (Jak) Inhibitors - Drugs For Cancer**		
INREBIC	Non – Preferred	
JAKAFI	Preferred	
OJJAARA	Non – Preferred	
VONJO	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Mitotic Inhibitors - Drugs For Cancer***		
etoposide	Preferred	
Nitrogen Mustards And Related Analogues - Drugs For Cancer***		
cyclophosphamide	Preferred	
Ornithine Decarboxylase (Odc) Inhibitors - Drugs For Cancer***		
IWILFIN	Non – Preferred	
Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors - Drugs For Cancer***		
COPIKTRA	Non – Preferred	
ITOVEBI	Non – Preferred	
PIQRAY (200 MG DAILY DOSE)	Non – Preferred	
PIQRAY (250 MG DAILY DOSE)	Non – Preferred	
PIQRAY (300 MG DAILY DOSE)	Non – Preferred	
ZYDELIG	Non – Preferred	
Poly (Adp-Ribose) Polymerase (Parp) Inhibitors - Drugs For Cancer***		
LYNPARZA	Non – Preferred	
RUBRACA	Non – Preferred	
TALZENNA	Non – Preferred	
ZEJULA	Non – Preferred	
Progestins-Antineoplastic - Drugs For Cancer***		
megestrol acetate	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Retinoids - Drugs For Cancer***		
tretinoin	Preferred	
Selective Estrogen Receptor Degraders - Drugs For Cancer***		
ORSERDU	Preferred	
Selective Retinoid X Receptor Agonists - Drugs For Cancer***		
bexarotene	Preferred	
TARGRETIN	Non – Preferred	
Topoisomerase I Inhibitors - Drugs For Cancer***		
HYCAMTIN	Preferred	
Urinary Tract Protective Agents - Drugs For Cancer***		
MESNEX	Preferred	
Vascular Endothelial Growth Factor (Vegf) Inhibitors - Drugs For Cancer***		
FRUZAQLA	Non – Preferred	
INLYTA	Non – Preferred	
LENVIMA (10 MG DAILY DOSE)	Non – Preferred	
LENVIMA (12 MG DAILY DOSE)	Non – Preferred	
LENVIMA (14 MG DAILY DOSE)	Non – Preferred	
LENVIMA (18 MG DAILY DOSE)	Non – Preferred	
LENVIMA (20 MG DAILY DOSE)	Non – Preferred	
LENVIMA (24 MG DAILY DOSE)	Non – Preferred	
LENVIMA (4 MG DAILY DOSE)	Non – Preferred	
LENVIMA (8 MG DAILY DOSE)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Antiparkinson And Related Therapy Agents* - Drugs For The Nervous System**		
****Adenosine Receptor Antagonist*** - Drugs For Parkinson***		
NOURIANZ	Non – Preferred	
****Antiparkinson Anticholinergics*** - Drugs For Parkinson***		
benztropine mesylate	Preferred	
trihexyphenidyl hcl	Preferred	
****Antiparkinson Dopaminergics*** - Drugs For Parkinson***		
amantadine hcl	Preferred	
bromocriptine mesylate	Preferred	
GOCOVRI	Non – Preferred	
INBRIJA	Non – Preferred	
OSMOLEX ER	Non – Preferred	
PARLODEL	Non – Preferred	
****Antiparkinson Monoamine Oxidase Inhibitors*** - Drugs For Parkinson***		
rasagiline mesylate	Non – Preferred	
selegiline hcl	Preferred	
AZILECT	Non – Preferred	
XADAGO	Non – Preferred	
ZELAPAR	Non – Preferred	
****Central/Peripheral Comt Inhibitors*** - Drugs For Parkinson***		
tolcapone	Non – Preferred	
TASMAR	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Decarboxylase Inhibitors - Drugs For Parkinson***		
carbidopa	Preferred	
LODOSYN	Non – Preferred	
Levodopa Combinations - Drugs For Parkinson***		
carbidopa-levodopa er	Preferred	
carbidopa-levodopa oral tablet	Preferred	
carbidopa-levodopa oral tablet dispersible	Non – Preferred	
carbidopa-levodopa-entacapone	Non – Preferred	
DHIVY	Non – Preferred	
RYTARY	Non – Preferred	
SINEMET	Non – Preferred	
VYALEV	Non – Preferred	
Nonergoline Dopamine Receptor Agonists - Drugs For Parkinson***		
apomorphine hcl	Non – Preferred	
pramipexole dihydrochloride	Preferred	
pramipexole dihydrochloride er	Non – Preferred	
ropinirole hcl	Preferred	QL (3 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 12 mg oral	Non – Preferred	QL (2 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 2 mg oral	Non – Preferred	QL (1 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 4 mg oral	Non – Preferred	
ropinirole hcl er tablet extended release 24 hour 6 mg oral	Non – Preferred	QL (1 EA per 1 day)
ropinirole hcl er tablet extended release 24 hour 8 mg oral	Non – Preferred	QL (1 EA per 1 day)
APOKYN	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUPRO	Non – Preferred	
ONAPGO	Non – Preferred	
Peripheral Comt Inhibitors - Drugs For Parkinson**		
entacapone	Preferred	
ONGENTYS	Non – Preferred	
***Antipsychotics/Antimanic Agents* - Drugs For The Nervous System**		
Antimanic Agents - Drugs For Severe Mental Disorders**		
lithium	Preferred	
lithium carbonate capsule 150 mg oral	Preferred	QL (16 EA per 1 day)
lithium carbonate capsule 300 mg oral	Preferred	
lithium carbonate capsule 300 mg oral	Preferred	QL (8 EA per 1 day)
lithium carbonate capsule 600 mg oral	Preferred	QL (4 EA per 1 day)
lithium carbonate er tablet extended release 300 mg oral	Preferred	QL (8 EA per 1 day)
lithium carbonate er tablet extended release 450 mg oral	Preferred	QL (6 EA per 1 day)
lithium carbonate oral tablet	Preferred	QL (8 EA per 1 day)
LITHOBID	Non – Preferred	QL (8 EA per 1 day)
Antipsychotics - Misc. - Drugs For Severe Mental Disorders**		
lurasidone hcl tablet 120 mg oral	Preferred	AL (Min 8 Years)
lurasidone hcl tablet 120 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
lurasidone hcl tablet 20 mg oral	Preferred	AL (Min 8 Years)
lurasidone hcl tablet 20 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
lurasidone hcl tablet 40 mg oral	Preferred	AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lurasidone hcl tablet 40 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
lurasidone hcl tablet 60 mg oral	Preferred	AL (Min 8 Years)
lurasidone hcl tablet 60 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
lurasidone hcl tablet 80 mg oral	Preferred	AL (Min 8 Years)
lurasidone hcl tablet 80 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
ziprasidone hcl	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
ziprasidone mesylate	Non – Preferred	AL (Min 18 Years)
CAPLYTA	Preferred	AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL	Non – Preferred	AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL	Non – Preferred	QL (8 EA per 1 day); AL (Min 8 Years)
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL	Non – Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
GEODON INTRAMUSCULAR	Non – Preferred	AL (Min 18 Years)
GEODON ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 40 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 60 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
LATUDA TABLET 80 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
NUPLAZID	Non – Preferred	AL (Min 8 Years)
VRAYLAR	Preferred	AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Benzisoxazoles - Drugs For Severe Mental Disorders***		
paliperidone er tablet extended release 24 hour 1.5 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
paliperidone er tablet extended release 24 hour 3 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
paliperidone er tablet extended release 24 hour 6 mg oral	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
paliperidone er tablet extended release 24 hour 9 mg oral	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
risperidone microspheres er	Non – Preferred	AL (Min 18 Years)
risperidone oral solution	Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
risperidone tablet 0.25 mg oral	Preferred	
risperidone tablet 0.25 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 0.5 mg oral	Preferred	
risperidone tablet 0.5 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 1 mg oral	Preferred	
risperidone tablet 1 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 2 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
risperidone tablet 3 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
risperidone tablet 4 mg oral	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
risperidone tablet dispersible 0.25 mg oral	Non – Preferred	AL (Min 8 Years)
risperidone tablet dispersible 0.5 mg oral	Non – Preferred	AL (Min 8 Years)
risperidone tablet dispersible 1 mg oral	Non – Preferred	AL (Min 8 Years)
risperidone tablet dispersible 2 mg oral	Non – Preferred	AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
risperidone tablet dispersible 4 mg oral	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
ERZOFRI	Non – Preferred	
FANAPT TABLET 1 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 10 MG ORAL	Non – Preferred	AL (Min 8 Years)
FANAPT TABLET 12 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 2 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 4 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 6 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TABLET 8 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
FANAPT TITRATION PACK	Non – Preferred	QL (1 PACK per 90 days); AL (Min 8 Years)
INVEGA HAFYERA	Preferred	ST; AL (Min 18 Years)
INVEGA SUSTENNA	Preferred	AL (Min 18 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
INVEGA TRINZA	Preferred	AL (Min 18 Years)
PERSERIS	Preferred	AL (Min 18 Years)
RISPERDAL CONSTA	Non – Preferred	AL (Min 18 Years)
RISPERDAL ORAL SOLUTION	Non – Preferred	QL (16 ML per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 0.5 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RISPERDAL TABLET 1 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 2 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 3 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
RISPERDAL TABLET 4 MG ORAL	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
RYKINDO	Non – Preferred	AL (Min 18 Years)
UZEDY	Preferred	AL (Min 18 Years)
Butyrophenones - Drugs For Severe Mental Disorders**		
haloperidol decanoate	Preferred	AL (Min 18 Years)
haloperidol lactate concentrate 10 mg/5ml oral	Preferred	
haloperidol lactate concentrate 2 mg/ml oral	Preferred	QL (50 ML per 1 day)
haloperidol lactate injection	Preferred	QL (4 ML per 1 day); AL (Min 3 Years)
haloperidol tablet 0.5 mg oral	Preferred	QL (5 EA per 1 day)
haloperidol tablet 1 mg oral	Preferred	QL (10 EA per 1 day)
haloperidol tablet 10 mg oral	Preferred	QL (10 EA per 1 day)
haloperidol tablet 2 mg oral	Preferred	
haloperidol tablet 2 mg oral	Preferred	QL (10 EA per 1 day)
haloperidol tablet 20 mg oral	Preferred	QL (5 EA per 1 day)
haloperidol tablet 5 mg oral	Preferred	QL (5 EA per 1 day)
Dibenzodiazepines - Drugs For Severe Mental Disorders**		
clozapine tablet 100 mg oral	Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
clozapine tablet 200 mg oral	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clozapine tablet 25 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
clozapine tablet 50 mg oral	Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
clozapine tablet dispersible 100 mg oral	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
clozapine tablet dispersible 12.5 mg oral	Non – Preferred	AL (Min 8 Years)
clozapine tablet dispersible 150 mg oral	Non – Preferred	QL (6 EA per 1 day); AL (Min 8 Years)
clozapine tablet dispersible 200 mg oral	Non – Preferred	QL (4 EA per 1 day); AL (Min 8 Years)
clozapine tablet dispersible 25 mg oral	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 100 MG ORAL	Non – Preferred	QL (9 EA per 1 day); AL (Min 8 Years)
CLOZARIL TABLET 25 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
VERSACLOZ	Non – Preferred	AL (Min 8 Years)
Dibenzo-Oxepino Pyrroles - Drugs For Severe Mental Disorders***		
asenapine maleate	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SAPHRIS	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SECUADO	Non – Preferred	AL (Min 18 Years)
Dibenzothiazepines - Drugs For Severe Mental Disorders***		
quetiapine fumarate er tablet extended release 24 hour 150 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate er tablet extended release 24 hour 200 mg oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
quetiapine fumarate er tablet extended release 24 hour 300 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate er tablet extended release 24 hour 400 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate er tablet extended release 24 hour 50 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 100 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 150 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 200 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 25 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 25 mg oral	Preferred	QL (3 EA per 1 day)
quetiapine fumarate tablet 300 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 400 mg oral	Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
quetiapine fumarate tablet 50 mg oral	Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 100 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 200 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 25 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 300 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL TABLET 50 MG ORAL	Non – Preferred	QL (3 EA per 1 day); AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	QL (2 EA per 1 day); AL (Min 8 Years)
Dibenzoxazepines - Drugs For Severe Mental Disorders**		
loxapine succinate capsule 10 mg oral	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
loxapine succinate capsule 25 mg oral	Preferred	QL (10 EA per 1 day); AL (Min 8 Years)
loxapine succinate capsule 5 mg oral	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
loxapine succinate capsule 50 mg oral	Preferred	QL (5 EA per 1 day); AL (Min 8 Years)
ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION	Non – Preferred	AL (Min 18 Years)
ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION	Preferred	AL (Min 18 Years)
Dihydroindolones - Drugs For Severe Mental Disorders**		
molindone hcl	Non – Preferred	
Phenothiazines - Drugs For Severe Mental Disorders**		
chlorpromazine hcl injection	Preferred	QL (2 ML per 1 day)
chlorpromazine hcl oral concentrate	Preferred	
chlorpromazine hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
chlorpromazine hcl tablet 100 mg oral	Preferred	QL (4 EA per 1 day)
chlorpromazine hcl tablet 200 mg oral	Preferred	QL (5 EA per 1 day)
chlorpromazine hcl tablet 25 mg oral	Preferred	
chlorpromazine hcl tablet 25 mg oral	Preferred	QL (4 EA per 1 day)
chlorpromazine hcl tablet 50 mg oral	Preferred	QL (4 EA per 1 day)
fluphenazine decanoate	Preferred	QL (8 ML per 28 days); AL (Min 18 Years)
fluphenazine hcl injection	Preferred	QL (4 ML per 1 day)
fluphenazine hcl oral concentrate	Preferred	QL (8 ML per 1 day)
fluphenazine hcl oral elixir	Preferred	QL (80 ML per 1 day)
fluphenazine hcl tablet 1 mg oral	Preferred	
fluphenazine hcl tablet 10 mg oral	Preferred	
fluphenazine hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
fluphenazine hcl tablet 2.5 mg oral	Preferred	
fluphenazine hcl tablet 2.5 mg oral	Preferred	QL (3 EA per 1 day)
fluphenazine hcl tablet 5 mg oral	Preferred	
fluphenazine hcl tablet 5 mg oral	Preferred	QL (3 EA per 1 day)
perphenazine tablet 16 mg oral	Preferred	QL (4 EA per 1 day)
perphenazine tablet 2 mg oral	Preferred	QL (6 EA per 1 day)
perphenazine tablet 4 mg oral	Preferred	QL (6 EA per 1 day)
perphenazine tablet 8 mg oral	Preferred	QL (5 EA per 1 day)
prochlorperazine	Preferred	QL (2 EA per 1 day)
prochlorperazine maleate tablet 10 mg oral	Preferred	
prochlorperazine maleate tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
prochlorperazine maleate tablet 5 mg oral	Preferred	
prochlorperazine maleate tablet 5 mg oral	Preferred	QL (8 EA per 1 day)
thioridazine hcl tablet 10 mg oral	Preferred	QL (6 EA per 1 day)
thioridazine hcl tablet 100 mg oral	Preferred	QL (8 EA per 1 day)
thioridazine hcl tablet 25 mg oral	Preferred	QL (3 EA per 1 day)
thioridazine hcl tablet 50 mg oral	Preferred	QL (3 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
trifluoperazine hcl tablet 1 mg oral	Preferred	QL (4 EA per 1 day)
trifluoperazine hcl tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
trifluoperazine hcl tablet 2 mg oral	Preferred	QL (4 EA per 1 day)
trifluoperazine hcl tablet 5 mg oral	Preferred	QL (3 EA per 1 day)
COMPRO	Preferred	QL (2 EA per 1 day)
Quinolinone Derivatives - Drugs For Severe Mental Disorders***		
aripiprazole oral solution	Non – Preferred	AL (Min 8 Years)
aripiprazole oral tablet	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
aripiprazole oral tablet dispersible	Non – Preferred	AL (Min 8 Years)
ABILIFY	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ABILIFY ASIMTUFII	Preferred	AL (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE	Preferred	QL (1 SYRINGE per 28 days); AL (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	Preferred	QL (1 VIAL per 28 days); AL (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT	Non – Preferred	AL (Min 8 Years)
ABILIFY MYCITE STARTER KIT	Non – Preferred	AL (Min 8 Years)
ARISTADA INITIO	Preferred	QL (1 SYRINGE per 365 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 1064 MG/3.9ML INTRAMUSCULAR	Preferred	QL (1 SYRINGE per 56 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 441 MG/1.6ML INTRAMUSCULAR	Preferred	QL (1 SYRINGE per 28 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 662 MG/2.4ML INTRAMUSCULAR	Preferred	QL (2.4 ML per 28 days); AL (Min 18 Years)
ARISTADA PREFILLED SYRINGE 882 MG/3.2ML INTRAMUSCULAR	Preferred	QL (3.2 ML per 28 days); AL (Min 18 Years)
OPIPZA	Non – Preferred	AL (Min 8 Years)
REXULTI	Preferred	AL (Min 8 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Thienbenzodiazepines - Drugs For Severe Mental Disorders***		
olanzapine intramuscular	Non – Preferred	QL (3 EA per 1 day); AL (Min 18 Years)
olanzapine oral	Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
ZYPREXA INTRAMUSCULAR	Non – Preferred	QL (3 EA per 1 day); AL (Min 18 Years)
ZYPREXA ORAL	Non – Preferred	QL (1 EA per 1 day); AL (Min 8 Years)
Thioxanthenes - Drugs For Severe Mental Disorders***		
thiothixene	Preferred	QL (6 EA per 1 day)
***Antiseptics & Disinfectants* - Antiseptics And Disinfectants**		
Chlorine Antiseptics - Antiseptics And Disinfectants***		
antiseptic skin cleanser	Preferred	OTC
chlorhexidine gluconate	Preferred	OTC
DYNA-HEX 4	Preferred	OTC
***Antivirals* - Drugs For Infections**		
Antiretroviral Combinations - Drugs For Viral Infections***		
abacavir sulfate-lamivudine	Preferred	QL (1 EA per 1 day)
efavirenz-emtricitab-tenofo df	Preferred	
efavirenz-lamivudine-tenofovir	Non – Preferred	QL (1 EA per 1 day)
emtricitabine-tenofovir df	Preferred	QL (1 EA per 1 day)
lamivudine-zidovudine	Preferred	QL (2 EA per 1 day)
lopinavir-ritonavir oral solution	Preferred	QL (10 ML per 1 day)
lopinavir-ritonavir oral tablet	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
triumeq pd	Preferred	
BIKTARVY TABLET 30-120-15 MG ORAL	Preferred	
BIKTARVY TABLET 50-200-25 MG ORAL	Preferred	QL (1 EA per 1 day)
CABENUVA	Preferred	
CIMDUO	Non – Preferred	QL (1 EA per 1 day)
COMPLERA	Preferred	QL (1 EA per 1 day)
DELSTRIGO	Preferred	QL (1 EA per 1 day)
DESCOVY TABLET 120-15 MG ORAL	Preferred	
DESCOVY TABLET 200-25 MG ORAL	Preferred	QL (1 EA per 1 day)
DOVATO	Preferred	QL (1 EA per 1 day)
EVOTAZ	Non – Preferred	
GENVOYA	Preferred	QL (1 EA per 1 day)
JULUCA	Preferred	
KALETRA	Non – Preferred	QL (10 ML per 1 day)
ODEFSEY	Preferred	QL (1 EA per 1 day)
PREZCOBIX	Preferred	
STRIBILD	Non – Preferred	
SYMFI	Preferred	QL (1 EA per 1 day)
SYMFI LO	Preferred	QL (1 EA per 1 day)
SYMTUZA	Preferred	
TRIUMEQ	Preferred	QL (1 EA per 1 day)
TRUVADA	Preferred	QL (1 EA per 1 day)
Antiretrovirals - Capsid Inhibitors - Drugs For Viral Infections***		
SUNLENCA	Preferred	PA
Antiretrovirals - Ccr5 Antagonists (Entry Inhibitor) - Drugs For Viral Infections***		
maraviroc	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SELZENTRY ORAL SOLUTION	Preferred	
SELZENTRY ORAL TABLET	Non – Preferred	
Antiretrovirals - Cd4-Directed Post-Attachment Inhibitor - Drugs For Viral Infections***		
TROGARZO	Preferred	PA
Antiretrovirals - Fusion Inhibitors - Drugs For Viral Infections***		
FUZEON	Non – Preferred	QL (2 EA per 1 day)
Antiretrovirals - Gp120-Directed Attachment Inhibitor - Drugs For Viral Infections***		
RUKOBIA	Preferred	
Antiretrovirals - Integrase Inhibitors - Drugs For Viral Infections***		
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML	Preferred	
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR	Non – Preferred	
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR	Preferred	
ISENTRESS HD	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL PACKET	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET	Preferred	QL (2 EA per 1 day)
ISENTRESS ORAL TABLET CHEWABLE	Preferred	QL (6 EA per 1 day)
TIVICAY	Preferred	QL (2 EA per 1 day)
TIVICAY PD	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretrovirals - Protease Inhibitors - Drugs For Viral Infections***		
atazanavir sulfate capsule 150 mg oral	Preferred	QL (1 EA per 1 day)
atazanavir sulfate capsule 200 mg oral	Preferred	QL (2 EA per 1 day)
atazanavir sulfate capsule 300 mg oral	Preferred	QL (1 EA per 1 day)
darunavir	Preferred	
fosamprenavir calcium	Preferred	QL (4 EA per 1 day)
ritonavir	Preferred	QL (12 EA per 1 day)
APTIVUS	Preferred	QL (4 EA per 1 day)
NORVIR ORAL PACKET	Preferred	
NORVIR ORAL TABLET	Preferred	QL (12 EA per 1 day)
PREZISTA	Preferred	
REYATAZ CAPSULE 200 MG ORAL	Preferred	QL (2 EA per 1 day)
REYATAZ CAPSULE 300 MG ORAL	Preferred	QL (1 EA per 1 day)
REYATAZ ORAL PACKET	Preferred	QL (6 EA per 1 day)
VIRACEPT TABLET 250 MG ORAL	Preferred	QL (10 EA per 1 day)
VIRACEPT TABLET 625 MG ORAL	Preferred	QL (4 EA per 1 day)
Antiretrovirals - Rti-Non-Nucleoside Analogues - Drugs For Viral Infections***		
efavirenz	Preferred	QL (1 EA per 1 day)
etravirine	Preferred	
nevirapine er	Preferred	QL (1 EA per 1 day)
nevirapine oral suspension	Preferred	QL (40 ML per 1 day)
nevirapine oral tablet	Preferred	QL (2 EA per 1 day)
EDURANT	Preferred	QL (1 EA per 1 day)
INTELENCE TABLET 100 MG ORAL	Preferred	QL (4 EA per 1 day)
INTELENCE TABLET 200 MG ORAL	Preferred	QL (2 EA per 1 day)
INTELENCE TABLET 25 MG ORAL	Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PIFELTRO	Preferred	
Antiretrovirals - Rti-Nucleoside Analogues-Purines - Drugs For Viral Infections***		
abacavir sulfate oral solution	Preferred	QL (30 ML per 1 day)
abacavir sulfate oral tablet	Preferred	QL (2 EA per 1 day)
ZIAGEN	Preferred	QL (30 ML per 1 day)
Antiretrovirals - Rti-Nucleoside Analogues-Pyrimidines - Drugs For Viral Infections***		
emtricitabine	Preferred	QL (1 EA per 1 day)
lamivudine oral solution	Preferred	QL (30 ML per 1 day)
lamivudine tablet 150 mg oral	Preferred	QL (2 EA per 1 day)
lamivudine tablet 300 mg oral	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL CAPSULE	Preferred	QL (1 EA per 1 day)
EMTRIVA ORAL SOLUTION	Preferred	QL (24 ML per 1 day)
EPIVIR ORAL SOLUTION	Non – Preferred	QL (30 ML per 1 day)
EPIVIR TABLET 150 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
EPIVIR TABLET 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
Antiretrovirals - Rti-Nucleoside Analogues-Thymidines - Drugs For Viral Infections***		
zidovudine oral capsule	Preferred	QL (2 EA per 1 day)
zidovudine oral syrup	Preferred	QL (60 ML per 1 day)
zidovudine oral tablet	Preferred	QL (2 EA per 1 day)
RETROVIR ORAL CAPSULE	Non – Preferred	QL (2 EA per 1 day)
RETROVIR ORAL SYRUP	Non – Preferred	QL (60 ML per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretrovirals - Rti-Nucleotide Analogues - Drugs For Viral Infections***		
tenofovir disoproxil fumarate	Preferred	QL (1 EA per 1 day)
VIREAD ORAL POWDER	Preferred	QL (8 GM per 1 day)
VIREAD ORAL TABLET	Preferred	QL (1 EA per 1 day)
Antiretrovirals Adjuvants - Drugs For Viral Infections***		
TYBOST	Non – Preferred	
Antiviral Combinations - Drugs For Infections***		
PAXLOVID (150/100)	Preferred	AL (Min 12 Years)
PAXLOVID (300/100)	Preferred	AL (Min 12 Years)
Cmv Agents - Drugs For Viral Infections***		
valganciclovir hcl oral solution reconstituted	Non – Preferred	QL (2 ML per 1 day)
valganciclovir hcl tablet 450 mg oral	Preferred	
valganciclovir hcl tablet 450 mg oral	Preferred	QL (2 EA per 1 day)
LIVTENCITY	Preferred	PA
PREVYMIS	Preferred	PA
VALCYTE	Non – Preferred	QL (2 EA per 1 day)
Hepatitis B Agents - Drugs For Viral Infections***		
adefovir dipivoxil	Non – Preferred	
entecavir	Preferred	QL (1 EA per 1 day)
lamivudine	Non – Preferred	QL (1 EA per 1 day)
BARACLUDE ORAL SOLUTION	Non – Preferred	
BARACLUDE ORAL TABLET	Non – Preferred	QL (1 EA per 1 day)
VEMLIDY	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hepatitis C Agent - Combinations - Drugs For Viral Infections***		
ledipasvir-sofosbuvir	Non – Preferred	
sofosbuvir-velpatasvir	Preferred	QL (1 EA per 1 day)
EPCLUSA ORAL PACKET	Non – Preferred	
EPCLUSA TABLET 200-50 MG ORAL	Non – Preferred	
EPCLUSA TABLET 400-100 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
HARVONI	Non – Preferred	
MAVYRET ORAL PACKET	Preferred	QL (5 EA per 1 day)
MAVYRET ORAL TABLET	Preferred	QL (3 EA per 1 day)
VOSEVI	Non – Preferred	
ZEPATIER	Non – Preferred	
Hepatitis C Agents - Drugs For Viral Infections***		
ribavirin	Preferred	
PEGASYS	Non – Preferred	QL (2 ML per 28 days)
SOVALDI	Non – Preferred	
Herpes Agents - Purine Analogues - Drugs For Viral Infections***		
acyclovir capsule 200 mg oral	Preferred	QL (50 EA per 30 days)
acyclovir suspension 200 mg/5ml oral	Preferred	QL (400 ML per 30 days)
acyclovir tablet 400 mg oral	Preferred	
acyclovir tablet 400 mg oral	Preferred	QL (2 EA per 1 day)
acyclovir tablet 800 mg oral	Preferred	
acyclovir tablet 800 mg oral	Preferred	QL (2 EA per 1 day)
valacyclovir hcl tablet 1 gm oral	Preferred	QL (30 EA per 30 days)
valacyclovir hcl tablet 500 mg oral	Preferred	QL (2 EA per 1 day)
SITAVIG	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VALTREX TABLET 1 GM ORAL	Non – Preferred	QL (30 EA per 30 days)
VALTREX TABLET 500 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
Herpes Agents - Thymidine Analogues - Drugs For Viral Infections***		
famciclovir	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
Influenza Agents - Drugs For Viral Infections***		
rimantadine hcl	Non – Preferred	QL (14 EA Max Qty Per Fill Retail)
Misc. Antivirals - Drugs For Viral Infections***		
LAGEVRIO	Preferred	AL (Min 18 Years)
Neuraminidase Inhibitors - Drugs For Viral Infections***		
oseltamivir phosphate capsule 30 mg oral	Preferred	QL (20 EA per 30 days)
oseltamivir phosphate capsule 45 mg oral	Preferred	QL (10 EA per 30 days)
oseltamivir phosphate capsule 75 mg oral	Preferred	QL (10 EA per 30 days)
oseltamivir phosphate oral suspension reconstituted	Preferred	QL (180 ML per 30 days)
RELENZA DISKHALER	Preferred	QL (20 EA Max Qty Per Fill Retail)
TAMIFLU CAPSULE 30 MG ORAL	Non – Preferred	QL (20 EA per 30 days)
TAMIFLU CAPSULE 45 MG ORAL	Non – Preferred	QL (10 EA per 30 days)
TAMIFLU CAPSULE 75 MG ORAL	Non – Preferred	QL (10 EA per 30 days)
TAMIFLU ORAL SUSPENSION RECONSTITUTED	Non – Preferred	QL (180 ML per 30 days)
Pa Endonuclease Inhibitors - Drugs For Viral Infections***		
XOFLUZA (40 MG DOSE)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XOFLUZA (80 MG DOSE)	Non – Preferred	
Rsv Agents - Nucleoside Analogues - Drugs For Viral Infections***		
ribavirin	Preferred	
VIRAZOLE	Non – Preferred	
***Beta Blockers* - Drugs For The Heart**		
Alpha-Beta Blockers - Drugs For High Blood Pressure***		
carvedilol phosphate er	Non – Preferred	
carvedilol tablet 12.5 mg oral	Preferred	QL (2 EA per 1 day)
carvedilol tablet 25 mg oral	Preferred	
carvedilol tablet 25 mg oral	Preferred	QL (2 EA per 1 day)
carvedilol tablet 3.125 mg oral	Preferred	
carvedilol tablet 3.125 mg oral	Preferred	QL (2 EA per 1 day)
carvedilol tablet 6.25 mg oral	Preferred	QL (2 EA per 1 day)
labetalol hcl	Preferred	
COREG	Non – Preferred	QL (2 EA per 1 day)
COREG CR	Non – Preferred	
Beta Blockers Cardio-Selective - Drugs For High Blood Pressure***		
acebutolol hcl	Preferred	
atenolol	Preferred	
betaxolol hcl	Preferred	
bisoprolol fumarate tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
bisoprolol fumarate tablet 5 mg oral	Preferred	QL (1 EA per 1 day)
metoprolol succinate er tablet extended release 24 hour 100 mg oral	Preferred	QL (1.5 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
metoprolol succinate er tablet extended release 24 hour 200 mg oral	Preferred	
metoprolol succinate er tablet extended release 24 hour 200 mg oral	Preferred	QL (2 EA per 1 day)
metoprolol succinate er tablet extended release 24 hour 25 mg oral	Preferred	QL (1 EA per 1 day)
metoprolol succinate er tablet extended release 24 hour 50 mg oral	Preferred	QL (1.5 EA per 1 day)
metoprolol tartrate	Preferred	
nebivolol hcl	Non – Preferred	
BYSTOLIC	Non – Preferred	
KAPSPARGO SPRINKLE	Non – Preferred	
LOPRESSOR	Non – Preferred	
TENORMIN	Non – Preferred	
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	QL (1.5 EA per 1 day)
Beta Blockers Non-Selective - Drugs For High Blood Pressure**		
nadolol	Preferred	QL (2 EA per 1 day)
pindolol	Preferred	
propranolol hcl	Preferred	
propranolol hcl er	Preferred	QL (1 EA per 1 day)
sotalol hcl	Preferred	
sotalol hcl (af)	Non – Preferred	
timolol maleate	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BETAPACE	Non – Preferred	
BETAPACE AF	Non – Preferred	
HEMANGEOL	Preferred	PA; AL (Max 1 Years)
INDERAL LA	Non – Preferred	QL (1 EA per 1 day)
INDERAL XL	Non – Preferred	
INNOPRAN XL	Non – Preferred	
SOTYLIZE	Non – Preferred	
***Calcium Channel Blockers* - Drugs For The Heart**		
****Calcium Channel Blockers*** - Drugs For High Blood Pressure***		
amlodipine besylate tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
amlodipine besylate tablet 2.5 mg oral	Preferred	QL (2 EA per 1 day)
amlodipine besylate tablet 5 mg oral	Preferred	QL (2 EA per 1 day)
diltiazem hcl	Preferred	QL (4 EA per 1 day)
diltiazem hcl er beads capsule extended release 24 hour 120 mg oral	Preferred	QL (1 EA per 1 day)
diltiazem hcl er beads capsule extended release 24 hour 180 mg oral	Preferred	QL (3 EA per 1 day)
diltiazem hcl er beads capsule extended release 24 hour 240 mg oral	Preferred	QL (2 EA per 1 day)
diltiazem hcl er beads capsule extended release 24 hour 300 mg oral	Preferred	QL (1 EA per 1 day)
diltiazem hcl er beads capsule extended release 24 hour 360 mg oral	Preferred	QL (1 EA per 1 day)
diltiazem hcl er beads capsule extended release 24 hour 420 mg oral	Preferred	QL (1 EA per 1 day)
diltiazem hcl er capsule extended release 12 hour 120 mg oral	Preferred	QL (2 EA per 1 day)
diltiazem hcl er capsule extended release 12 hour 60 mg oral	Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diltiazem hcl er capsule extended release 12 hour 90 mg oral	Preferred	
diltiazem hcl er capsule extended release 12 hour 90 mg oral	Preferred	QL (2 EA per 1 day)
diltiazem hcl er capsule extended release 24 hour 120 mg oral	Preferred	
diltiazem hcl er capsule extended release 24 hour 180 mg oral	Preferred	QL (3 EA per 1 day)
diltiazem hcl er capsule extended release 24 hour 240 mg oral	Preferred	
diltiazem hcl er coated beads capsule extended release 24 hour 120 mg oral	Preferred	QL (1 EA per 1 day)
diltiazem hcl er coated beads capsule extended release 24 hour 180 mg oral	Preferred	QL (3 EA per 1 day)
diltiazem hcl er coated beads capsule extended release 24 hour 240 mg oral	Preferred	QL (2 EA per 1 day)
diltiazem hcl er coated beads capsule extended release 24 hour 300 mg oral	Preferred	QL (1 EA per 1 day)
diltiazem hcl er coated beads capsule extended release 24 hour 360 mg oral	Preferred	
diltiazem hcl er oral tablet extended release 24 hour	Preferred	
dilt-xr capsule extended release 24 hour 120 mg oral	Preferred	
dilt-xr capsule extended release 24 hour 180 mg oral	Preferred	QL (3 EA per 1 day)
dilt-xr capsule extended release 24 hour 240 mg oral	Preferred	
felodipine er	Preferred	QL (1 EA per 1 day)
isradipine	Non – Preferred	
levamlodipine maleate	Non – Preferred	
nicardipine hcl	Non – Preferred	
nifedipine	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
nifedipine er	Preferred	QL (1 EA per 1 day)
nifedipine er osmotic release	Preferred	QL (1 EA per 1 day)
nimodipine	Preferred	
nisoldipine er	Non – Preferred	
verapamil hcl	Preferred	QL (4 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 100 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 100 mg oral	Preferred	QL (2 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 120 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 120 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 180 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 180 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 200 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 200 mg oral	Preferred	QL (2 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 240 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 240 mg oral	Preferred	QL (2 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 300 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 300 mg oral	Preferred	QL (1 EA per 1 day)
verapamil hcl er capsule extended release 24 hour 360 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 360 mg oral	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
verapamil hcl er oral tablet extended release	Preferred	QL (2 EA per 1 day)
CARDIZEM	Non – Preferred	QL (4 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	
CARDIZEM LA	Non – Preferred	
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
CARTIA XT CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)
KATERZIA	Non – Preferred	
MATZIM LA	Preferred	
NORLIQVA	Non – Preferred	
NORVASC TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
NORVASC TABLET 2.5 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NORVASC TABLET 5 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NYMALIZE	Non – Preferred	
PROCARDIA XL	Non – Preferred	QL (1 EA per 1 day)
SULAR	Non – Preferred	
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Preferred	QL (3 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Preferred	QL (2 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Preferred	QL (1 EA per 1 day)
TIADYLT ER CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL	Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
***Cardiotonics* - Drugs For The Heart**		
****Cardiac Glycosides*** - Drugs For The Heart***		
digoxin oral solution	Preferred	
digoxin tablet 125 mcg oral	Preferred	
digoxin tablet 250 mcg oral	Preferred	
digoxin tablet 62.5 mcg oral	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Cardiovascular Agents - Misc.* - Drugs For The Heart**		
****Calcium Channel Blocker & Hmg Coa Reductase Inhibit Comb*** - Drugs For Cholesterol***		
amlodipine-atorvastatin	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 10-10 MG ORAL	Non – Preferred	QL (1 EA per 28 days)
CADUET TABLET 10-20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 10-40 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 10-80 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-40 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
CADUET TABLET 5-80 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
****Cardiac Myosin Inhibitors*** - Drugs For The Heart***		
CAMZYOS	Non – Preferred	
****Cardiovascular Anti-Inflammatory/Immune Modulators*** - Drugs For The Heart***		
LODOCO	Non – Preferred	
****Neprilysin Inhib (Arni)-Angiotensin Ii Recept Antag Comb*** - Drugs For High Blood Pressure***		
ENTRESTO ORAL CAPSULE SPRINKLE	Preferred	
ENTRESTO ORAL TABLET	Preferred	QL (2 EA per 1 day)
****Nitrate & Vasodilator Combinations*** - Drugs For High Blood Pressure***		
isosorb dinitrate-hydralazine	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIDIL	Preferred	
Pde Inhibitor-Endothelin Recptor Antagonist Combinations - Drugs For Cholesterol***		
OPSYNVI	Non – Preferred	
Prostaglandin Vasodilators - Drugs For High Blood Pressure***		
epoprostenol sodium solution reconstituted 0.5 mg intravenous	Preferred	
epoprostenol sodium solution reconstituted 0.5 mg intravenous	Preferred	PA
epoprostenol sodium solution reconstituted 1.5 mg intravenous	Preferred	
epoprostenol sodium solution reconstituted 1.5 mg intravenous	Preferred	PA
treprostinil	Non – Preferred	
FLOLAN	Preferred	PA
ORENITRAM	Non – Preferred	
ORENITRAM MONTH 1	Non – Preferred	
ORENITRAM MONTH 2	Non – Preferred	
ORENITRAM MONTH 3	Non – Preferred	
REMODULIN	Non – Preferred	
TYVASO	Non – Preferred	
TYVASO DPI MAINTENANCE KIT	Non – Preferred	
TYVASO DPI TITRATION KIT	Non – Preferred	
TYVASO REFILL KIT	Non – Preferred	
TYVASO STARTER KIT	Non – Preferred	
VELETRI	Non – Preferred	PA
VENTAVIS	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pulm Hyperten-Soluble Guanylate Cyclase Stimulator (Sgc) - Drugs For High Blood Pressure***		
ADEMPAS	Non – Preferred	
Pulmonary Hypertension - Endothelin Receptor Antagonists - Drugs For High Blood Pressure***		
ambrisentan	Non – Preferred	PA; QL (1 EA per 1 day)
bosentan	Non – Preferred	PA; QL (2 EA per 1 day)
LETAIRIS	Preferred	PA; QL (1 EA per 1 day)
OPSUMIT	Non – Preferred	QL (1 EA per 1 day)
TRACLEER	Preferred	PA; QL (2 EA per 1 day)
Pulmonary Hypertension - Phosphodiesterase Inhibitors - Drugs For High Blood Pressure***		
sildenafil citrate intravenous	Non – Preferred	PA
sildenafil citrate suspension reconstituted 10 mg/ml oral	Non – Preferred	
sildenafil citrate suspension reconstituted 10 mg/ml oral	Non – Preferred	PA
sildenafil citrate tablet 20 mg oral	Preferred	
sildenafil citrate tablet 20 mg oral	Preferred	PA; QL (3 EA per 1 day)
tadalafil (pah)	Preferred	PA; QL (2 EA per 1 day)
ADCIRCA	Preferred	PA; QL (2 EA per 1 day)
REVATIO INTRAVENOUS	Non – Preferred	
REVATIO ORAL	Non – Preferred	PA; QL (3 EA per 1 day)
TADLIQ	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pulmonary Hypertension - Prostacyclin Receptor Agonist - Drugs For High Blood Pressure***		
UPTRAVI	Non – Preferred	
UPTRAVI TITRATION	Non – Preferred	
Selective Cgmp Phosphodiesterase Type 5 Inhibitors - Drugs For The Heart***		
tadalafil	Non – Preferred	
CIALIS	Non – Preferred	
Sinus Node Inhibitors** - Drugs For High Blood Pressure		
CORLANOR ORAL SOLUTION	Non – Preferred	
CORLANOR ORAL TABLET	Non – Preferred	QL (2 EA per 1 day)
Transthyretin Stabilizers - Drugs For The Heart***		
VYNDAMAX	Non – Preferred	
VYNDAQEL	Non – Preferred	
Vasoactive Soluble Guanylate Cyclase Stimulator (Sgc) - Drugs For Angina***		
VERQUVO TABLET 10 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 10 MG ORAL	Preferred	PA
VERQUVO TABLET 2.5 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 2.5 MG ORAL	Preferred	PA
VERQUVO TABLET 5 MG ORAL	Non – Preferred	PA
VERQUVO TABLET 5 MG ORAL	Preferred	PA

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Cephalosporins* - Drugs For Infections**		
****Cephalosporin Combinations*** - Antibiotics***		
AVYCAZ	Preferred	
****Cephalosporins - 1St Generation*** - Antibiotics***		
cefadroxil	Preferred	
cefazolin sodium	Preferred	
cefazolin sodium-dextrose	Preferred	
cephalexin	Preferred	
****Cephalosporins - 2Nd Generation*** - Antibiotics***		
cefaclor capsule 250 mg oral	Preferred	
cefaclor capsule 500 mg oral	Preferred	QL (14 EA Max Qty Per Fill Retail)
cefaclor er	Non – Preferred	
cefoxitin sodium	Preferred	
cefoxitin sodium-dextrose	Preferred	
cefprozil oral suspension reconstituted	Preferred	
cefprozil tablet 250 mg oral	Non – Preferred	QL (20 EA Max Qty Per Fill Retail)
cefprozil tablet 500 mg oral	Non – Preferred	
cefuroxime axetil	Preferred	
****Cephalosporins - 3Rd Generation*** - Antibiotics***		
cefdinir	Preferred	
cefixime oral capsule	Preferred	QL (1 EA Max Qty Per Fill Retail)
cefixime oral suspension reconstituted	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cefpodoxime proxetil	Non – Preferred	
ceftazidime	Preferred	
ceftriaxone sodium in dextrose	Preferred	
ceftriaxone sodium injection	Preferred	QL (2 EA per 1 day)
ceftriaxone sodium intravenous	Preferred	
ceftriaxone sodium-dextrose	Preferred	
TAZICEF	Preferred	
Cephalosporins - 4Th Generation - Antibiotics**		
cefepime hcl	Preferred	
cefepime-dextrose	Preferred	
Chemicals		
Fixed Oils*		
castor oil	Preferred	
Contraceptives* - Drugs For Women		
Biphasic Contraceptives - Oral - Birth Control Pills**		
desogestrel-ethinyl estradiol	Preferred	
viorele	Preferred	
AZURETTE	Preferred	
KARIVA	Preferred	
LO LOESTRIN FE	Preferred	
PIMTREA	Preferred	
SIMLIYA	Preferred	
VOLNEA	Preferred	
Combination Contraceptives - Oral - Birth Control Pills**		
alyacen 1/35	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
briellyn	Preferred	
drospiren-eth estrad-levomefol	Preferred	
drospirenone-ethinyl estradiol	Preferred	
ethynodiol diac-eth estradiol	Preferred	
levonorgest-eth estradiol-iron	Preferred	
levonorgestrel-ethinyl estrad	Preferred	
marlissa	Preferred	
norethin ace-eth estrad-fe	Preferred	
norethindrone acet-ethinyl est	Preferred	
norethin-eth estradiol-fe	Preferred	
norgestimate-eth estradiol	Preferred	
AFIRMELLE	Preferred	
ALTAVERA	Preferred	
APRI	Preferred	
AUBRA EQ	Preferred	
AUROVELA 1.5/30	Preferred	
AUROVELA 1/20	Preferred	
AUROVELA 24 FE	Preferred	
AUROVELA FE 1.5/30	Preferred	
AUROVELA FE 1/20	Preferred	
AVIANE	Preferred	
AYUNA	Preferred	
BALCOLTRA	Preferred	
BALZIVA	Preferred	
BEYAZ	Preferred	
BLISOVI 24 FE	Preferred	
BLISOVI FE 1.5/30	Preferred	
BLISOVI FE 1/20	Preferred	
CHARLOTTE 24 FE	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHATEAL EQ	Preferred	
CRYSELLE-28	Preferred	
CYRED EQ	Preferred	
DASETTA 1/35 (28)	Preferred	
ELINEST	Preferred	
ENSKYCE	Preferred	
ESTARYLLA	Preferred	
FALMINA	Preferred	
FEIRZA 1.5/30	Preferred	
FEIRZA 1/20	Preferred	
FEMLYV	Preferred	
FINZALA	Preferred	
GEMMILY	Preferred	
HAILEY 1.5/30	Preferred	
HAILEY 24 FE	Preferred	
HAILEY FE 1.5/30	Preferred	
HAILEY FE 1/20	Preferred	
ISIBLOOM	Preferred	
JASMIEL	Preferred	
JOYEAUX	Preferred	
JULEBER	Preferred	
JUNEL 1.5/30	Preferred	
JUNEL 1/20	Preferred	
JUNEL FE 1.5/30	Preferred	
JUNEL FE 1/20	Preferred	
JUNEL FE 24	Preferred	
KAITLIB FE	Preferred	
KALLIGA	Preferred	
KELNOR 1/35	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KELNOR 1/50	Preferred	
KURVELO	Preferred	
LARIN 1.5/30	Preferred	
LARIN 1/20	Preferred	
LARIN 24 FE	Preferred	
LARIN FE 1.5/30	Preferred	
LARIN FE 1/20	Preferred	
LAYOLIS FE	Preferred	
LESSINA	Preferred	
LEVORA 0.15/30 (28)	Preferred	
LOESTRIN 1.5/30 (21)	Preferred	
LOESTRIN 1/20 (21)	Preferred	
LOESTRIN FE 1.5/30	Preferred	
LOESTRIN FE 1/20	Preferred	
LORYNA	Preferred	
LOW-OGESTREL	Preferred	
LO-ZUMANDIMINE	Preferred	
LUTERA	Preferred	
MERZEE	Preferred	
MIBELAS 24 FE	Preferred	
MICROGESTIN 1.5/30	Preferred	
MICROGESTIN 1/20	Preferred	
MICROGESTIN FE 1.5/30	Preferred	
MICROGESTIN FE 1/20	Preferred	
MILI	Preferred	
MINZOYA	Preferred	
MONO-LINYAH	Preferred	
NECON 0.5/35 (28)	Preferred	
NEXTSTELLIS	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NIKKI	Preferred	
NORTREL 0.5/35 (28)	Preferred	
NORTREL 1/35 (21)	Preferred	
NORTREL 1/35 (28)	Preferred	
NYLIA 1/35	Preferred	
OCELLA	Preferred	
PHILITH	Preferred	
PORTIA-28	Preferred	
RECLIPSEN	Preferred	
SAFYRAL	Preferred	
SPRINTEC 28	Preferred	
SRONYX	Preferred	
SYEDA	Preferred	
TARINA 24 FE	Preferred	
TARINA FE 1/20 EQ	Preferred	
TAYSOFY	Preferred	
TAYTULLA	Preferred	
TURQOZ	Preferred	
TYBLUME	Preferred	
VALTYA 1/50	Preferred	
VESTURA	Preferred	
VIENVA	Preferred	
VYFEMLA	Preferred	
VYLIBRA	Preferred	
WERA	Preferred	
WYMZYA FE	Preferred	
YASMIN 28	Preferred	
YAZ	Preferred	
ZOVIA 1/35 (28)	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZUMANDIMINE	Preferred	
Combination Contraceptives - Transdermal - Birth Control Pills***		
norelgestromin-eth estradiol	Preferred	QL (3 EA per 28 days)
TWIRLA	Preferred	QL (3 EA per 28 days)
XULANE	Preferred	QL (3 EA per 28 days)
ZAFEMY	Preferred	QL (3 EA per 28 days)
Combination Contraceptives - Vaginal - Birth Control Pills***		
etonogestrel-ethinyl estradiol ring 0.12-0.015 mg/24hr vaginal	Preferred	QL (1 EA per 28 days)
ANNOVERA	Preferred	QL (1 EA per 28 days)
ELURYNG	Preferred	QL (1 EA per 28 days)
ENILLORING	Preferred	QL (1 EA per 28 days)
HALOETTE	Preferred	QL (1 EA per 28 days)
NUVARING RING 0.12-0.015 MG/24HR VAGINAL	Preferred	QL (1 EA per 28 days)
Continuous Contraceptives - Oral - Birth Control Pills***		
levonorgestrel-ethinyl estrad	Preferred	
AMETHYST	Preferred	
DOLISHALE	Preferred	
Emergency Contraceptives - Birth Control Pills***		
levonorgestrel	Preferred	OTC
ECONTRA ONE-STEP	Preferred	OTC
ELLA	Preferred	
HER STYLE	Preferred	OTC
MY CHOICE	Preferred	OTC
MY WAY	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEW DAY	Preferred	OTC
OPTION 2	Preferred	OTC
Extended-Cycle Contraceptives - Oral - Birth Control Pills***		
levonorgest-eth est & eth est	Preferred	
levonorgest-eth estrad 91-day	Preferred	QL (1 EA per 1 day)
ASHLYNA	Preferred	QL (1 EA per 1 day)
CAMRESE	Preferred	QL (1 EA per 1 day)
CAMRESE LO	Preferred	QL (1 EA per 1 day)
DAYSEE	Preferred	QL (1 EA per 1 day)
ICLEVIA	Preferred	
INTROVALE	Preferred	
JAIMIESS	Preferred	QL (1 EA per 1 day)
JOLESSA	Preferred	
LOJAIMIESS	Preferred	QL (1 EA per 1 day)
RIVELSA	Preferred	
SETLAKIN	Preferred	
SIMPESSE	Preferred	QL (1 EA per 1 day)
Four Phase Contraceptives - Oral - Birth Control Pills***		
NATAZIA	Preferred	
Progestin Contraceptives - Injectable - Birth Control Pills***		
medroxyprogesterone acetate	Preferred	QL (1 ML per 84 days)
DEPO-PROVERA	Preferred	QL (1 ML per 84 days)
DEPO-SUBQ PROVERA 104	Preferred	
Progestin Contraceptives - Oral - Birth Control Pills***		
norethindrone	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CAMILA	Preferred	QL (1 EA per 1 day)
DEBLITANE	Preferred	QL (1 EA per 1 day)
ERRIN	Preferred	QL (1 EA per 1 day)
HEATHER	Preferred	QL (1 EA per 1 day)
INCASSIA	Preferred	QL (1 EA per 1 day)
JENCYCLA	Preferred	QL (1 EA per 1 day)
LYLEQ	Preferred	QL (1 EA per 1 day)
NORA-BE	Preferred	QL (1 EA per 1 day)
OPILL	Preferred	OTC
SHAROBEL	Preferred	QL (1 EA per 1 day)
SLYND	Preferred	
Triphasic Contraceptives - Oral - Birth Control Pills***		
alyacen 7/7/7	Preferred	
levonorg-eth estrad triphasic	Preferred	
norgestim-eth estrad triphasic	Preferred	
ARANELLE	Preferred	
DASETTA 7/7/7	Preferred	
ENPRESSE-28	Preferred	
LEENA	Preferred	
LEVONEST	Preferred	
NORTREL 7/7/7	Preferred	
NYLIA 7/7/7	Preferred	
TILIA FE	Preferred	
TRI-ESTARYLLA	Preferred	
TRI-LEGEST FE	Preferred	
TRI-LINYAH	Preferred	
TRI-LO-ESTARYLLA	Preferred	
TRI-LO-MARZIA	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRI-LO-MILI	Preferred	
TRI-LO-SPRINTEC	Preferred	
TRI-MILI	Preferred	
TRINESSA (28)	Preferred	
TRI-SPRINTEC	Preferred	
TRIVORA (28)	Preferred	
TRI-VYLIBRA	Preferred	
TRI-VYLIBRA LO	Preferred	
VELIVET	Preferred	
XARAH FE	Preferred	
***Corticosteroids* - Hormones**		
****Glucocorticosteroids*** - Drugs For Inflammation***		
budesonide	Non – Preferred	
budesonide er	Non – Preferred	
cortisone acetate	Non – Preferred	
dexamethasone	Preferred	
dexamethasone sodium phosphate	Preferred	
hydrocortisone	Preferred	
hydrocortisone sod suc (pf)	Preferred	
methylprednisolone oral tablet	Preferred	
methylprednisolone oral tablet therapy pack	Preferred	QL (21 EA Max Qty Per Fill Retail)
prednisolone	Preferred	
prednisolone sodium phosphate oral tablet dispersible	Non – Preferred	
prednisolone sodium phosphate solution 10 mg/5ml oral	Preferred	
prednisolone sodium phosphate solution 15 mg/5ml oral	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
prednisolone sodium phosphate solution 20 mg/5ml oral	Preferred	QL (150 ML Max Qty Per Fill Retail)
prednisolone sodium phosphate solution 25 mg/5ml oral	Preferred	
prednisolone sodium phosphate solution 6.7 (5 base) mg/5ml oral	Preferred	
prednisone oral solution	Preferred	
prednisone oral tablet	Preferred	
prednisone tablet therapy pack 10 mg (21) oral	Preferred	
prednisone tablet therapy pack 10 mg (48) oral	Preferred	QL (48 EA Max Qty Per Fill Retail)
prednisone tablet therapy pack 5 mg (21) oral	Preferred	
prednisone tablet therapy pack 5 mg (48) oral	Preferred	QL (48 EA Max Qty Per Fill Retail)
AGAMREE	Non – Preferred	
ALKINDI SPRINKLE	Non – Preferred	
CORTEF	Non – Preferred	
DEXAMETHASONE INTENSOL	Preferred	
EMFLAZA	Non – Preferred	
HEMADY	Non – Preferred	
MEDROL ORAL TABLET	Non – Preferred	
MEDROL ORAL TABLET THERAPY PACK	Non – Preferred	QL (21 EA Max Qty Per Fill Retail)
PREDNISONE INTENSOL	Preferred	
RAYOS	Non – Preferred	
SOLU-CORTEF	Non – Preferred	
TAPERDEX 12-DAY	Non – Preferred	
TAPERDEX 6-DAY	Non – Preferred	
TAPERDEX 7-DAY	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TARPEYO	Non – Preferred	
UCERIS	Non – Preferred	
Mineralocorticoids - Drugs For Inflammation**		
fludrocortisone acetate	Preferred	
***Cough/Cold/Allergy* - Drugs For The Lungs**		
Antitussive - Nonnarcotic - Drugs For Allergies**		
benzonatate oral capsule 100 mg	Preferred	QL (6 EA per 1 day); AL (Min 10 Years)
benzonatate oral capsule 200 mg	Preferred	QL (3 EA per 1 day); AL (Min 10 Years)
cvs tussin maximum strength	Preferred	OTC
dextromethorphan polistirex er	Preferred	OTC
Antitussive-Expectorant - Drugs For Cough And Cold**		
dextromethorphan-guaifenesin	Preferred	OTC; QL (120 ML per 30 days)
guaifenesin-codeine	Preferred	OTC
Decongestant & Antihistamine - Drugs For Cough And Cold**		
allergy relief d-24	Preferred	OTC
cetirizine-pseudoephedrine er	Preferred	OTC; QL (2 EA per 1 day)
cold & allergy	Preferred	OTC
loratadine-d 12hr	Preferred	OTC; QL (2 EA per 1 day)
promethazine vc	Preferred	
rynex pse	Preferred	OTC
LOHIST-D	Preferred	OTC
SUDOGEST SINUS/ALLERGY	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Decongestant W/ Expectorant - Drugs For Cough And Cold***		
ed bron gp	Preferred	OTC
Decongestant-Analgesic - Drugs For Cough And Cold***		
cvs cold & sinus relief	Preferred	OTC
Expectorants - Drugs For Cough And Cold***		
guaifenesin	Preferred	OTC
guaifenesin er	Preferred	OTC
Misc. Respiratory Inhalants - Drugs For Allergies***		
sodium chloride	Preferred	
Mucolytics - Drugs For The Lungs***		
acetylcysteine	Preferred	
Non-Narc Antitussive-Antihistamine - Drugs For Cough And Cold***		
promethazine-dm	Preferred	
Non-Narc Antitussive-Decongestant - Drugs For Cough And Cold***		
SUDAFED PE COLD & COUGH CHILD	Preferred	OTC
Non-Narc Antitussive-Decongestant-Antihistamine - Drugs For Cough And Cold***		
pseudoeph-bromphen-dm	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Opioid Antitussive-Antihistamine - Drugs For Cough And Cold***		
promethazine-codeine	Preferred	QL (180 ML per 30 days); AL (Min 18 Years)
***Dermatologicals* - Drugs For The Skin**		
Acne Antibiotics - Drugs For The Skin***		
clindamycin phosphate external foam	Non – Preferred	AL (Min 10 Years)
clindamycin phosphate external lotion	Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years)
clindamycin phosphate external solution	Preferred	QL (2 ML per 1 day); AL (Min 10 Years)
clindamycin phosphate external swab	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
clindamycin phosphate gel 1 % external	Preferred	AL (Min 10 Years)
clindamycin phosphate gel 1 % external	Preferred	QL (2.5 GM per 1 day); AL (Min 10 Years)
dapsone	Non – Preferred	AL (Min 10 Years)
ery	Non – Preferred	QL (2 EA per 1 day)
erythromycin external gel	Preferred	QL (1 GM per 1 day); AL (Min 10 Years)
erythromycin external solution	Preferred	QL (2 ML per 1 day); AL (Min 10 Years)
sulfacetamide sodium (acne)	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years)
ACZONE	Non – Preferred	AL (Min 10 Years)
CLEOCIN-T	Non – Preferred	QL (60 ML Max Qty Per Fill Retail); AL (Min 10 Years)
CLINDACIN	Non – Preferred	AL (Min 10 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLINDACIN ETZ	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
CLINDACIN-P	Preferred	QL (2 EA per 1 day); AL (Min 10 Years)
CLINDAGEL	Non – Preferred	QL (2.5 ML per 1 day); AL (Min 10 Years)
ERYGEL	Non – Preferred	QL (1 GM per 1 day); AL (Min 10 Years)
KLARON	Non – Preferred	QL (118 ML per 30 days); AL (Min 10 Years)
Acne Combinations - Drugs For The Skin**		
adapalene-benzoyl peroxide	Non – Preferred	AL (Min 10 Years)
benzoyl peroxide-erythromycin	Preferred	AL (Min 10 Years)
bp 10-1	Non – Preferred	AL (Min 10 Years)
clindamycin phos-benzoyl perox	Non – Preferred	AL (Min 10 Years)
clindamycin-tretinoin	Non – Preferred	AL (Min 10 Years)
sss 10-5	Non – Preferred	AL (Min 10 Years)
sulfacetamide sodium-sulfur	Non – Preferred	AL (Min 10 Years)
sulfacetamide sod-sulfur wash	Non – Preferred	AL (Min 10 Years)
sulfacetamide-sulfur in urea	Non – Preferred	AL (Min 10 Years)
ACANYA	Non – Preferred	AL (Min 10 Years)
AVAR CLEANSER	Non – Preferred	AL (Min 10 Years)
BENZAMYCIN	Non – Preferred	AL (Min 10 Years)
CABTREO	Non – Preferred	AL (Min 10 Years)
CLINDACIN ETZ	Non – Preferred	AL (Min 10 Years)
EPIDUO	Non – Preferred	AL (Min 10 Years)
EPIDUO FORTE	Non – Preferred	AL (Min 10 Years)
NEUAC	Non – Preferred	AL (Min 10 Years)
ONEXTON	Non – Preferred	AL (Min 10 Years)
SUMADAN	Non – Preferred	AL (Min 10 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUMADAN WASH	Non – Preferred	AL (Min 10 Years)
SUMAXIN	Non – Preferred	AL (Min 10 Years)
SUMAXIN CP	Non – Preferred	AL (Min 10 Years)
TWYNEO	Non – Preferred	AL (Min 10 Years and Max 20 Years)
ZIANA	Non – Preferred	AL (Min 10 Years)
Acne Products - Drugs For The Skin**		
adapalene external cream	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
adapalene external gel	Non – Preferred	AL (Min 10 Years)
isotretinoin capsule 10 mg oral	Non – Preferred	AL (Min 12 Years)
isotretinoin capsule 20 mg oral	Non – Preferred	AL (Min 12 Years)
isotretinoin capsule 25 mg oral	Non – Preferred	AL (Min 12 Years)
isotretinoin capsule 30 mg oral	Non – Preferred	QL (2 EA per 1 day)
isotretinoin capsule 35 mg oral	Non – Preferred	AL (Min 12 Years)
isotretinoin capsule 40 mg oral	Non – Preferred	AL (Min 12 Years)
tazarotene	Non – Preferred	AL (Min 10 Years)
tretinoin cream 0.025 % external	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
tretinoin cream 0.05 % external	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
tretinoin cream 0.1 % external	Preferred	
tretinoin cream 0.1 % external	Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
tretinoin gel 0.01 % external	Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
tretinoin gel 0.025 % external	Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
tretinoin gel 0.05 % external	Preferred	AL (Min 10 Years)
tretinoin microsphere	Non – Preferred	AL (Min 10 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
tretinoin microsphere pump	Non – Preferred	AL (Min 10 Years)
ABSORICA CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 25 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ABSORICA CAPSULE 35 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
ABSORICA LD	Non – Preferred	AL (Min 10 Years)
AKLIEF	Non – Preferred	
ALTRENO	Non – Preferred	AL (Min 10 Years)
AMNESTEEM	Non – Preferred	AL (Min 12 Years)
ARAZLO	Non – Preferred	AL (Min 10 Years)
ATRALIN	Non – Preferred	AL (Min 10 Years)
BENZAC AC WASH	Non – Preferred	AL (Min 10 Years)
CLARAVIS CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
CLARAVIS CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
CLARAVIS CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
DIFFERIN EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
DIFFERIN EXTERNAL GEL	Non – Preferred	AL (Min 10 Years)
EPSOLAY	Non – Preferred	
FABIOR	Non – Preferred	AL (Min 10 Years)
RETIN-A EXTERNAL CREAM	Non – Preferred	QL (45 GM per 30 days); AL (Min 10 Years)
RETIN-A EXTERNAL GEL	Non – Preferred	QL (45 GM Max Qty Per Fill Retail); AL (Min 10 Years)
RETIN-A MICRO	Non – Preferred	AL (Min 10 Years)
RETIN-A MICRO PUMP	Non – Preferred	AL (Min 10 Years)
WINLEVI	Non – Preferred	AL (Min 10 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZENATANE CAPSULE 10 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 20 MG ORAL	Non – Preferred	AL (Min 12 Years)
ZENATANE CAPSULE 30 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
ZENATANE CAPSULE 40 MG ORAL	Non – Preferred	AL (Min 12 Years)
Agents For External Genital And Perianal Warts - Drugs For The Skin***		
VEREGEN	Non – Preferred	
Antibiotic Mixtures Topical - Drugs For The Skin***		
goodsense first aid antibiotic	Preferred	OTC
ra antibiotic + pain relief	Preferred	OTC
ra antibiotic plus	Preferred	OTC
triple antibiotic	Preferred	OTC
triple antibiotic pain relief	Preferred	OTC
NEOSPORIN + PAIN RELIEF MAX ST	Preferred	OTC
NEOSPORIN PLUS PAIN RELIEF MS	Preferred	OTC
Antibiotic Steroid Combinations - Topical - Drugs For The Skin***		
NEO-SYNALAR	Non – Preferred	
Antibiotics - Topical - Drugs For The Skin***		
gentamicin sulfate	Preferred	
mupirocin	Preferred	QL (110 GM per 30 days)
mupirocin calcium	Non – Preferred	
Antifungals - Topical Combinations - Drugs For The Skin***		
clotrimazole-betamethasone external cream	Non – Preferred	QL (60 GM per 30 days)
clotrimazole-betamethasone external lotion	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
miconazole-zinc oxide-petrolat	Non – Preferred	
nystatin-triamcinolone	Non – Preferred	
FUNGIZYL AC	Non – Preferred	
MYCOZYL HC	Non – Preferred	
VUSION	Non – Preferred	
Antifungals - Topical - Drugs For The Skin**		
ciclopirox external gel	Non – Preferred	
ciclopirox external shampoo	Non – Preferred	QL (120 ML per 30 days)
ciclopirox olamine external cream	Non – Preferred	QL (60 GM per 30 days)
ciclopirox olamine external suspension	Non – Preferred	QL (30 ML per 30 days)
ciclopirox solution 8 % external	Non – Preferred	QL (6.6 ML per 30 days)
ciclopirox treatment	Non – Preferred	
naftifine hcl	Non – Preferred	
nystatin cream 100000 unit/gm external	Preferred	QL (60 GM per 30 days)
nystatin ointment 100000 unit/gm external	Preferred	QL (60 GM per 30 days)
nystatin powder 100000 unit/gm external	Preferred	
nystatin powder 100000 unit/gm external	Preferred	QL (60 GM Max Qty Per Fill Retail)
CICLODAN	Non – Preferred	QL (6.6 ML per 30 days)
KLAYESTA	Preferred	QL (60 GM Max Qty Per Fill Retail)
MYCOZYL AL	Non – Preferred	
NAFTIN	Non – Preferred	
NYAMYC	Preferred	QL (60 GM Max Qty Per Fill Retail)
NYSTOP	Preferred	QL (60 GM Max Qty Per Fill Retail)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anti-Inflammatory Agents - Topical - Drugs For The Skin**		
diclofenac epolamine	Non – Preferred	
diclofenac sodium gel 1 % external (rx)	Non – Preferred	QL (200 GM per 30 days)
diclofenac sodium solution 1.5 % external	Non – Preferred	QL (10 ML per 1 day)
diclofenac sodium solution 2 % external	Non – Preferred	
LICART	Non – Preferred	
PENNSAID	Non – Preferred	
Anti-Inflammatory Combinations - Topical - Drugs For The Skin**		
DICLOGEN	Non – Preferred	
LEXTOL	Non – Preferred	
TRIFENA PAIN RELIEF	Non – Preferred	
Antineoplastic Alkylating Agents - Topical - Drugs For The Skin**		
VALCHLOR	Non – Preferred	
Antineoplastic Antimetabolites - Topical - Drugs For The Skin**		
fluorouracil	Non – Preferred	
Antineoplastic Or Premalignant Lesions - Topical Nsaid's - Drugs For The Skin**		
diclofenac sodium	Non – Preferred	
Antipruritic Combinations - Topical - Drugs For The Skin**		
anti-itch	Preferred	OTC
Antipruritics - Topical - Drugs For The Skin**		
doxepin hcl	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRUDOXIN	Non – Preferred	
ZONALON	Non – Preferred	
Antipsoriatics - Systemic - Drugs For The Skin**		
acitretin	Non – Preferred	
methoxsalen rapid	Non – Preferred	
BIMZELX	Non – Preferred	
COSENTYX	Preferred	PA
COSENTYX (300 MG DOSE)	Preferred	PA
COSENTYX SENSOREADY (300 MG)	Preferred	PA
COSENTYX SENSOREADY PEN	Preferred	PA
COSENTYX UNOREADY	Preferred	PA
ILUMYA	Non – Preferred	
OTULFI	Non – Preferred	
PYZCHIVA	Non – Preferred	
SELARSDI	Non – Preferred	
SILIQ	Non – Preferred	
SKYRIZI	Non – Preferred	
SKYRIZI PEN	Non – Preferred	
SOTYKTU	Non – Preferred	
SPEVIGO	Non – Preferred	
STELARA	Non – Preferred	
STEQEYMA	Non – Preferred	
TALTZ	Non – Preferred	
TREMFYA	Non – Preferred	
YESINTEK	Non – Preferred	
Antipsoriatics - Drugs For The Skin**		
calcipotriene external cream	Preferred	QL (4 GM per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
calcipotriene external foam	Non – Preferred	
calcipotriene external ointment	Preferred	QL (4 GM per 1 day)
calcipotriene external solution	Preferred	QL (60 ML Max Qty Per Fill Retail)
calcitriol	Non – Preferred	
tazarotene external cream	Non – Preferred	QL (3 GM per 1 day)
tazarotene external gel	Non – Preferred	
SORILUX	Non – Preferred	
VECTICAL	Non – Preferred	
VTAMA	Non – Preferred	
ZORYVE	Non – Preferred	
Antiseborrheic Products - Drugs For The Skin**		
selenium sulfide external lotion	Preferred	
selenium sulfide external shampoo	Non – Preferred	
sodium sulfacetamide wash	Non – Preferred	
sulfacetamide sodium	Non – Preferred	
sulfacetamide sodium (cleans)	Non – Preferred	
ZORYVE	Non – Preferred	
Antiviral Topical Combinations - Drugs For The Skin**		
XERESE	Non – Preferred	
Antivirals - Topical - Drugs For The Skin**		
acyclovir external cream	Non – Preferred	
acyclovir ointment 5 % external	Non – Preferred	QL (15 GM per 30 days)
penciclovir	Non – Preferred	
DENAVIR	Non – Preferred	
ZOVIRAX EXTERNAL CREAM	Non – Preferred	
ZOVIRAX EXTERNAL OINTMENT	Non – Preferred	QL (15 GM per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Astringents - Drugs For The Skin**		
XERAC AC	Non – Preferred	
Atopic Dermatitis - Janus Kinase (Jak) Inhibitors - Drugs For The Skin**		
CIBINQO	Non – Preferred	
OPZELURA	Non – Preferred	
Atopic Dermatitis - Monoclonal Antibodies - Drugs For The Skin**		
ADBRY	Non – Preferred	
DUPIXENT SOLUTION AUTO-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Non – Preferred	PA
DUPIXENT SOLUTION AUTO-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Preferred	
DUPIXENT SOLUTION AUTO-INJECTOR 200 MG/1.14ML SUBCUTANEOUS	Preferred	PA
DUPIXENT SOLUTION AUTO-INJECTOR 300 MG/2ML SUBCUTANEOUS	Non – Preferred	PA
DUPIXENT SOLUTION AUTO-INJECTOR 300 MG/2ML SUBCUTANEOUS	Preferred	
DUPIXENT SOLUTION AUTO-INJECTOR 300 MG/2ML SUBCUTANEOUS	Preferred	PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	Preferred	PA
EBGLYSS	Non – Preferred	
Burn Products - Drugs For The Skin**		
mafenide acetate	Preferred	
silver sulfadiazine	Preferred	
SILVADENE	Non – Preferred	
SSD	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SULFAMYLON	Preferred	
Cauterizing Agent Combinations - Drugs For The Skin**		
ARZOL SILVER NIT APPLICATORS	Non – Preferred	
Cauterizing Agents - Drugs For The Skin**		
silver nitrate	Non – Preferred	
Corticosteroids - Topical - Drugs For The Skin**		
alclometasone dipropionate	Preferred	QL (60 GM per 30 days)
amcinonide	Non – Preferred	
betamethasone dipropionate aug external cream	Non – Preferred	QL (45 GM Max Qty Per Fill Retail)
betamethasone dipropionate aug external gel	Non – Preferred	QL (60 GM per 30 days)
betamethasone dipropionate aug external lotion	Non – Preferred	QL (120 ML per 30 days)
betamethasone dipropionate aug ointment 0.05 % external	Non – Preferred	QL (60 GM per 30 days)
betamethasone dipropionate external cream	Non – Preferred	QL (60 GM per 30 days)
betamethasone dipropionate external lotion	Non – Preferred	QL (120 ML per 30 days)
betamethasone dipropionate external ointment	Non – Preferred	QL (60 GM per 30 days)
betamethasone valerate external cream	Preferred	QL (60 GM per 30 days)
betamethasone valerate external foam	Non – Preferred	
betamethasone valerate external lotion	Preferred	QL (120 ML per 30 days)
betamethasone valerate external ointment	Preferred	QL (45 GM Max Qty Per Fill Retail)
clobetasol propionate cream 0.05 % external	Preferred	
clobetasol propionate cream 0.05 % external	Preferred	QL (60 GM Max Qty Per Fill Retail)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clobetasol propionate e	Preferred	QL (60 GM Max Qty Per Fill Retail)
clobetasol propionate emulsion	Non – Preferred	
clobetasol propionate external foam	Non – Preferred	
clobetasol propionate external gel	Preferred	QL (60 GM Max Qty Per Fill Retail)
clobetasol propionate external liquid	Non – Preferred	
clobetasol propionate external lotion	Non – Preferred	
clobetasol propionate external ointment	Preferred	QL (60 GM Max Qty Per Fill Retail)
clobetasol propionate external shampoo	Non – Preferred	
clobetasol propionate solution 0.05 % external	Preferred	QL (50 ML per 30 days)
clocortolone pivalate	Non – Preferred	
desonide external cream	Preferred	
desonide external lotion	Non – Preferred	
desonide external ointment	Preferred	
desoximetasone	Non – Preferred	
diflorasone diacetate	Preferred	QL (60 GM per 30 days)
fluocinolone acetonide body	Preferred	
fluocinolone acetonide cream 0.01 % external	Preferred	
fluocinolone acetonide cream 0.025 % external	Preferred	QL (60 GM per 30 days)
fluocinolone acetonide external ointment	Preferred	QL (60 GM per 30 days)
fluocinolone acetonide external solution	Preferred	
fluocinolone acetonide scalp	Preferred	
fluocinonide cream 0.05 % external	Preferred	QL (60 GM Max Qty Per Fill Retail)
fluocinonide cream 0.1 % external	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluocinonide emulsified base	Preferred	QL (60 GM Max Qty Per Fill Retail)
fluocinonide external gel	Preferred	QL (60 GM Max Qty Per Fill Retail)
fluocinonide external ointment	Preferred	QL (60 GM Max Qty Per Fill Retail)
fluocinonide external solution	Preferred	QL (60 ML Max Qty Per Fill Retail)
flurandrenolide	Non – Preferred	
fluticasone propionate external cream	Preferred	QL (60 GM Max Qty Per Fill Retail)
fluticasone propionate external lotion	Non – Preferred	
fluticasone propionate external ointment	Preferred	QL (60 GM Max Qty Per Fill Retail)
halcinonide	Non – Preferred	
halobetasol propionate external cream	Preferred	QL (50 GM per 30 days)
halobetasol propionate external foam	Non – Preferred	
halobetasol propionate ointment 0.05 % external	Preferred	QL (50 GM per 30 days)
hydrocortisone butyrate	Non – Preferred	
hydrocortisone complete kit	Preferred	
hydrocortisone cream 1 % external (rx)	Preferred	QL (454 GM Max Qty Per Fill Retail)
hydrocortisone cream 2.5 % external	Preferred	QL (90 GM per 30 days)
hydrocortisone external cream 0.5 %	Preferred	OTC
hydrocortisone external lotion	Preferred	QL (120 ML per 30 days)
hydrocortisone external ointment	Preferred	QL (90 GM per 30 days)
hydrocortisone valerate	Preferred	
instacort 5	Preferred	OTC
mometasone furoate external cream	Preferred	QL (45 GM per 30 days)
mometasone furoate external ointment	Preferred	QL (45 GM Max Qty Per Fill Retail)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
mometasone furoate external solution	Preferred	QL (60 ML Max Qty Per Fill Retail)
triamcinolone acetonide cream 0.025 % external	Preferred	QL (90 GM per 30 days)
triamcinolone acetonide cream 0.1 % external	Preferred	QL (90 GM per 30 days)
triamcinolone acetonide cream 0.5 % external	Preferred	QL (90 GM per 30 days)
triamcinolone acetonide external aerosol solution	Non – Preferred	
triamcinolone acetonide lotion 0.025 % external	Preferred	QL (120 ML per 30 days)
triamcinolone acetonide lotion 0.1 % external	Preferred	QL (120 ML per 30 days)
triamcinolone acetonide ointment 0.025 % external	Preferred	QL (90 GM per 30 days)
triamcinolone acetonide ointment 0.05 % external	Non – Preferred	
triamcinolone acetonide ointment 0.1 % external	Preferred	
triamcinolone acetonide ointment 0.5 % external	Preferred	QL (90 GM per 30 days)
BRYHALI	Non – Preferred	
CLOBEX	Non – Preferred	
CLOBEX SPRAY	Non – Preferred	
CLODAN	Non – Preferred	
CLODERM	Non – Preferred	
CORDRAN	Non – Preferred	
DERMA-SMOOTHE/FS BODY	Non – Preferred	
DERMA-SMOOTHE/FS SCALP	Non – Preferred	
DESOWEN	Non – Preferred	
DIPROLENE OINTMENT 0.05 % EXTERNAL	Non – Preferred	QL (60 GM per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYDROXYM	Non – Preferred	
LOCOID	Non – Preferred	
SYNALAR	Non – Preferred	QL (60 GM per 30 days)
TEXACORT	Non – Preferred	
TOPICORT	Non – Preferred	
TOVET	Non – Preferred	
VANOS	Non – Preferred	
Depigmenting Agents - Drugs For The Skin**		
hydroquinone	Preferred	
BLANCHE	Preferred	
Emollient/Keratolytic Agents - Drugs For The Skin**		
urea cream 20 % external (rx)	Preferred	
urea cream 39 % external	Preferred	
urea cream 39.5 % external	Preferred	
urea cream 40 % external	Preferred	QL (85 GM per 30 days)
DERMACINRX UREA	Preferred	
Emollients - Drugs For The Skin**		
ammonium lactate external cream	Non – Preferred	
ammonium lactate external lotion	Preferred	
vitamin c brightening serum	Non – Preferred	
Imidazole-Related Antifungals - Topical - Drugs For The Skin**		
clotrimazole external cream	Preferred	QL (60 GM per 30 days)
clotrimazole external solution	Non – Preferred	QL (30 ML per 30 days)
econazole nitrate	Preferred	QL (30 GM per 30 days)
ketoconazole external cream	Preferred	QL (60 GM Max Qty Per Fill Retail)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ketoconazole external foam	Non – Preferred	
ketoconazole shampoo 2 % external	Preferred	
ketoconazole shampoo 2 % external	Preferred	QL (120 ML Max Qty Per Fill Retail)
luliconazole	Non – Preferred	
oxiconazole nitrate	Non – Preferred	
ERTACZO	Non – Preferred	
JUBLIA	Non – Preferred	
KETODAN	Non – Preferred	
LUZU	Non – Preferred	
OXISTAT	Non – Preferred	
Immunomodulators Imidazoquinolinamines - Topical - Drugs For The Skin**		
imiquimod cream 3.75 % external	Non – Preferred	AL (Min 10 Years)
imiquimod cream 5 % external	Preferred	QL (12 EA per 30 days); AL (Min 10 Years)
imiquimod cream 5 % external	Preferred	QL (12 PACKET per 30 days); AL (Min 10 Years)
imiquimod pump	Non – Preferred	AL (Min 10 Years)
ZYCLARA	Non – Preferred	AL (Min 10 Years)
ZYCLARA PUMP	Non – Preferred	AL (Min 10 Years)
Insect Repellents - Drugs For The Skin**		
cvs insect repellent	Preferred	OTC
COLEMAN 100 MAX CONTINUOUS SPR	Preferred	OTC
OFF ACTIVE	Preferred	OTC
OFF DEEP WOODS	Preferred	OTC
REPEL SPORTSMEN MAX	Preferred	OTC
SAWYER INSECT REPELLENT	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRATHON INSECT REPELLENT	Preferred	OTC
Keratolytic/Antimitotic/Vesicant Agents - Drugs For The Skin**		
podofilox	Preferred	
salicylic acid external foam	Non – Preferred	
salicylic acid external gel	Preferred	
salicylic acid external ointment	Preferred	
salicylic acid wart remover	Preferred	
CONDYLOX	Preferred	
PODOCON-25	Non – Preferred	
SALICATE	Non – Preferred	
SALYCIM	Non – Preferred	
YCANTH	Non – Preferred	
Keratolytic/Antimitotic/Vesicant Combinations - Drugs For The Skin**		
UREA-SALICYLIC ACID	Non – Preferred	
Local Anesthetics - Topical - Drugs For The Skin**		
lidocaine external patch	Preferred	QL (3 EA per 1 day)
lidocaine hcl cream 3 % external (rx)	Preferred	
lidocaine hcl cream 4.12 % external	Non – Preferred	
lidocaine hcl external solution	Preferred	
lidocaine hcl urethral/mucosal	Preferred	
lidocaine ointment 5 % external	Preferred	QL (50 GM per 30 days)
DERMACINRX LIDOGEL	Non – Preferred	
GLYDO	Preferred	
LIDOCAN	Preferred	QL (3 EA per 1 day)
LIDODERM	Non – Preferred	QL (3 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIDOREX	Non – Preferred	
LIDOTRAL	Non – Preferred	
LIDOTRAN	Non – Preferred	
LYDEXA	Non – Preferred	
QUTENZA	Non – Preferred	
QUTENZA (2 PATCH)	Non – Preferred	
QUTENZA (4 PATCH)	Non – Preferred	
TRIDACAINE XL	Preferred	
ZTLIDO	Non – Preferred	
Macrolide Immunosuppressants - Topical - Drugs For The Skin**		
pimecrolimus	Preferred	PA
tacrolimus	Preferred	PA; ST
ELIDEL	Preferred	PA
HYFTOR	Non – Preferred	
Misc. Dermatological Products - Drugs For The Skin**		
ALADERM PLUS	Non – Preferred	
HYLATOPIC PLUS	Non – Preferred	
NUVAIL	Non – Preferred	
Misc. Topical - Drugs For The Skin**		
SOFDRA	Non – Preferred	
Oxaborole-Related Antifungals - Topical - Drugs For The Skin**		
tavaborole	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Phosphodiesterase 4 (Pde4) Inhibitors - Topical - Drugs For The Skin***		
EUCRISA	Preferred	PA
ZORYVE	Non – Preferred	
Photodynamic Therapy Agents - Topical - Drugs For The Skin***		
AMELUZ	Non – Preferred	
LEVULAN KERASTICK	Preferred	
Rosacea Agents - Drugs For The Skin***		
azelaic acid	Non – Preferred	
brimonidine tartrate	Non – Preferred	
doxycycline	Non – Preferred	
ivermectin	Non – Preferred	
metronidazole	Preferred	
FINACEA	Non – Preferred	
METROCREAM	Non – Preferred	AL (Min 10 Years)
METROGEL	Non – Preferred	
METROLOTION	Non – Preferred	
MIRVASO	Non – Preferred	
NORITATE	Non – Preferred	
ORACEA	Non – Preferred	
RHOFADE	Non – Preferred	
SOOLANTRA	Non – Preferred	
Scabicide Combinations - Drugs For The Skin***		
ft lice killing max st	Preferred	OTC
goodsense complete lice kit	Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lice killing shampoo max str	Preferred	OTC
Scabicides & Pediculicides - Drugs For The Skin**		
gnp lice treatment	Preferred	OTC; QL (118 ML per 30 days)
goodsense lice killing	Preferred	OTC; QL (118 ML per 30 days)
ivermectin	Non – Preferred	
malathion	Non – Preferred	
permethrin	Non – Preferred	
spinosad	Non – Preferred	
CROTAN	Non – Preferred	
ELIMITE	Non – Preferred	
NATROBA	Preferred	
Skin Cleansers - Drugs For The Skin**		
HYCLODEX	Non – Preferred	
Skin Protectants - Drugs For The Skin**		
SCARTRATE	Non – Preferred	
Steroid-Local Anesthetic Combinations - Drugs For The Skin**		
EPIFOAM	Non – Preferred	
HYDROCAINE	Non – Preferred	
RADIAURA	Non – Preferred	
Tar Products - Drugs For The Skin**		
therapeutic	Preferred	OTC
THERAPEUTIC T+PLUS	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Topical Anesthetic Combinations - Drugs For The Skin***		
lidocaine-prilocaine	Non – Preferred	
LIDOTRAL-MENTHOL	Non – Preferred	
XYLIDERM	Non – Preferred	QL (10 EA per 1 day)
Topical Selective Retinoid X Receptor Agonists - Drugs For The Skin***		
bexarotene	Non – Preferred	
TARGRETIN	Preferred	
Topical Steroid Combinations - Drugs For The Skin***		
calcipotriene-betameth diprop	Non – Preferred	
DUOBRII	Non – Preferred	
ENSTILAR	Non – Preferred	
TACLONEX	Non – Preferred	
Wound Care Combinations - Drugs For The Skin***		
bpco	Non – Preferred	
Wound Dressings - Drugs For The Skin***		
ACTICOAT FLEX 3 4"X4"	Preferred	
ALLEVYN ADHESIVE	Preferred	OTC
COMFORT-AID 1.5"X2.5"	Preferred	OTC
FILSUVEZ	Non – Preferred	
Wound Treatment - Gene Therapy - Drugs For The Skin***		
VYJUVEK	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diagnostic Products		
****Diagnostic Tests******		
blood glucose test	Non – Preferred	OTC
blood glucose test strips 333	Non – Preferred	OTC; QL (5 EA per 1 day)
cvs digital pregnancy test	Preferred	OTC
cvs early pregnancy	Preferred	OTC
cvs early result pregnancy diagnostic test in vitro	Non – Preferred	OTC
cvs early result pregnancy diagnostic test in vitro	Preferred	OTC
cvs glucose meter test strips	Non – Preferred	OTC
cvs one step pregnancy diagnostic test in vitro	Non – Preferred	OTC
cvs one step pregnancy diagnostic test in vitro	Preferred	OTC
cvs pregnancy test kit	Preferred	OTC
digital pregnancy	Preferred	OTC
early pregnancy	Preferred	OTC
early result pregnancy	Preferred	OTC
easy plus ii glucose test	Non – Preferred	OTC
easy talk blood glucose test	Non – Preferred	OTC
easy talk plus ii test strips	Non – Preferred	OTC
easy trak blood glucose test	Non – Preferred	OTC
easy trak ii glucose test	Non – Preferred	OTC
element compact test	Non – Preferred	OTC
eq blood glucose test	Non – Preferred	OTC
eq pregnancy test	Non – Preferred	OTC
eq pregnancy test early result	Preferred	OTC
eql one-step pregnancy diagnostic test in vitro	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
eql one-step pregnancy diagnostic test in vitro	Preferred	OTC
eql pregnancy early result	Preferred	OTC
eql pregnancy test digital	Preferred	OTC
ft early result pregnancy	Preferred	OTC
ft one step pregnancy	Non – Preferred	OTC
ge100 blood glucose test	Non – Preferred	OTC
ght test	Non – Preferred	OTC
glucose meter test	Non – Preferred	OTC
gnp advanced pregnancy test	Preferred	OTC
gnp easy touch glucose test	Non – Preferred	OTC
gnp one step pregnancy	Preferred	OTC
gnp pregnancy test	Preferred	OTC
goodsense blood glucose	Non – Preferred	OTC
ketone test	Preferred	OTC
kroger blood glucose test	Non – Preferred	OTC
kroger premium glucose test	Non – Preferred	OTC
meijer blood glucose test	Non – Preferred	OTC
meijer essential glucose test	Non – Preferred	OTC
one drop test	Non – Preferred	OTC
one step pregnancy diagnostic test in vitro	Non – Preferred	OTC
one step pregnancy diagnostic test in vitro	Preferred	OTC
one-step pregnancy diagnostic test in vitro	Non – Preferred	OTC
one-step pregnancy diagnostic test in vitro	Preferred	OTC
pharmacist choice no coding	Non – Preferred	OTC
pregnancy test diagnostic test in vitro	Non – Preferred	OTC
pregnancy test diagnostic test in vitro	Preferred	OTC
premium blood glucose test	Non – Preferred	OTC
pro voice v8/v9 glucose	Non – Preferred	OTC
sb pregnancy test kit diagnostic test in vitro	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sb pregnancy test kit diagnostic test in vitro	Preferred	OTC
sm pregnancy test kit diagnostic test in vitro	Non – Preferred	OTC
sm pregnancy test kit diagnostic test in vitro	Preferred	OTC
tgt blood glucose test	Non – Preferred	OTC
true focus blood glucose strip	Non – Preferred	OTC
verasens blood glucose test	Non – Preferred	OTC
ACCU-CHEK AVIVA PLUS	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK GUIDE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CHEK SMARTVIEW	Non – Preferred	OTC; QL (5 EA per 1 day)
ACCU-CLEAR PREGNANCY DIAGNOSTIC TEST IN VITRO	Non – Preferred	OTC
ACCU-CLEAR PREGNANCY DIAGNOSTIC TEST IN VITRO	Preferred	OTC
ACCUTREND GLUCOSE	Non – Preferred	OTC
ADVANCE INTUITION TEST	Non – Preferred	OTC
ADVANCE MICRO-DRAW TEST	Non – Preferred	OTC
ADVOCATE REDI-CODE	Non – Preferred	OTC
ADVOCATE REDI-CODE+ TEST	Non – Preferred	OTC
ADVOCATE TEST	Non – Preferred	OTC
AGAMATRIX AMP TEST	Non – Preferred	OTC
AGAMATRIX JAZZ TEST	Non – Preferred	OTC
AGAMATRIX PRESTO TEST	Non – Preferred	OTC
ASSURE 3 TEST	Non – Preferred	OTC
ASSURE 4 TEST	Non – Preferred	OTC
ASSURE II	Non – Preferred	OTC
ASSURE II CHECK	Non – Preferred	OTC
ASSURE PLATINUM	Non – Preferred	OTC
ASSURE PRISM MULTI TEST	Non – Preferred	OTC
ASSURE PRO TEST	Non – Preferred	OTC
BIOTEL CARE TEST STRIPS	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLULINK GLUCOSE TEST	Non – Preferred	OTC
CAREONE BLOOD GLUCOSE TEST	Non – Preferred	OTC
CARESENS N GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
CARETOUCH TEST	Non – Preferred	OTC
CHEMSTRIP K	Preferred	OTC
CLEARBLUE DIGITAL PLUS	Preferred	OTC
CLEARBLUE DIGITAL PREGNANCY DIAGNOSTIC TEST IN VITRO	Non – Preferred	OTC
CLEARBLUE DIGITAL PREGNANCY DIAGNOSTIC TEST IN VITRO	Preferred	OTC
CLEARBLUE PLUS PREGNANCY DIAGNOSTIC TEST IN VITRO	Non – Preferred	OTC
CLEARBLUE PLUS PREGNANCY DIAGNOSTIC TEST IN VITRO	Preferred	OTC
CLEVER CHEK AUTO-CODE TEST	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC
CLEVER CHEK TEST	Non – Preferred	OTC
CLEVER CHOICE AUTO-CODE TEST	Non – Preferred	OTC
CLEVER CHOICE MICRO TEST	Non – Preferred	OTC
CLEVER CHOICE NO CODING	Non – Preferred	OTC
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC
CONTOUR NEXT TEST STRIP IN VITRO	Non – Preferred	OTC
CONTOUR NEXT TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
CONTOUR PLUS TEST	Preferred	OTC
CONTOUR TEST STRIP IN VITRO	Non – Preferred	OTC
CONTOUR TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
COOL BLOOD GLUCOSE TEST STRIPS	Non – Preferred	OTC
CVS ADVANCED GLUCOSE TEST	Non – Preferred	OTC
D-CARE BLOOD GLUCOSE	Non – Preferred	
DIATHRIVE BLOOD GLUCOSE TEST	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIATHRIVE GLUCOSE TEST	Non – Preferred	OTC
DIATHRIVE+ GLUCOSE TEST	Non – Preferred	OTC
DUO-CARE TEST	Non – Preferred	OTC
EASY STEP TEST	Non – Preferred	OTC
EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO	Non – Preferred	OTC
EASY TOUCH HEALTHPRO GLUCOSE STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
EASY TOUCH TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
EASY TOUCH TEST STRIP IN VITRO	Non – Preferred	OTC
EASYGLUCO	Non – Preferred	OTC
EASYMAX 15 TEST	Non – Preferred	OTC
EASYMAX TEST	Non – Preferred	OTC
EASYPRO BLOOD GLUCOSE TEST	Non – Preferred	OTC
EASYPRO PLUS	Non – Preferred	OTC
ELEMENT TEST	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
EMBRACE EVO BLOOD GLUCOSE TEST	Non – Preferred	OTC
EMBRACE PRO GLUCOSE TEST	Non – Preferred	OTC
EMBRACE TALK GLUCOSE TEST	Non – Preferred	OTC
EMBRACE WAVE BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
EPT	Preferred	OTC
EPT DIGITAL	Preferred	OTC
EVOLUTION AUTOCODE	Non – Preferred	OTC
FACT PLUS+ PREGNANCY	Preferred	OTC
FIFTY50 GLUCOSE TEST 2.0	Non – Preferred	OTC
FIRST RESPONSE PREGNANCY	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA 6 CONNECT	Non – Preferred	OTC
FORA 6 CONNECT/GTEL TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
FORA D40/G31 BLOOD GLUCOSE	Non – Preferred	OTC
FORA G20 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA GD20 TEST	Non – Preferred	OTC
FORA GD50 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA GTEL BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA TN'G ADVANCE PRO	Non – Preferred	OTC
FORA TN'G/TN'G VOICE	Non – Preferred	OTC
FORA V10 BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORA V30A BLOOD GLUCOSE TEST	Non – Preferred	OTC
FORACARE GD40 TEST	Non – Preferred	OTC
FORACARE PREMIUM V10 TEST	Non – Preferred	OTC
FORACARE TEST N GO TEST	Non – Preferred	OTC
FREESTYLE INSULINX TEST	Non – Preferred	OTC
FREESTYLE LITE TEST	Non – Preferred	OTC
FREESTYLE PRECISION NEO TEST	Non – Preferred	OTC
FREESTYLE TEST	Non – Preferred	OTC
GENULTIMATE TEST	Non – Preferred	OTC
GLUCO PERFECT 3 TEST	Non – Preferred	OTC
GLUCOCARD 01 SENSOR PLUS	Non – Preferred	OTC
GLUCOCARD EXPRESSION TEST	Non – Preferred	OTC
GLUCOCARD SHINE TEST	Non – Preferred	OTC
GLUCOCARD VITAL TEST	Non – Preferred	OTC
GLUCOCARD X-SENSOR	Non – Preferred	OTC
GLUCOCOM TEST	Non – Preferred	OTC
GLUCONAVII BLOOD GLUCOSE TEST	Non – Preferred	OTC
GNP TRUE METRIX GLUCOSE STRIPS	Non – Preferred	OTC
GNP TRUETRACK SMART SYSTEM	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GNP TRUETRACK TEST STRIPS	Non – Preferred	OTC
GOJJI BLOOD GLUCOSE TEST	Non – Preferred	OTC
GOJJI BLOOD TEST STRIP/LANCETS	Non – Preferred	OTC
HW EMBRACE PRO GLUCOSE TEST	Non – Preferred	OTC
HW EMBRACE TALK GLUCOSE TEST	Non – Preferred	OTC
IGLUCOSE TEST STRIPS	Non – Preferred	OTC
IHEALTH BLOOD GLUCOSE TEST STR	Non – Preferred	OTC
IN TOUCH BLOOD GLUCOSE TEST	Non – Preferred	OTC
INFINITY BLOOD GLUCOSE TEST	Non – Preferred	OTC
INFINITY VOICE	Non – Preferred	OTC
KROGER HEALTHPRO GLUCOSE TEST	Non – Preferred	OTC
MEIJER TRUETEST TEST	Non – Preferred	OTC
MEIJER TRUETRACK TEST	Non – Preferred	OTC
MICRODOT TEST	Non – Preferred	OTC
MM BLULINK GLUCOSE TEST	Non – Preferred	OTC
MM EASY TOUCH GLUCOSE	Non – Preferred	OTC
MYGLUCOHEALTH TEST	Non – Preferred	OTC
NEUTEK 2TEK TEST	Non – Preferred	OTC
NOVA MAX GLUCOSE TEST	Non – Preferred	OTC
ON CALL EXPRESS BLOOD GLUCOSE	Non – Preferred	OTC
ONETOUCH ULTRA	Non – Preferred	OTC
ONETOUCH ULTRA BLUE TEST	Non – Preferred	OTC
ONETOUCH ULTRA TEST	Non – Preferred	OTC
ONETOUCH VERIO	Non – Preferred	OTC
OPTIUMEZ TEST	Non – Preferred	OTC
PHARMACIST CHOICE AUTOCODE	Non – Preferred	OTC
PIP BLOOD GLUCOSE TEST STRIP	Non – Preferred	OTC; QL (5 EA per 1 day)
POCKETCHEM EZ TEST	Non – Preferred	OTC
PRECISION XTRA BLOOD GLUCOSE	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY NO CODING BLOOD GLUC	Non – Preferred	OTC
PTS PANELS EGLU TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
PURALIN ONE-STEP PREGNANCY	Preferred	OTC
QUICK TOUCH BLOOD GLUCOSE TEST	Non – Preferred	OTC
QUICKTEK TEST	Non – Preferred	OTC
QUINTET AC BLOOD GLUCOSE TEST	Non – Preferred	OTC
QUINTET BLOOD GLUCOSE TEST	Non – Preferred	OTC
REFUAH PLUS BLOOD GLUCOSE TEST	Non – Preferred	OTC
RELION BLOOD GLUCOSE TEST	Non – Preferred	OTC
RELION CONFIRM/MICRO TEST	Non – Preferred	OTC
RELION GLUCOSE TEST STRIPS	Non – Preferred	OTC
RELION PREMIER TEST	Non – Preferred	OTC
RELION PRIME TEST	Non – Preferred	OTC
RELION TRUE METRIX TEST STRIPS	Non – Preferred	OTC
RELION ULTIMA TEST	Non – Preferred	OTC
REXALL BLOOD GLUCOSE TEST	Non – Preferred	OTC
RIGHTEST GS100 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GS300 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GS550 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GT333 BLOOD GLUCOSE	Non – Preferred	OTC; QL (5 EA per 1 day)
RIGHTEST GT333 GLUCOSE TEST	Non – Preferred	OTC; QL (5 EA per 1 day)
SMART SENSE PREMIUM TEST	Non – Preferred	OTC
SMART SENSE VALUE TEST	Non – Preferred	OTC
SMARTEST BLOOD GLUCOSE TEST	Non – Preferred	OTC
SOLUS V2 TEST	Non – Preferred	OTC
SUPREME TEST	Non – Preferred	OTC
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC; QL (5 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE METRIX PRO BLOOD GLUCOSE	Non – Preferred	OTC
TRUETEST TEST	Non – Preferred	OTC
TRUETRACK TEST	Non – Preferred	OTC
UNISTRIP1 GENERIC	Non – Preferred	OTC
VIVAGUARD INO TEST STRIPS	Non – Preferred	OTC
***Digestive Aids* - Drugs For The Stomach**		
****Digestive Enzymes*** - Drugs For The Stomach***		
CREON	Preferred	
PERTZYE	Non – Preferred	
VIOKACE	Non – Preferred	
ZENPEP	Preferred	
***Diuretics* - Drugs For The Heart**		
****Carbonic Anhydrase Inhibitors*** - Drugs For High Blood Pressure***		
acetazolamide	Preferred	
acetazolamide er	Preferred	
dichlorphenamide	Non – Preferred	
methazolamide	Preferred	
KEVEYIS	Non – Preferred	
****Diuretic Combinations*** - Drugs For High Blood Pressure***		
amiloride-hydrochlorothiazide	Preferred	
spironolactone-hctz	Preferred	
triamterene-hctz	Preferred	
****Loop Diuretics*** - Drugs For High Blood Pressure***		
bumetanide	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ethacrynic acid	Preferred	
furosemide	Preferred	
torsemide	Preferred	
BUMEX	Non – Preferred	
EDECRIN	Non – Preferred	
LASIX	Non – Preferred	
Potassium Sparing Diuretics - Drugs For High Blood Pressure**		
amiloride hcl	Preferred	
spironolactone oral suspension	Non – Preferred	
spironolactone oral tablet	Preferred	
triamterene	Preferred	
ALDACTONE	Non – Preferred	
CAROSPIR	Non – Preferred	
Thiazides And Thiazide-Like Diuretics - Drugs For High Blood Pressure**		
chlorthalidone	Preferred	
hydrochlorothiazide	Preferred	
indapamide	Preferred	
metolazone	Preferred	
DIURIL	Preferred	
THALITONE	Non – Preferred	
Endocrine And Metabolic Agents - Misc.* - Hormones		
Abortifacient - Progesterone Receptor Antagonists - Drugs For Women**		
mifepristone	Preferred	
MIFEPREX	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bisphosphonates - Drugs For Menopause And Bone Loss**		
alendronate sodium oral solution	Preferred	QL (10.8 ML per 1 day)
alendronate sodium tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
alendronate sodium tablet 35 mg oral	Preferred	QL (4 EA per 28 days)
alendronate sodium tablet 5 mg oral	Preferred	
alendronate sodium tablet 70 mg oral	Preferred	QL (4 EA per 28 days)
ibandronate sodium tablet 150 mg oral	Non – Preferred	QL (1 EA per 30 days)
risedronate sodium	Non – Preferred	
ACTONEL	Non – Preferred	
ATELVIA	Non – Preferred	
BINOSTO	Non – Preferred	
FOSAMAX	Non – Preferred	QL (4 EA per 28 days)
FOSAMAX PLUS D	Non – Preferred	
Calcimimetic Agents - Drugs For Menopause And Bone Loss**		
cinacalcet hcl	Non – Preferred	
SENSIPAR	Non – Preferred	
Calcitonins - Drugs For Menopause And Bone Loss**		
calcitonin (salmon)	Preferred	QL (3.7 ML per 30 days)
Carnitine Replenisher - Agents - Drugs For Menopause And Bone Loss**		
levocarnitine	Non – Preferred	
levocarnitine sf	Non – Preferred	
CARNITOR	Non – Preferred	
CARNITOR SF	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cortisol Synthesis Inhibitors - Hormones***		
ISTURISA	Non – Preferred	
RECORLEV	Non – Preferred	
Dopamine Receptor Agonists - Drugs For Women***		
cabergoline tablet 0.5 mg oral	Preferred	
cabergoline tablet 0.5 mg oral	Preferred	QL (16 EA per 30 days)
Fabry Disease - Agents - Drugs For Menopause And Bone Loss***		
GALAFOLD	Non – Preferred	
Gnrh/Lhrh Antagonists - Drugs For Women***		
ORILISSA	Preferred	PA
Growth Hormone Releasing Hormones (Ghrh) - Drugs For Growth***		
EGRIFTA SV	Non – Preferred	
Growth Hormones - Drugs For Growth***		
GENOTROPIN	Preferred	PA
GENOTROPIN MINIQUICK	Preferred	PA
HUMATROPE	Non – Preferred	
NGENLA	Non – Preferred	
NORDITROPIN FLEXPRO	Non – Preferred	
NUTROPIN AQ NUSPIN 10	Non – Preferred	
NUTROPIN AQ NUSPIN 20	Non – Preferred	
NUTROPIN AQ NUSPIN 5	Non – Preferred	
OMNITROPE	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROSTIM	Non – Preferred	
SKYTROFA	Non – Preferred	
SOGROYA	Non – Preferred	
ZOMACTON	Non – Preferred	
Hereditary Tyrosinemia Type 1 (Ht-1) Treatment - Agents - Drugs For Menopause And Bone Loss***		
nitisinone	Preferred	
NITYR	Non – Preferred	
ORFADIN ORAL CAPSULE	Preferred	
ORFADIN ORAL SUSPENSION	Non – Preferred	
Homocystinuria Treatment - Agents - Drugs For Menopause And Bone Loss***		
betaine	Non – Preferred	
CYSTADANE	Non – Preferred	
Hyperammonemia Treatment - Agents - Drugs For Menopause And Bone Loss***		
carglumic acid	Preferred	PA
CARBAGLU	Preferred	
Hyperparathyroid Treatment - Vitamin D Analogs - Drugs For Menopause And Bone Loss***		
calcitriol	Preferred	
doxercalciferol	Preferred	
paricalcitol	Non – Preferred	QL (1 EA per 1 day)
RAYALDEE	Non – Preferred	
ROCALTROL	Non – Preferred	
ZEMPLAR	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Insulin-Like Growth Factors (Somatomedins) - Hormones***		
INCRELEX	Non – Preferred	
Lhrh/Gnrh Agonist Analog Pituitary Suppressants - Drugs For Women***		
SYNAREL	Non – Preferred	
Non-Steroidal Mineralocorticoid Receptor Antagonists - Hormones***		
KERENDIA	Preferred	PA
Phenylketonuria Treatment - Agents - Drugs For Menopause And Bone Loss***		
sapropterin dihydrochloride	Non – Preferred	
JAVYGTOR	Non – Preferred	
KUVAN	Non – Preferred	
Selective Estrogen Receptor Modulators (Serms) - Drugs For Menopause And Bone Loss***		
raloxifene hcl	Non – Preferred	
EVISTA	Non – Preferred	
OSPHENA	Non – Preferred	
Selective Vasopressin V2-Receptor Antagonists - Hormones***		
tolvaptan	Non – Preferred	
JYNARQUE	Non – Preferred	
SAMSCA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Somatostatic Agents - Drugs For Growth***		
lanreotide acetate	Non – Preferred	
octreotide acetate	Non – Preferred	
MYCAPSSA	Non – Preferred	
SANDOSTATIN	Non – Preferred	
SANDOSTATIN LAR DEPOT	Non – Preferred	
SIGNIFOR	Non – Preferred	
SIGNIFOR LAR	Non – Preferred	
SOMATULINE DEPOT	Non – Preferred	
Urea Cycle Disorder - Agents - Drugs For Menopause And Bone Loss***		
sodium phenylbutyrate	Non – Preferred	
BUPHENYL	Non – Preferred	
OLPRUVA (2 GM DOSE)	Non – Preferred	
OLPRUVA (3 GM DOSE)	Non – Preferred	
OLPRUVA (4 GM DOSE)	Non – Preferred	
OLPRUVA (5 GM DOSE)	Non – Preferred	
OLPRUVA (6 GM DOSE)	Non – Preferred	
OLPRUVA (6.67 GM DOSE)	Non – Preferred	
PHEBURANE	Non – Preferred	
RAVICTI	Non – Preferred	
Vasopressin - Hormones***		
desmopressin ace spray refrig	Preferred	QL (5 ML per 30 days)
desmopressin acetate	Preferred	QL (3 EA per 1 day)
desmopressin acetate spray solution 0.01 % nasal	Preferred	QL (5 ML per 30 days)
DDAVP	Non – Preferred	QL (3 EA per 1 day)
NOCDURNA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Estrogens* - Hormones**		
****Estrogen & Androgen*** - Drugs For Women***		
est estrogens-methyltest ds	Preferred	
est estrogens-methyltest hs	Preferred	
****Estrogen & Progestin*** - Drugs For Women***		
estradiol-norethindrone acet	Preferred	QL (1 EA per 1 day)
norethindrone-eth estradiol	Non – Preferred	QL (1 EA per 1 day)
ACTIVELLA	Non – Preferred	QL (1 EA per 1 day)
ANGELIQ	Non – Preferred	
BIJUVA	Non – Preferred	
CLIMARA PRO	Non – Preferred	
COMBIPATCH	Preferred	QL (8 PATCH per 28 days)
FYAVOLV	Non – Preferred	QL (1 EA per 1 day)
JINTELI	Non – Preferred	QL (1 EA per 1 day)
MIMVEY	Preferred	QL (1 EA per 1 day)
PREMPHASE	Preferred	QL (1 EA per 1 day)
PREMPRO	Preferred	QL (1 EA per 1 day)
****Estrogen-Progestin-Gnrh Antagonist*** - Drugs For Woman***		
MYFEMBREE	Preferred	PA
ORIAHNN	Preferred	PA
****Estrogens*** - Drugs For Women***		
estradiol oral	Preferred	
estradiol patch twice weekly 0.025 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch twice weekly 0.0375 mg/24hr transdermal	Preferred	QL (8 EA per 28 days)

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
estradiol patch twice weekly 0.0375 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch twice weekly 0.05 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch twice weekly 0.075 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch twice weekly 0.1 mg/24hr transdermal	Preferred	QL (8 PATCH per 28 days)
estradiol patch weekly 0.025 mg/24hr transdermal	Preferred	
estradiol patch weekly 0.0375 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.05 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.06 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.075 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol patch weekly 0.1 mg/24hr transdermal	Preferred	QL (4 EA per 28 days)
estradiol transdermal gel	Non – Preferred	
estradiol valerate	Non – Preferred	
ALORA	Non – Preferred	QL (8 EA per 28 days)
CLIMARA PATCH WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	
CLIMARA PATCH WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.06 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
CLIMARA PATCH WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLIMARA PATCH WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (4 EA per 28 days)
DELESTROGEN	Non – Preferred	
DEPO-ESTRADIOL	Non – Preferred	
DIVIGEL	Non – Preferred	
DOTTI PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Preferred	QL (8 PATCH per 28 days)
DOTTI PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Preferred	QL (8 PATCH per 28 days)
DOTTI PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
DOTTI PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
DOTTI PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Preferred	QL (8 EA per 28 days)
ELESTRIN	Non – Preferred	
ESTRACE	Non – Preferred	
EVAMIST	Non – Preferred	
LYLLANA	Preferred	QL (8 EA per 28 days)
MENEST	Preferred	
MENOSTAR	Non – Preferred	
MINIVELLE PATCH TWICE WEEKLY 0.025 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.0375 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 PATCH per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.05 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.075 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
MINIVELLE PATCH TWICE WEEKLY 0.1 MG/24HR TRANSDERMAL	Non – Preferred	QL (8 EA per 28 days)
PREMARIN	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIVELLE-DOT	Non – Preferred	QL (8 EA per 28 days)
Estrogen-Selective Estrogen Receptor Modulator Comb - Drugs For Women***		
DUAVEE	Non – Preferred	
***Fluoroquinolones* - Drugs For Infections**		
Fluoroquinolones - Antibiotics***		
ciprofloxacin hcl tablet 250 mg oral	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin hcl tablet 500 mg oral	Preferred	AL (Min 16 Years)
ciprofloxacin hcl tablet 500 mg oral	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin hcl tablet 750 mg oral	Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)
ciprofloxacin in d5w	Preferred	
levofloxacin in d5w	Preferred	
levofloxacin intravenous	Preferred	
levofloxacin oral solution	Preferred	QL (280 ML Max Qty Per Fill Retail); AL (Max 12 Years)
levofloxacin oral tablet	Preferred	QL (14 EA Max Qty Per Fill Retail); AL (Min 16 Years)
moxifloxacin hcl	Preferred	AL (Min 16 Years)
ofloxacin	Non – Preferred	AL (Min 16 Years)
BAXDELA	Non – Preferred	AL (Min 16 Years)
CIPRO ORAL SUSPENSION RECONSTITUTED	Non – Preferred	AL (Min 16 Years)
CIPRO ORAL TABLET	Non – Preferred	QL (28 EA Max Qty Per Fill Retail); AL (Min 16 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Gastrointestinal Agents - Misc.* - Drugs For The Stomach**		
****5-Ht4 Receptor Agonists*** - Drugs For The Stomach***		
MOTEGRITY	Non – Preferred	
****Antiflatulents*** - Drugs For The Stomach***		
gas relief	Preferred	OTC
simethicone	Preferred	OTC
****Bile Acid Synthesis Disorder Agents*** - Drugs For The Stomach***		
CHOLBAM	Non – Preferred	
****Cic Agents - Guanylate Cyclase-C (Gc-C) Agonists*** - Drugs For Constipation***		
TRULANCE	Non – Preferred	
****Farnesoid X Receptor (Fxr) Agonists*** - Drugs For The Stomach***		
OCALIVA	Non – Preferred	
****Gallstone Solubilizing Agents*** - Drugs For The Stomach***		
ursodiol oral capsule	Preferred	
ursodiol oral tablet	Non – Preferred	
CHENODAL	Non – Preferred	
RELTONE	Non – Preferred	
URSO FORTE	Non – Preferred	
****Gastrointestinal Antiallergy Agents*** - Drugs For The Stomach***		
cromolyn sodium	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GASTROCROM	Non – Preferred	
Gastrointestinal Chloride Channel Activators - Drugs For Irritable Bowel Syndrome***		
lubiprostone	Non – Preferred	QL (2 EA per 1 day)
AMITIZA	Non – Preferred	QL (2 EA per 1 day)
Gastrointestinal Stimulants - Drugs For The Stomach***		
metoclopramide hcl oral solution	Preferred	
metoclopramide hcl oral tablet	Preferred	
metoclopramide hcl oral tablet dispersible	Non – Preferred	
GIMOTI	Non – Preferred	
REGLAN	Non – Preferred	
Glucagon-Like Peptide-2 (Glp-2) Analogs - Drugs For The Stomach***		
GATTEX	Non – Preferred	
Hepatotropics - Thyroid Hormone Receptor-Beta Agonists - Drugs For The Stomach***		
REZDIFFRA	Preferred	PA
Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists - Drugs For Constipation***		
LINZESS	Non – Preferred	QL (1 EA per 1 day)
Ibs Agent - Mu-Opioid Receptor Agonists - Drugs For Irritable Bowel Syndrome***		
VIBERZI	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lbs Agent - Selective 5-Ht3 Receptor Antagonists - Drugs For Irritable Bowel Syndrome***		
alosetron hcl	Non – Preferred	
LOTRONEX	Non – Preferred	
lbs Agent - Sodium/Hydrogen Exchanger 3 (Nhe3) Inhibitor - Drugs For Irritable Bowel Syndrome***		
IBSRELA	Non – Preferred	
Inflammatory Bowel Agents - Drugs For Inflammatory Bowel Disease***		
balsalazide disodium	Preferred	
mesalamine er	Non – Preferred	QL (4 EA per 1 day)
mesalamine oral capsule delayed release	Non – Preferred	QL (6 EA per 1 day)
mesalamine rectal enema	Preferred	
mesalamine suppository 1000 mg rectal	Preferred	QL (42 EA per 30 days)
mesalamine tablet delayed release 1.2 gm oral	Non – Preferred	QL (4 EA per 1 day)
mesalamine tablet delayed release 800 mg oral	Non – Preferred	
mesalamine tablet delayed release 800 mg oral	Non – Preferred	QL (6 EA per 1 day)
mesalamine-cleanser	Non – Preferred	
sulfasalazine	Preferred	
APRISO	Non – Preferred	QL (4 EA per 1 day)
AZULFIDINE	Non – Preferred	
AZULFIDINE EN-TABS	Non – Preferred	
CANASA	Non – Preferred	QL (42 EA per 30 days)
COLAZAL	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DELZICOL	Non – Preferred	QL (6 EA per 1 day)
DIPENTUM	Non – Preferred	
LIALDA	Non – Preferred	QL (4 EA per 1 day)
PENTASA	Preferred	
ROWASA	Non – Preferred	
SFROWASA	Preferred	
Integrin Receptor Antagonists - Drugs For Inflammatory Bowel Disease***		
ENTYVIO	Non – Preferred	
ENTYVIO PEN	Non – Preferred	
Interleukin Antagonists - Drugs For Inflammatory Bowel Disease***		
OMVOH	Non – Preferred	
OMVOH (300 MG DOSE)	Non – Preferred	
OTULFI	Non – Preferred	
PYZCHIVA	Non – Preferred	
SKYRIZI	Non – Preferred	
STELARA	Non – Preferred	
STEQEYMA	Non – Preferred	
YESINTEK	Non – Preferred	
Intestinal Acidifiers - Drugs For The Stomach***		
enulose	Preferred	
lactulose encephalopathy	Preferred	
Peripheral Opioid Receptor Antagonists - Drugs For The Stomach***		
alvimopan	Non – Preferred	
MOVANTIK	Non – Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELISTOR	Non – Preferred	
SYMPROIC	Non – Preferred	QL (1 EA per 1 day)
Phosphate Binder Agents - Drugs For The Stomach***		
calcium acetate	Preferred	
calcium acetate (phos binder)	Preferred	
lanthanum carbonate	Preferred	
sevelamer carbonate oral packet	Non – Preferred	
sevelamer carbonate oral tablet	Preferred	
sevelamer hcl	Preferred	
AURYXIA	Non – Preferred	QL (12 EA per 1 day)
FOSRENOL ORAL PACKET	Preferred	
FOSRENOL ORAL TABLET CHEWABLE	Non – Preferred	
RENVELA	Non – Preferred	
VELPHORO	Non – Preferred	
Tumor Necrosis Factor Alpha Blockers - Drugs For Inflammatory Bowel Disease***		
infliximab	Non – Preferred	
AVSOLA	Non – Preferred	
CIMZIA	Non – Preferred	
CIMZIA (2 SYRINGE)	Preferred	PA
CIMZIA-STARTER	Preferred	PA
INFLECTRA	Non – Preferred	
REMICADE	Non – Preferred	
RENFLEXIS	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Genitourinary Agents - Miscellaneous* - Drugs For The Urinary System**		
****5-Alpha Reductase Inhibitors*** - Drugs For The Prostate***		
dutasteride	Non – Preferred	
finasteride	Preferred	QL (1 EA per 1 day)
AVODART	Non – Preferred	
PROSCAR	Non – Preferred	QL (1 EA per 1 day)
****Alpha 1-Adrenoceptor Antagonists*** - Drugs For The Prostate***		
alfuzosin hcl er	Preferred	QL (1 EA per 1 day)
silodosin	Non – Preferred	
tamsulosin hcl	Preferred	QL (2 EA per 1 day)
CARDURA XL	Non – Preferred	
RAPAFLO	Non – Preferred	
****Citrates*** - Drugs For Infections***		
cytra k crystals	Non – Preferred	
pot & sod cit-cit ac	Non – Preferred	
potassium citrate er	Non – Preferred	
potassium citrate-citric acid	Non – Preferred	
sod citrate-citric acid solution 1.5-1 gm/15ml oral	Preferred	QL (500 ML per 30 days)
sod citrate-citric acid solution 3-2 gm/30ml oral	Preferred	QL (500 ML per 30 days)
sod citrate-citric acid solution 500-334 mg/5ml oral (rx)	Preferred	QL (500 ML per 30 days)
tricitrates	Non – Preferred	
ORACIT	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UROCIT-K 10	Non – Preferred	
UROCIT-K 15	Non – Preferred	
Cystinosis Agents - Drugs For The Urinary System**		
CYSTAGON	Preferred	
PROCYSBI	Non – Preferred	
Genitourinary Irrigants - Drugs For The Urinary System**		
sodium chloride	Preferred	
Interstitial Cystitis Agents - Drugs For The Urinary System**		
ELMIRON	Non – Preferred	
Phosphates - Drugs For Infections**		
K-PHOS NO 2	Non – Preferred	
Prostatic Hypertrophy Agent Combinations - Drugs For The Prostate**		
dutasteride-tamsulosin hcl	Non – Preferred	
Urinary Analgesics - Drugs For Infections**		
phenazopyridine hcl	Preferred	
PYRIDIUM	Non – Preferred	
Urinary Stone Agents - Drugs For The Urinary System**		
tiopronin	Non – Preferred	
LITHOSTAT	Non – Preferred	
THIOLA	Non – Preferred	
THIOLA EC	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Gout Agents* - Drugs For Pain And Fever**		
****Gout Agent Combinations*** - Gout Drugs***		
colchicine-probenecid	Preferred	
****Gout Agents*** - Gout Drugs***		
allopurinol	Preferred	
colchicine capsule 0.6 mg oral	Non – Preferred	QL (9 EA per 30 days)
colchicine tablet 0.6 mg oral	Non – Preferred	QL (9 EA per 30 days)
febuxostat	Non – Preferred	QL (1 EA per 1 day)
MITIGARE	Non – Preferred	QL (9 EA per 30 days)
ULORIC	Non – Preferred	QL (1 EA per 1 day)
****Uricosurics*** - Gout Drugs***		
probenecid	Preferred	
***Hematological Agents - Misc.* - Drugs For The Blood**		
****Agents For Congenital Thrombotic Thrombocytopenic Purpura* - Drugs For The Blood***		
adzynma	Non – Preferred	
****Antihemophilic Products - Monoclonal Antibodies*** - Drugs For The Blood***		
HEMLIBRA	Preferred	PA
****Antihemophilic Products*** - Drugs To Prevent Bleeding***		
adynovate	Preferred	PA
obizur	Preferred	PA
rixubis	Preferred	PA

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVATE	Preferred	PA
AFSTYLA	Preferred	PA
ALPHANATE	Preferred	PA
ALPHANINE SD	Preferred	PA
ALPROLIX	Preferred	PA
BENEFIX	Preferred	PA
COAGADEX	Preferred	PA
CORIFACT	Preferred	PA
ELOCTATE	Preferred	PA
ESPEROCT	Preferred	PA
FEIBA	Preferred	PA
HEMOFIL M	Preferred	PA
HUMATE-P	Preferred	PA
IDELVION	Preferred	PA
IXINITY	Preferred	PA
JIVI	Preferred	PA
KOATE	Preferred	PA
KOATE-DVI	Preferred	PA
KOGENATE FS	Preferred	PA
KOVALTRY	Preferred	PA
NOVOEIGHT	Preferred	PA
NOVOSEVEN RT	Preferred	PA
NUWIQ	Preferred	PA
PROFILNINE	Preferred	PA
REBINYN	Preferred	PA
RECOMBINATE	Preferred	PA
SEVENFACT	Preferred	PA
TRETTEN	Preferred	PA
VONVENDI	Preferred	PA

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WILATE	Preferred	PA
XYNTHA	Preferred	PA
XYNTHA SOLOFUSE	Preferred	PA
Bradykinin B2 Receptor Antagonists - Drugs For The Blood**		
icatibant acetate	Non – Preferred	
FIRAZYR	Non – Preferred	
SAJAZIR	Non – Preferred	
C1 Esterase Inhibitors - Drugs For The Blood**		
BERINERT	Preferred	PA
CINRYZE	Non – Preferred	
HAEGARDA	Non – Preferred	
RUCONEST	Non – Preferred	
Complement C1 Inhibitors - Drugs For The Blood**		
ENJAYMO	Non – Preferred	
Complement C3 Inhibitors - Drugs For The Blood**		
EMPAVELI	Non – Preferred	
Complement C5 Inhibitors - Drugs For The Blood**		
PIASKY	Non – Preferred	
SOLIRIS	Non – Preferred	
ULTOMIRIS	Non – Preferred	
VEOPOZ	Non – Preferred	
ZILBRYSQ	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Complement C5a Receptor Inhibitors - Drugs For The Blood**		
TAVNEOS	Non – Preferred	
Complement Factor B Inhibitors - Drugs For The Blood**		
FABHALTA	Non – Preferred	
Complement Factor D Inhibitors - Drugs For The Blood**		
VOYDEYA	Non – Preferred	
Direct-Acting P2y12 Inhibitors - Drugs For The Blood**		
BRILINTA	Preferred	
Hematorheologic Agents - Drugs For The Blood**		
pentoxifylline er	Preferred	
Phosphodiesterase Iii Inhibitors - Drugs For The Blood**		
cilostazol	Non – Preferred	
Plasma Kallikrein Inhibitors - Monoclonal Antibodies - Drugs For The Blood**		
TAKHZYRO	Non – Preferred	
Plasma Kallikrein Inhibitors - Drugs For The Blood**		
KALBITOR	Non – Preferred	
ORLADEYO	Non – Preferred	
Platelet Aggregation Inhibitor Combinations - Drugs For The Blood**		
aspirin-dipyridamole er	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Platelet Aggregation Inhibitors - Drugs For The Blood***		
dipyridamole	Preferred	
Quinazoline Agents - Drugs For The Blood***		
anagrelide hcl	Preferred	
AGRYLIN	Non – Preferred	
Spleen Tyrosine Kinase (Syk) Inhibitors - Drugs For The Blood***		
TAVALISSE	Non – Preferred	
Thienopyridine Derivatives - Drugs For The Blood***		
clopidogrel bisulfate tablet 300 mg oral	Preferred	QL (1 EA per 30 days)
clopidogrel bisulfate tablet 75 mg oral	Preferred	QL (1 EA per 1 day)
prasugrel hcl	Non – Preferred	
EFFIENT	Non – Preferred	
PLAVIX	Non – Preferred	QL (1 EA per 1 day)
***Hematopoietic Agents* - Drugs For Nutrition**		
Agents For Sickle Cell Disease - Autologous Gene Therapy - Drugs For Nutrition***		
CASGEVY	Non – Preferred	
LYFGENIA	Non – Preferred	
Amino Acids - Drugs For Nutrition***		
l-glutamine	Non – Preferred	
ENDARI	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cobalamins - Drugs For Nutrition***		
cyanocobalamin	Preferred	
Cytotoxic Agents - Drugs For Nutrition***		
DROXIA	Preferred	
SIKLOS	Preferred	AL (Min 2 Years and Max 17 Years)
XROMI	Non – Preferred	
Erythroid Maturation Agents - Drugs For Nutrition***		
REBLOZYL	Non – Preferred	
Erythropoiesis-Stimulating Agents (Esas) - Drugs For Nutrition***		
ARANESP (ALBUMIN FREE)	Non – Preferred	
EPOGEN	Preferred	PA
MIRCERA	Non – Preferred	
PROCRIT	Preferred	PA
RETACRIT	Non – Preferred	
Folic Acid/Folates - Drugs For Nutrition***		
folic acid oral tablet 1 mg	Preferred	
folic acid oral tablet 400 mcg, 800 mcg	Preferred	OTC
Granulocyte Colony-Stimulating Factors (G-Csf) - Drugs For Nutrition***		
releuko	Non – Preferred	
FULPHILA	Non – Preferred	
FYLNETRA	Non – Preferred	
GRANIX	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEULASTA	Non – Preferred	
NEULASTA ONPRO	Non – Preferred	
NEUPOGEN	Preferred	
NIVESTYM	Non – Preferred	
NYVEPRIA	Non – Preferred	
ROLVEDON	Non – Preferred	
STIMUFEND	Non – Preferred	
UDENYCA	Non – Preferred	
UDENYCA ONBODY	Non – Preferred	
ZARXIO	Non – Preferred	
ZIEXTENZO	Non – Preferred	
Granulocyte/Macrophage Colony-Stimulating Factor(Gm-Csf) - Drugs For Nutrition***		
LEUKINE	Preferred	
Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitors - Drugs For Nutrition***		
VAFSEO	Non – Preferred	
Iron - Drugs For Nutrition***		
ferretts	Preferred	OTC
ferric x-150	Preferred	OTC
ferrous fumarate	Preferred	OTC
ferrous sulfate	Preferred	OTC
iron supplement	Preferred	OTC
FERREX 150	Preferred	OTC
FERROCITE	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Selectin Blockers - Drugs For Nutrition***		
ADAKVEO	Non – Preferred	
Thrombopoietin (Tpo) Receptor Agonists - Drugs For Nutrition***		
ALVAIZ	Non – Preferred	
DOPTELET	Non – Preferred	
MULPLETA	Non – Preferred	
NPLATE	Non – Preferred	
PROMACTA ORAL PACKET	Non – Preferred	
PROMACTA TABLET 12.5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROMACTA TABLET 25 MG ORAL	Non – Preferred	
PROMACTA TABLET 50 MG ORAL	Non – Preferred	
PROMACTA TABLET 75 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
***Hemostatics* - Drugs For The Blood**		
Hemostatics - Systemic - Drugs To Prevent Bleeding***		
aminocaproic acid	Preferred	
tranexamic acid	Preferred	QL (28 EA per 30 days); AL (Min 12 Years)
***Hypnotics/Sedatives/Sleep Disorder Agents* - Drugs For The Nervous System**		
Antihistamine Hypnotics - Drugs For Insomnia***		
ra nighttime sleep aid	Preferred	OTC
ra sleep aid	Preferred	OTC
sleep aid	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Barbiturate Hypnotics - Drugs For Insomnia***		
phenobarbital	Preferred	
Benzodiazepine Hypnotics - Drugs For Seizures /Personality Disorder/Nerve Pain***		
estazolam	Preferred	
flurazepam hcl	Non – Preferred	
midazolam hcl	Non – Preferred	
quazepam	Preferred	
temazepam capsule 15 mg oral	Preferred	QL (1 EA per 1 day)
temazepam capsule 22.5 mg oral	Preferred	
temazepam capsule 30 mg oral	Preferred	QL (1 EA per 1 day)
temazepam capsule 7.5 mg oral	Preferred	
triazolam	Preferred	QL (1 EA per 1 day)
HALCION	Non – Preferred	
RESTORIL CAPSULE 15 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 22.5 MG ORAL	Non – Preferred	
RESTORIL CAPSULE 30 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
RESTORIL CAPSULE 7.5 MG ORAL	Non – Preferred	
Hypnotics - Tricyclic Agents - Drugs For Insomnia***		
doxepin hcl	Non – Preferred	
Non-Benzodiazepine - Gaba-Receptor Modulators - Drugs For Insomnia***		
eszopiclone	Non – Preferred	
zaleplon	Non – Preferred	
zolpidem tartrate er	Non – Preferred	
zolpidem tartrate oral capsule	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
zolpidem tartrate sublingual	Non – Preferred	
zolpidem tartrate tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
zolpidem tartrate tablet 5 mg oral	Preferred	
zolpidem tartrate tablet 5 mg oral	Preferred	QL (1 EA per 1 day)
AMBIEN CR	Non – Preferred	
AMBIEN TABLET 10 MG ORAL	Non – Preferred	
AMBIEN TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
AMBIEN TABLET 5 MG ORAL	Non – Preferred	
AMBIEN TABLET 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
EDLUAR	Non – Preferred	
LUNESTA	Non – Preferred	
Orexin Receptor Antagonists - Drugs For Insomnia**		
BELSOMRA	Non – Preferred	
DAYVIGO	Non – Preferred	
QUVIVIQ	Non – Preferred	
Selective Melatonin Receptor Agonists - Drugs For Insomnia**		
ramelteon	Non – Preferred	QL (1 EA per 1 day)
tasimelteon	Non – Preferred	
HETLIOZ	Non – Preferred	
HETLIOZ LQ	Non – Preferred	
ROZEREM	Non – Preferred	
***Laxatives* - Drugs For The Stomach**		
Bowel Evacuant Combinations - Drugs To Prevent Constipation**		
na sulfate-k sulfate-mg sulf	Preferred	Qty Max 354 mL
peg 3350-kcl-na bicarb-nacl	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
peg-3350/electrolytes	Preferred	QL (4000 ML Max Qty Per Fill Retail)
Bulk Laxatives - Drugs To Prevent Constipation***		
natural fiber laxative	Preferred	OTC
psyllium fiber	Preferred	OTC
qc natural vegetable	Preferred	OTC
Laxatives - Miscellaneous - Drugs To Prevent Constipation***		
glycerin (adult)	Preferred	OTC
polyethylene glycol 3350 oral packet	Preferred	OTC; QL (1 EA per 1 day)
polyethylene glycol 3350 oral powder	Preferred	QL (34 GM per 1 day)
Laxatives & Dss - Drugs To Prevent Constipation***		
senna-docusate sodium	Preferred	OTC
Lubricant Laxatives - Drugs To Prevent Constipation***		
cvs mineral oil enema	Preferred	OTC
mineral oil heavy	Preferred	
Saline Laxative Mixtures - Drugs To Prevent Constipation***		
enema ready-to-use	Preferred	OTC
Saline Laxatives - Drugs To Prevent Constipation***		
magnesium citrate	Preferred	OTC
milk of magnesia	Preferred	OTC
Stimulant Laxatives - Drugs To Prevent Constipation***		
bisacodyl	Preferred	OTC
castor oil	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sennosides	Preferred	OTC
Surfactant Laxatives - Drugs To Prevent Constipation**		
docusate sodium oral capsule 100 mg	Preferred	OTC
docusate sodium oral capsule 250 mg	Preferred	
***Macrolides* - Drugs For Infections**		
Azithromycin - Antibiotics**		
azithromycin oral suspension reconstituted	Preferred	QL (30 ML Max Qty Per Fill Retail)
azithromycin tablet 250 mg oral	Preferred	QL (6 EA Max Qty Per Fill Retail)
azithromycin tablet 500 mg oral	Preferred	QL (4 EA per 1 day)
azithromycin tablet 600 mg oral	Preferred	QL (8 EA per 28 days)
ZITHROMAX ORAL PACKET	Preferred	
ZITHROMAX ORAL SUSPENSION RECONSTITUTED	Non – Preferred	QL (30 ML Max Qty Per Fill Retail)
ZITHROMAX TABLET 250 MG ORAL	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
ZITHROMAX TABLET 500 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
ZITHROMAX TRI-PAK	Non – Preferred	QL (4 EA per 1 day)
ZITHROMAX Z-PAK	Non – Preferred	QL (6 EA Max Qty Per Fill Retail)
Clarithromycin - Antibiotics**		
clarithromycin er	Preferred	QL (14 EA Max Qty Per Fill Retail)
clarithromycin oral suspension reconstituted	Preferred	QL (150 ML Max Qty Per Fill Retail)
clarithromycin oral tablet	Preferred	QL (28 EA Max Qty Per Fill Retail)
Erythromycins - Antibiotics**		
erythromycin	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
erythromycin base	Preferred	
erythromycin ethylsuccinate	Preferred	
E.E.S. 400	Preferred	
E.E.S. GRANULES	Preferred	
ERYPED 400	Preferred	
ERY-TAB	Preferred	
Fidaxomicin - Antibiotics**		
DIFICID	Preferred	
***Medical Devices And Supplies* - Medical Supplies And Durable Medical Equipment**		
Applicators,Cotton Balls,Etc - Medical Supplies And Durable Medical Equipment**		
alcohol prep	Preferred	OTC
alcohol swabs	Preferred	OTC
cvs alcohol prep pads	Preferred	OTC
easy comfort alcohol pads	Preferred	OTC
eql alcohol swabs	Preferred	OTC
hm sterile alcohol prep	Preferred	OTC
pure comfort alcohol prep	Preferred	OTC
ra alcohol swabs	Preferred	OTC
sb alcohol prep	Preferred	OTC
sm alcohol prep	Preferred	OTC
sure comfort alcohol prep	Preferred	OTC
ALCOHOL SWABSTICK	Preferred	OTC
CARETOUCH ALCOHOL PREP	Preferred	OTC
COMFORT TOUCH ALCOHOL PREP	Preferred	OTC
CURITY ALCOHOL PREPS	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH ALCOHOL PREP MEDIUM	Preferred	OTC
RELION ALCOHOL SWABS	Preferred	OTC
WEBCOL ALCOHOL PREP LARGE	Preferred	OTC
Cervical Caps - Medical Supplies And Durable Medical Equipment**		
FEMCAP	Preferred	
Condoms - Male - Medical Supplies And Durable Medical Equipment**		
aimsco lubricated	Preferred	OTC
kimono	Preferred	OTC
kimono micro thin	Preferred	OTC
kimono micro thin plus	Preferred	OTC
kimono plus	Preferred	OTC
kimono ps	Preferred	OTC
kimono ps plus	Preferred	OTC
kimono sensation	Preferred	OTC
kimono sensation plus	Preferred	OTC
maxx	Preferred	OTC
maxx plus	Preferred	OTC
DUREX EXTRA SENSITIVE THIN	Preferred	OTC
FANTASY LUBRICATED	Preferred	OTC
FANTASY LUBRICATED/SPERMICIDE	Preferred	OTC
KAMELEON LUBRICATED	Preferred	OTC
KIMONO COLORS	Preferred	OTC
KIMONO MAXX-LARGE FLARE	Preferred	OTC
KIMONO SPECIAL	Preferred	OTC
REALITY LATEX CONDOMS	Preferred	OTC
REALITY LATEX/ULTRA TEXTURED	Preferred	OTC
REALITY LATEX/ULTRA THIN	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TROJAN ENZ	Preferred	OTC
TROJAN ULTRA RIBBED LUBRICATED	Preferred	OTC
TRUSTEX COLOR CONDOMS + LUBE	Preferred	OTC
TRUSTEX LUB/RIBBED/STUDDED	Preferred	OTC
TRUSTEX LUB/SPERMICIDE EX ST	Preferred	OTC
TRUSTEX LUB/SPERMICIDE XL	Preferred	OTC
TRUSTEX LUBRICATED	Preferred	OTC
TRUSTEX LUBRICATED EX LARGE	Preferred	OTC
TRUSTEX LUBRICATED EXTRA ST	Preferred	OTC
TRUSTEX LUBRICATED/SPERMICIDE	Preferred	OTC
TRUSTEX NATURAL CONDOMS + LUBE	Preferred	OTC
TRUSTEX NON-LUBRICATED	Preferred	OTC
TRUSTEX RIA LUB/SPERMICIDE	Preferred	OTC
TRUSTEX RIA LUBRICATED	Preferred	OTC
TRUSTEX RIA NON-LUBRICATED	Preferred	OTC
TRUSTEX-NONOXYNOL-9/RIB/STUD	Preferred	OTC
Diaphragms - Medical Supplies And Durable Medical Equipment**		
OMNIFLEX DIAPHRAGM	Preferred	
WIDE-SEAL DIAPHRAGM 60	Preferred	
WIDE-SEAL DIAPHRAGM 65	Preferred	
WIDE-SEAL DIAPHRAGM 70	Preferred	
WIDE-SEAL DIAPHRAGM 75	Preferred	
WIDE-SEAL DIAPHRAGM 80	Preferred	
WIDE-SEAL DIAPHRAGM 85	Preferred	
WIDE-SEAL DIAPHRAGM 90	Preferred	
WIDE-SEAL DIAPHRAGM 95	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gauze Pads & Dressings - Medical Supplies And Durable Medical Equipment***		
bandage new generation large	Preferred	OTC
cvs gauze	Preferred	OTC
cvs gauze pad sterile	Preferred	OTC
cvs gauze sterile	Preferred	OTC
eql gauze	Preferred	OTC
eql gauze sterile	Preferred	OTC
gauze pads	Preferred	OTC
gauze type vii medi-pak	Preferred	OTC
hm sterile pads	Preferred	OTC
qc border island gauze	Preferred	OTC
qc sterile pads	Preferred	OTC
ra sterile	Preferred	OTC
sm bandage roll	Preferred	OTC
sm gauze	Preferred	OTC
sm rolled gauze 2"x4.1yd	Preferred	OTC
sm rolled gauze 3"x4.1yd	Preferred	OTC
sm sterile	Preferred	OTC
sterile	Preferred	OTC
sterile bandage roll 2.25"x3yd	Preferred	OTC
sterile gauze	Preferred	OTC
stretch gauze bandage	Preferred	OTC
surgical gauze sponge	Preferred	OTC
AMD FOAM DRESSING	Preferred	
AMD FOAM DRESSING TOPSHEET	Preferred	
BAND-AID GAUZE LARGE	Preferred	OTC
BAND-AID GAUZE MEDIUM	Preferred	OTC
BAND-AID GAUZE SMALL	Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BAND-AID KLING ROLLED GAUZE LG	Preferred	OTC
BAND-AID KLING ROLLED GAUZE SM	Preferred	OTC
COMPEED SKIN PROTECTOR DRESS	Preferred	OTC
COPA ISLAND BORDERED FOAM	Preferred	OTC
COPA PLUS HYDROPHILIC FOAM	Preferred	OTC
COVRSITE COVER DRESSING	Preferred	OTC
COVRSITE PLUS COMPOSITE DRESS	Preferred	OTC
CURITY ALL PURPOSE SPONGES	Preferred	OTC
CURITY AMD ANTIMICROBIAL SPNGE PAD 2"X2"	Preferred	OTC
CURITY AMD ANTIMICROBIAL SPNGE PAD 4"X4"	Preferred	
CURITY COVER SPONGE	Preferred	OTC
CURITY GAUZE	Preferred	OTC
CURITY GAUZE SPONGE	Preferred	OTC
CURITY NON-ADHERENT STRIPS	Preferred	OTC
CURITY SPONGES	Preferred	OTC
DERMACEA GAUZE SPONGE	Preferred	OTC
DERMACEA IV DRAIN SPONGES	Preferred	OTC
DERMACEA IV SPONGES	Preferred	OTC
DERMACEA NON-WOVEN SPONGES	Preferred	OTC
DERMACEA TYPE VII GAUZE	Preferred	OTC
EXCILON IV SPONGES	Preferred	OTC
J & J GAUZE	Preferred	OTC
KENDALL HYDROPHILIC FOAM DRESS	Preferred	OTC
KENDALL HYDROPHILIC FOAM PLUS	Preferred	OTC
MIRASORB SPONGES	Preferred	OTC
RESTORE CONTACT LAYER	Preferred	OTC
SOF-WIK	Preferred	OTC
THERAGAUZE	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Glucose Monitoring Test Supplies - Medical Supplies And Durable Medical Equipment***		
blood glucose monitor system	Non – Preferred	OTC
blood glucose monitoring 333	Non – Preferred	OTC
blood glucose system pak	Non – Preferred	OTC
careone advanced lancing dev	Preferred	OTC
careone lancet thin 23g	Preferred	OTC
comfort assured lancets 28g	Preferred	OTC
comfort assured lancets 33g	Preferred	OTC
cvs lancets 21g	Preferred	OTC
cvs lancets micro thin 33g	Preferred	OTC
cvs lancets original	Preferred	OTC
cvs lancets thin 26g	Preferred	OTC
diabetes care	Non – Preferred	OTC
diabetes monitor digit add-on	Non – Preferred	OTC
diabetes monitor digit soln	Non – Preferred	OTC
easy mini eject lancing device	Preferred	OTC
easy mini lancing device	Preferred	OTC
easy plus ii control	Preferred	OTC
easy plus ii glucose system	Non – Preferred	OTC
easy talk blood glucose system	Non – Preferred	OTC
easy talk control	Preferred	OTC
easy trak blood glucose system	Non – Preferred	OTC
easy trak ii blood glucose sys	Non – Preferred	OTC
element compact control 2	Preferred	OTC
element compact control 3	Preferred	OTC
element compact glucose system	Non – Preferred	OTC
element compact v glucose sys	Non – Preferred	OTC
embrace lancing device/ejector	Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
eql color lancets 21g	Preferred	OTC
eql color lancets micro 33g	Preferred	OTC
eql super thin lancets 30g	Preferred	OTC
eql thin lancets 26g	Preferred	OTC
ge100 blood glucose system	Non – Preferred	OTC
ght blood glucose monitor	Non – Preferred	OTC
goodsense blood glucose	Non – Preferred	OTC
guardian sensor 3	Preferred	PA
kroger blood glucose	Non – Preferred	OTC
kroger premium blood glucose	Non – Preferred	OTC
meijer blood glucose	Non – Preferred	OTC
meijer essential blood glucose	Non – Preferred	OTC
meijer premium blood glucose	Non – Preferred	OTC
one drop blood glucose monitor	Non – Preferred	OTC
oval tape	Non – Preferred	OTC
pro voice v9 glucose system	Non – Preferred	OTC
safety lancet 30g/pressure act	Preferred	OTC
safety lancets 28g	Preferred	OTC
select-lite device/lancets	Preferred	OTC
tgt blood glucose monitoring	Non – Preferred	OTC
verasens blood glucose meter	Non – Preferred	OTC
verasens blood glucose system	Non – Preferred	OTC
ACCU-CHEK AVIVA	Preferred	OTC
ACCU-CHEK AVIVA PLUS	Non – Preferred	OTC
ACCU-CHEK FASTCLIX LANCET	Preferred	OTC
ACCU-CHEK FASTCLIX LANCETS	Preferred	OTC
ACCU-CHEK GUIDE	Non – Preferred	OTC
ACCU-CHEK GUIDE CONTROL	Preferred	OTC
ACCU-CHEK GUIDE ME	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK SAFE-T PRO LANCETS	Preferred	OTC
ACCU-CHEK SMARTVIEW CONTROL	Preferred	OTC
ACCU-CHEK SOFTCLIX LANCET DEV	Preferred	OTC
ACCU-CHEK SOFTCLIX LANCETS	Preferred	OTC
ACCUTREND GLUCOSE CONTROL	Preferred	OTC
ADVANCE INTUITION METER	Non – Preferred	OTC
ADVANCE INTUITION MONITOR	Non – Preferred	OTC
ADVANCE MICRO-DRAW CONTROL	Preferred	OTC
ADVANCE MICRO-DRAW METER	Non – Preferred	OTC
ADVANCE MICRO-DRAW NORMAL	Preferred	OTC
ADVOCATE BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
ADVOCATE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
ADVOCATE CONTROL SOLUTION	Preferred	OTC
ADVOCATE LANCETS	Preferred	OTC
ADVOCATE LANCETS 30G	Preferred	OTC
ADVOCATE LANCING DEVICE	Preferred	OTC
ADVOCATE RAPID-SAFE LANCING	Preferred	OTC
ADVOCATE REDI-CODE	Non – Preferred	OTC
ADVOCATE REDI-CODE+	Non – Preferred	OTC
ADVOCATE REDI-CODE+ CONTROL	Preferred	OTC
ADVOCATE SAFETY LANCETS	Preferred	OTC
ADVOCATE SAFETY LANCETS 26G	Preferred	OTC
AGAMATRIX CONTROL	Preferred	OTC
AGAMATRIX CONTROL LEVEL 2	Preferred	OTC
AGAMATRIX CONTROL LEVEL 4	Preferred	OTC
AGAMATRIX JAZZ WIRELESS 2	Non – Preferred	OTC
AGAMATRIX PRESTO	Non – Preferred	OTC
ASSURE 3 CONTROL	Preferred	OTC
ASSURE 3 METER	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASSURE 4 CONTROL LEVEL 1 & 2	Preferred	OTC
ASSURE 4 METER	Non – Preferred	OTC
ASSURE PLATINUM METER	Non – Preferred	OTC
ASSURE PRISM MULTI METER	Non – Preferred	OTC
ASSURE PRO BLOOD GLUCOSE METER	Non – Preferred	OTC
AUTO-LANCET	Preferred	OTC
AUTO-LANCET MINI	Preferred	OTC
AUTOLET II CLINISAFE	Preferred	OTC
AUTOLET LANCING DEVICE	Preferred	OTC
AUTOLET LITE CLINISAFE	Preferred	OTC
AUTOLET LITE STARTER PACK	Preferred	OTC
AUTOLET MINI	Preferred	OTC
AUTOLET PLATFORMS	Preferred	OTC
AUTOLET PLUS	Preferred	OTC
BD LATITUDE DIABETES	Non – Preferred	OTC
BD LOGIC BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
BD MICROTAINER LANCETS	Preferred	
BIGFOOT UNITY PROGRAM	Non – Preferred	
BIOTEL CARE BLOOD GLUCOSE	Non – Preferred	OTC
BIOTEL CARE BLOOD GLUCOSE SYST	Non – Preferred	OTC
BLULINK GLUCOSE MONITORING SYS	Non – Preferred	OTC
CAREONE BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
CAREONE LANCET SUPER THIN 30G	Preferred	OTC
CARESENS LANCETS	Preferred	OTC
CARESENS N FELIZ	Non – Preferred	OTC
CARESENS N FELIZ BT	Non – Preferred	OTC
CARESENS N GLUCOSE SYSTEM	Non – Preferred	OTC
CARESENS N VOICE SYSTEM	Non – Preferred	OTC
CARETOUCH MONITOR SYSTEM	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARETOUCH SAFETY LANCETS	Preferred	OTC
CARETOUCH SAFETY LANCETS 26G	Preferred	OTC
CARETOUCH TWIST LANCETS 28G	Preferred	OTC
CARETOUCH TWIST LANCETS 30G	Preferred	OTC
CARETOUCH TWIST LANCETS 33G	Preferred	OTC
CLEANLET LANCETS 28G	Preferred	OTC
CLEVER CHEK AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHEK AUTO-CODE VOICE	Non – Preferred	OTC
CLEVER CHEK LANCETS	Preferred	OTC
CLEVER CHEK SYSTEM	Non – Preferred	OTC
CLEVER CHOICE AUTO-CODE SYSTEM	Non – Preferred	OTC
CLEVER CHOICE LANCETS 21G	Preferred	OTC
CLEVER CHOICE LANCETS 23G	Preferred	OTC
CLEVER CHOICE LANCETS 28G	Preferred	OTC
CLEVER CHOICE MICRO SYSTEM	Non – Preferred	OTC
CLEVER CHOICE MINI SYSTEM	Non – Preferred	OTC
CLEVER CHOICE TALK SYSTEM	Non – Preferred	OTC
COAGUCHEK LANCETS	Preferred	OTC
CONTOUR BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
CONTOUR CONTROL	Preferred	OTC
CONTOUR MONITOR	Non – Preferred	OTC
CONTOUR NEXT CONTROL	Preferred	OTC
CONTOUR NEXT EZ	Non – Preferred	OTC
CONTOUR NEXT GEN MONITOR	Non – Preferred	OTC
CONTOUR NEXT LINK	Non – Preferred	OTC
CONTOUR NEXT MONITOR	Non – Preferred	OTC
CONTOUR NEXT ONE	Non – Preferred	OTC
CONTOUR PLUS BLUE	Preferred	OTC
COOL MONITOR	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COOL MONITOR KIT	Non – Preferred	OTC
CVS BLOOD GLUCOSE METER	Non – Preferred	OTC
D-CARE GLUCOMETER	Non – Preferred	
DEXCOM G6 RECEIVER DEVICE	Non – Preferred	
DEXCOM G6 RECEIVER DEVICE	Preferred	PA; QL (1 EA per 365 days)
DEXCOM G6 SENSOR	Non – Preferred	
DEXCOM G6 SENSOR	Preferred	PA; QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER	Non – Preferred	PA
DEXCOM G6 TRANSMITTER	Preferred	PA; QL (1 EA per 90 days)
DEXCOM G7 RECEIVER DEVICE	Non – Preferred	
DEXCOM G7 RECEIVER DEVICE	Preferred	PA; QL (1 EA per 365 days)
DEXCOM G7 SENSOR	Non – Preferred	
DEXCOM G7 SENSOR	Preferred	PA; QL (3 EA per 30 days)
DIATHRIVE BLOOD GLUCOSE METER	Non – Preferred	OTC
DIATHRIVE+ GLUCOSE MONITOR	Non – Preferred	OTC
EASY STEP CONTROL	Preferred	OTC
EASY STEP GLUCOSE MONITOR	Non – Preferred	OTC
EASY TOUCH GLUCOSE SYSTEM	Non – Preferred	OTC
EASY TOUCH HEALTHPRO GLUCOSE	Non – Preferred	OTC
EASY TOUCH LANCETS 21G	Preferred	OTC
EASY TOUCH LANCETS 23G	Preferred	OTC
EASY TOUCH LANCETS 26G	Preferred	OTC
EASY TOUCH LANCETS 28G	Preferred	OTC
EASY TOUCH LANCETS 28G/TWIST	Preferred	OTC
EASY TOUCH LANCETS 30G	Preferred	OTC
EASY TOUCH LANCETS 30G/TWIST	Preferred	OTC
EASY TOUCH LANCETS 32G	Preferred	OTC
EASY TOUCH LANCETS 32G/TWIST	Preferred	OTC
EASY TOUCH LANCETS 33G/TWIST	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH LANCING DEVICE	Preferred	OTC
EASY TOUCH SAFETY LANCETS 21G	Preferred	OTC
EASY TOUCH SAFETY LANCETS 23G	Preferred	OTC
EASY TOUCH SAFETY LANCETS 26G	Preferred	OTC
EASY TOUCH SAFETY LANCETS 28G	Preferred	OTC
EASYGLUCO	Non – Preferred	OTC
EASYMAX NG BLOOD GLUCOSE	Non – Preferred	OTC
EASYMAX V BLOOD GLUCOSE	Non – Preferred	OTC
EASYPRO BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
EASYPRO PLUS	Non – Preferred	OTC
ELEMENT AUTOCODE SYSTEM	Non – Preferred	OTC
ELEMENT CONTROL	Preferred	OTC
ELEMENT PLUS	Non – Preferred	OTC
EMBRACE BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
EMBRACE CONTROL	Preferred	OTC
EMBRACE EVO GLUCOSE MONITOR	Non – Preferred	OTC
EMBRACE EVO GLUCOSE MONITORING	Non – Preferred	OTC
EMBRACE PRO GLUCOSE METER	Non – Preferred	OTC
EMBRACE TALK BLOOD GLUCOSE	Non – Preferred	OTC
EMBRACE TALK MONITORING SYSTEM	Non – Preferred	OTC
EMBRACE WAVE BLOOD GLUCOSE	Non – Preferred	OTC
EMBRACE WAVE GLUCOSE METER	Non – Preferred	OTC
ENLITE GLUCOSE SENSOR	Non – Preferred	PA
EVERSENSE 365 SENSOR/HOLDER	Non – Preferred	
EVERSENSE 365 SMART TRANSMIT	Non – Preferred	PA
EVERSENSE SENSOR/HOLDER	Non – Preferred	PA
EVERSENSE SMART TRANSMITTER	Non – Preferred	PA
EVOLUTION AUTOCODE	Non – Preferred	OTC
E-Z JECT LANCET MICRO-THIN 33G	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
E-Z JECT LANCET SUPER THIN 30G	Preferred	OTC
E-Z JECT LANCETS	Preferred	OTC
E-Z JECT LANCETS 21G	Preferred	OTC
E-Z JECT LANCETS THIN 26G	Preferred	OTC
EZ-LETS LANCETS 21G	Preferred	OTC
EZ-LETS LANCETS 26G	Preferred	OTC
FIFTY50 GLUCOSE METER 2.0	Non – Preferred	OTC
FORA G20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA G30A BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GD20 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GD50 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA GTEL BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORA PREMIUM V10 BLE SYSTEM	Non – Preferred	OTC
FORA TEST N' GO MONITOR	Non – Preferred	OTC
FORA TN'G VOICE	Non – Preferred	OTC
FORA V12 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
FORACARE GD40 MONITOR	Non – Preferred	OTC
FORACARE PREMIUM V10	Non – Preferred	OTC
FORACARE TEST N GO MONITOR	Non – Preferred	OTC
FREESTYLE CONTROL SOLUTION	Preferred	OTC
FREESTYLE FREEDOM LITE	Non – Preferred	OTC
FREESTYLE LIBRE 14 DAY READER	Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 14 DAY SENSOR	Preferred	PA; QL (2 EA per 28 days)
FREESTYLE LIBRE 2 PLUS SENSOR	Preferred	
FREESTYLE LIBRE 2 READER DEVICE	Non – Preferred	
FREESTYLE LIBRE 2 READER DEVICE	Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 2 SENSOR	Non – Preferred	
FREESTYLE LIBRE 2 SENSOR	Preferred	PA; QL (2 EA per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 3 PLUS SENSOR	Preferred	PA
FREESTYLE LIBRE 3 READER DEVICE	Non – Preferred	
FREESTYLE LIBRE 3 READER DEVICE	Preferred	PA; QL (1 EA per 365 days)
FREESTYLE LIBRE 3 SENSOR	Non – Preferred	
FREESTYLE LIBRE 3 SENSOR	Preferred	PA; QL (2 EA per 28 days)
FREESTYLE LITE	Non – Preferred	OTC
FREESTYLE PRECISION NEO SYSTEM	Non – Preferred	OTC
GENTEEL CONTACT TIPS (BLUE)	Preferred	OTC
GENTEEL CONTACT TIPS (CLEAR)	Preferred	OTC
GENTEEL CONTACT TIPS (GREEN)	Preferred	OTC
GENTEEL CONTACT TIPS (ORANGE)	Preferred	OTC
GENTEEL CONTACT TIPS (RAINBOW)	Preferred	OTC
GENTEEL CONTACT TIPS (VIOLET)	Preferred	OTC
GENTEEL CONTACT TIPS (YELLOW)	Preferred	OTC
GENTEEL LANCING KIT (BLUE)	Preferred	OTC
GENTEEL NOZZLES	Preferred	OTC
GLUCO PERFECT 3 METER	Non – Preferred	OTC
GLUCOCARD 01 BLOOD GLUCOSE	Non – Preferred	OTC
GLUCOCARD 01-MINI GLUCOSE	Non – Preferred	OTC
GLUCOCARD EXPRESSION MONITOR	Non – Preferred	OTC
GLUCOCARD SHINE	Non – Preferred	OTC
GLUCOCARD SHINE CONNEX	Non – Preferred	OTC
GLUCOCARD SHINE EXPRESS	Non – Preferred	OTC
GLUCOCARD SHINE XL	Non – Preferred	OTC
GLUCOCARD VITAL MONITOR	Non – Preferred	OTC
GLUCOCARD X-METER	Non – Preferred	OTC
GLUCOCOM BLOOD GLUCOSE MONITOR	Non – Preferred	OTC
GLUCOCOM MONITOR	Non – Preferred	OTC
GLUCONAVII BLOOD GLUCOSE SYS	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GNP EASY TOUCH CONT HIGH/LOW	Preferred	OTC
GNP EASY TOUCH GLUCOSE METER	Non – Preferred	OTC
GNP TRUE METRIX AIR METER	Non – Preferred	OTC
GNP TRUE METRIX GLUCOSE METER	Non – Preferred	OTC
GUARDIAN 4 GLUCOSE SENSOR	Preferred	PA
GUARDIAN 4 TRANSMITTER	Preferred	PA
GUARDIAN CONNECT TRANSMITTER	Preferred	PA
GUARDIAN LINK 3 TRANSMITTER	Preferred	PA
GUARDIAN REAL-TIME CHARGER	Non – Preferred	
GUARDIAN REAL-TIME REPLACE PED	Non – Preferred	PA
GUARDIAN REAL-TIME TEST PLUG	Non – Preferred	
GUARDIAN SENSOR (3)	Preferred	PA
HEALTHPRO BLOOD GLUCOSE MONITO	Non – Preferred	OTC
HM EMBRACE TALK SYSTEM	Non – Preferred	OTC
HW EMBRACE PRO GLUCOSE METER	Non – Preferred	OTC
HW EMBRACE TALK BLOOD GLUCOSE	Non – Preferred	OTC
HYPOLANCE AST LANCING	Preferred	OTC
IGLUCOSE MONITORING SYSTEM	Non – Preferred	OTC
IHEALTH GLUCO+ KIT 10	Non – Preferred	OTC
IHEALTH GLUCO+ KIT 100	Non – Preferred	OTC
IN TOUCH	Non – Preferred	OTC
IN TOUCH GLUCOSE CONTROL	Preferred	OTC
INFINITY BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
INFINITY CONTROL	Preferred	OTC
INFINITY VOICE	Non – Preferred	OTC
KROGER HEALTHPRO CONTROL HI/LO	Preferred	OTC
MEIJER TRUE2GO BLOOD GLUCOSE	Non – Preferred	OTC
MEIJER TRUERESULT GLUCOSE SYS	Non – Preferred	OTC
MEIJER TRUETRACK GLUCOSE SYS	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICRODOT BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
MINILINK REAL-TIME TRANSMITTER	Non – Preferred	PA
MINIMED 630G GUARDIAN PRESS	Non – Preferred	PA
MM BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
MM BLOOD GLUCOSE SYSTEM REFILL	Non – Preferred	OTC
MM BLULINK GLUCOSE MONIT SYS	Non – Preferred	OTC
MM EASY TOUCH GLUCOSE METER	Non – Preferred	OTC
MULTI-LANCET DEVICE 2	Preferred	OTC
MYGLUCOHEALTH BLOOD GLUCOSE	Non – Preferred	OTC
NOVA MAX BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
ON CALL EXPRESS MONITORING SYS	Non – Preferred	OTC
ONETOUCH DELICA PLUS LANCET30G	Preferred	OTC
ONETOUCH DELICA PLUS LANCET33G	Preferred	OTC
ONETOUCH DELICA PLUS LANCING	Preferred	OTC
ONETOUCH ULTRA 2	Non – Preferred	OTC
ONETOUCH ULTRA CONTROL	Preferred	OTC
ONETOUCH VERIO	Preferred	OTC
ONETOUCH VERIO FLEX SYSTEM	Non – Preferred	OTC
ONETOUCH VERIO REFLECT	Non – Preferred	OTC
PARADIGM REAL-TIME TRANSMITTER	Non – Preferred	PA
PERFECT LANCETS 28G	Preferred	OTC
PHARMACIST CHOICE AUTOCODE SYS	Non – Preferred	OTC
PHARMACIST CHOICE MINI SYSTEM	Non – Preferred	OTC
PIP BLOOD GLUCOSE MONITORING	Non – Preferred	OTC
POCKETCHEM EZ CONTROL	Preferred	OTC
POCKETCHEM EZ SYSTEM	Non – Preferred	OTC
POGO AUTOMATIC BLOOD GLUCOSE	Non – Preferred	OTC
PRECISION XTRA	Non – Preferred	OTC
PRODIGY AUTOCODE BLOOD GLUCOSE	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY CONTROL SOLUTION	Preferred	OTC
PRODIGY LANCING DEVICE	Preferred	OTC
PRODIGY NO CODING BLOOD GLUC	Non – Preferred	OTC
PRODIGY POCKET BLOOD GLUCOSE	Non – Preferred	OTC
PRODIGY VOICE BLOOD GLUCOSE	Non – Preferred	OTC
QUICK TOUCH BLOOD GLUCOSE	Non – Preferred	OTC
QUICKTEK	Non – Preferred	OTC
QUICKTEK/METER	Non – Preferred	OTC
QUINTET AC BLOOD GLUCOSE	Non – Preferred	OTC
QUINTET BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
REFUAH PLUS MONITORING SYSTEM	Non – Preferred	OTC
RELION ALL-IN-ONE	Non – Preferred	OTC
RELION CONFIRM GLUCOSE MONITOR	Non – Preferred	OTC
RELION LANCETS MICRO-THIN 33G	Preferred	OTC
RELION LANCETS THIN 26G	Preferred	OTC
RELION LANCETS ULTRA-THIN 30G	Preferred	OTC
RELION LANCING DEVICE	Preferred	OTC
RELION MICRO	Non – Preferred	OTC
RELION PREMIER BLU MONITOR	Non – Preferred	OTC
RELION PREMIER CLASSIC	Non – Preferred	OTC
RELION PREMIER COMPACT SYSTEM	Non – Preferred	OTC
RELION PREMIER VOICE MONITOR	Non – Preferred	OTC
RELION PRIME MONITOR	Non – Preferred	OTC
RELION TRUE MET AIR GLUC METER	Non – Preferred	OTC
RELION ULTIMA GLUCOSE SYSTEM	Non – Preferred	OTC
RELION ULTRA THIN LANCETS 30G	Preferred	OTC
RELION ULTRA THIN PLUS LANCETS	Preferred	OTC
REXALL BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
RIGHTEST ALTERNATE SITE ADAPT	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIGHTEST GM100 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GM300 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GM550 BLOOD GLUCOSE	Non – Preferred	OTC
RIGHTEST GT333 BLOOD GLUCOSE	Non – Preferred	OTC
SAFETY LANCETS	Preferred	OTC
SAFETY LANCETS 21G	Preferred	OTC
SMART SENSE PREMIUM SYSTEM	Non – Preferred	OTC
SMART SENSE VALUE GLUCOSE SYS	Non – Preferred	OTC
SMARTEST EJECT	Non – Preferred	OTC
SMARTEST EJECT STARTER	Non – Preferred	OTC
SMARTEST PERSONA STARTER	Non – Preferred	OTC
SMARTEST PRONTO STARTER	Non – Preferred	OTC
SMARTEST PROTEGE	Non – Preferred	OTC
SMARTEST PROTEGE STARTER	Non – Preferred	OTC
SOLUS V2 BLOOD GLUCOSE SYSTEM	Non – Preferred	OTC
TEMPO REFILL	Non – Preferred	OTC
TEMPO WELCOME	Non – Preferred	
TRUE FOCUS BLOOD GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX AIR GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX GO GLUCOSE METER	Non – Preferred	OTC
TRUE METRIX METER	Non – Preferred	OTC
TRUERESULT BLOOD GLUCOSE	Non – Preferred	OTC
TRUETRACK BLOOD GLUCOSE	Non – Preferred	OTC
TRUETRACK SMART SYSTEM	Non – Preferred	OTC
UNISTIK 1	Preferred	OTC
UNISTIK 2	Preferred	OTC
UNISTIK 2 COMFORT	Preferred	OTC
UNISTIK 2 EXTRA	Preferred	OTC
UNISTIK 2 NEONATAL	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNISTIK 2 NORMAL	Preferred	OTC
UNISTIK 2 SUPER	Preferred	OTC
UNISTIK 3	Preferred	OTC
UNISTIK 3 COMFORT	Preferred	OTC
UNISTIK 3 EXTRA	Preferred	OTC
UNISTIK 3 NEONATAL	Preferred	OTC
UNISTIK 3 NORMAL	Preferred	OTC
UNISTIK CZT COMFORT	Preferred	OTC
UNISTIK CZT NORMAL	Preferred	OTC
VIVAGUARD INO GLUCOSE METER	Non – Preferred	OTC
VIVAGUARD INO SMART GLUC METER	Non – Preferred	OTC
Insulin Administration Supplies - Medical Supplies And Durable Medical Equipment***		
ilet insulin pump	Preferred	PA
EXTENDED RESERVOIR 3ML	Non – Preferred	
ILET CONTACT DETACH 23" 6MM	Preferred	PA
ILET INFUSION-INSET 23" 6MM	Preferred	PA
ILET INFUSION-INSET 32" 6MM	Preferred	PA
ILET STARTER - CONTACT DETACH	Preferred	PA
ILET STARTER KIT - INSET 23"	Preferred	PA
ILET STARTER KIT - INSET 32"	Preferred	PA
OMNIPOD 5 DEXG7G6 INTRO GEN 5	Preferred	PA; QL (1 EA per 365 days)
OMNIPOD 5 DEXG7G6 PODS GEN 5	Non – Preferred	QL (15 EA per 30 days)
OMNIPOD 5 DEXG7G6 PODS GEN 5	Preferred	PA; QL (15 EA per 30 days)
OMNIPOD DASH INTRO (GEN 4)	Non – Preferred	
OMNIPOD DASH PDM (GEN 4)	Non – Preferred	
OMNIPOD DASH PODS (GEN 4)	Preferred	PA; QL (15 EA per 30 days)
V-GO 20	Non – Preferred	PA
V-GO 30	Non – Preferred	PA

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
V-GO 40	Non – Preferred	PA
Misc. Devices - Medical Supplies And Durable Medical Equipment***		
14-count warmer	Preferred	OTC
2-way foley stabilization dev	Preferred	
3-in-1 bedside toilet	Preferred	OTC
adapter cap	Preferred	
adjust bath/shower seat	Preferred	OTC
adjust bath/shower seat/back	Preferred	OTC
adjust fold cane/york handle	Preferred	OTC
adjustable aluminum cane	Preferred	OTC
adjustable aluminum cane 3/4"	Preferred	OTC
adjustable aluminum cane 5/8"	Preferred	OTC
adjustable aluminum cane 7/8"	Preferred	OTC
adjustable folding cane	Preferred	OTC
adult push button alum crutch	Preferred	OTC
aluminum blanket support	Preferred	OTC
aluminum flip off seals 13mm	Preferred	
aluminum flip off seals 20mm	Preferred	
amber glass bottle	Preferred	
amber glass vials 2ml	Preferred	
amber glass vials 2ml/13mm	Preferred	
autoclave air filter	Preferred	
autoclave paper 36" x 36"	Preferred	
autoclave printer paper	Preferred	
baby fridge	Preferred	OTC
bamboo cane	Preferred	OTC
bandage scissors	Preferred	OTC
bath/shower seat	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
bathtub safety rail	Preferred	OTC
bed wedge	Preferred	OTC
beutlich ph test roll	Preferred	OTC
bi-focal magnifier	Preferred	OTC
blood collection tube holder	Preferred	OTC
blood pressure smart card	Preferred	OTC
bmi digital smart scale	Preferred	OTC
bottle 120ml/spray/clr plastic	Preferred	
bottle 2oz/blue glass/dropper	Preferred	
bottle 500ml/boston round/cap	Preferred	
bottle 8oz/boston round/cap	Preferred	
breast pump	Preferred	OTC
breathe comfort nasal irrigat	Preferred	OTC
breathe ease pulse oximeter	Preferred	OTC
cane holder	Preferred	OTC
cane tips	Preferred	OTC
cane tips 3/4"	Preferred	OTC
cane tips 7/8"	Preferred	OTC
cane tips for alum 3/4"	Preferred	OTC
cane tips for wood 3/4"	Preferred	OTC
cane tips for wood 5/8"	Preferred	OTC
cane tips for wood 7/8"	Preferred	OTC
cane wrist strap	Preferred	OTC
cervical pillow	Preferred	OTC
cervical pillow/cover	Preferred	OTC
chemo transfer pin	Preferred	OTC
classics rolling walker	Preferred	OTC
cleanroom tacky mat 18"x36"	Preferred	
clear glass vial 10ml	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clear glass vials 2ml	Preferred	
comfort curve massage cushion	Preferred	OTC
commode bedside	Preferred	OTC
commode bedside/back	Preferred	OTC
commode pail	Preferred	OTC
commode splash guard	Preferred	OTC
contour fitted sheets	Preferred	OTC
contour mattress cover	Preferred	OTC
coverall boots/disposable/univ	Preferred	
coverall w/hood/3xl	Preferred	
coverall w/hood/small	Preferred	
coverall w/hood/xl	Preferred	
coverall w/hood/xxl	Preferred	
cvs alkaline batteries size aa	Preferred	OTC
cvs diabetic organizer	Preferred	OTC
cvs ear plugs	Preferred	OTC
dental guard	Preferred	OTC
deodorant tubes 2.65oz-caps	Preferred	
dial-a-dose syringe 15ml	Preferred	
dial-a-dose syringe 30ml	Preferred	
dial-a-dose syringe 60ml	Preferred	
dispenser 50ml/foamer pump	Preferred	
dispenser md jar 50ml	Preferred	
dispenser md pen 6.5ml	Preferred	
dispenser md pump 0.5ml	Preferred	
dropping bottle 30ml	Preferred	
droptainer tip caps	Preferred	OTC
droptainers ophthalmic 3ml	Preferred	
droptainers ophthalmic 7ml	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
earpopper middle ear inflation	Preferred	
easy feed electric breast pump	Preferred	OTC
egg crate bed pad	Preferred	OTC
extendable bedside rail	Preferred	OTC
eye/ear dropper	Preferred	OTC
face shield full length	Preferred	
face shield full length/clear	Preferred	
filter 0.22 micron/73mm/1000ml	Preferred	
filter attachment	Preferred	
foil wrapper 3" x 3"	Preferred	
folding reacher	Preferred	OTC
foot massager	Preferred	OTC
head lice comb	Preferred	OTC
heelboot laundry bag	Preferred	OTC
heelboot liner large	Preferred	OTC
heelboot liner regular	Preferred	OTC
illusions aa breast prosthesis	Preferred	
illusions c breast prosthesis	Preferred	
indicator/biological test	Preferred	
lumbar cushion	Preferred	OTC
magnifier hands-free	Preferred	OTC
ACU-LIFE CRUSHER/CONTAINER	Preferred	OTC
ADD-VANTAGE ADDAPTOR CONNECTOR	Preferred	
ALL-BODY MASSAGE	Preferred	OTC
ALPHAMOP FOAM REPLACEMENT PADS	Preferred	
AMEDA ADAPTER CAP	Preferred	OTC
AMEDA BREAST FLANGE INSERT	Preferred	OTC
AMEDA ONE-HAND BREAST PUMP	Preferred	OTC
AMEDA PLATINUM BREAST PUMP	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMEDA SILICONE TUBING	Preferred	OTC
AMEDA TUBING ADAPTER	Preferred	OTC
AMIELLE VAGINAL TRAINER	Preferred	
ANGEL WING BLOOD COLLECT SET	Preferred	
ANGEL WING LUER ADAPTER/HOLDER	Preferred	
ANGEL WING TRANSFER DEVICE	Preferred	
ANGEL WING TUBE HOLDER	Preferred	
APNEASTRIP	Preferred	
ARGYLE SARATOGA SUMP DRAIN	Preferred	
ARGYLE TRACH TUBE HOLDER	Preferred	OTC
AVOSTARTGRIP	Preferred	
CAREX WHEELCHAIR	Preferred	OTC
CINIS PREEMIE HALO LARGE	Preferred	OTC
CINIS PREEMIE HALO MEDIUM	Preferred	OTC
CINIS PREEMIE HALO SMALL	Preferred	OTC
CLEVER CHOICE HYDROTHERAPY SYS	Preferred	OTC
CLEVER CHOICE PULSE OXIMETER	Preferred	
CLINERE EARWAX CLEANERS	Preferred	OTC
COMAR PRESS-IN BOTTLE ADAPTERS	Preferred	
COMFORT FIT FLANGES LARGE	Preferred	OTC
COMFORT PERSONAL CLEANS CART	Preferred	OTC
COMFORT PERSONAL SHAMPOO CAP	Preferred	OTC
COMFORT PERSONAL WARMER 14-CT	Preferred	OTC
COMFORT PERSONAL WARMER 28-CT	Preferred	OTC
ECO-SMARTFUNNEL 186ML	Preferred	
E-Z LOCK RAISED TOILET SEAT	Preferred	OTC
EZY DOSE ADULT-LOCK PILL CUT	Preferred	OTC
HEAT THERAPY	Preferred	OTC
HURRIPAK PERIO IRRIGATION TIPS	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HURRIPAK PERIODONTAL ANESTHETI	Preferred	OTC
ICY DIAMOND TOTE CANVAS	Preferred	OTC
ICY DIAMOND TOTE NON LEATHER	Preferred	OTC
ICY HOT TENS THERAPY REFILL	Preferred	OTC
MAD NASAL	Preferred	
MAD NASAL ATOMIZATION DEVICE	Preferred	
Needles & Syringes - Medical Supplies And Durable Medical Equipment***		
1st tier unifine pentips	Non – Preferred	OTC
1st tier unifine pentips plus	Non – Preferred	OTC
aq insulin syringe	Non – Preferred	
aqinject pen needle	Non – Preferred	
aum insulin safety pen needle	Non – Preferred	OTC
aum mini insulin pen needle	Non – Preferred	OTC
aum pen needle	Non – Preferred	OTC
aurora pen needles	Non – Preferred	OTC
careone insulin syringe	Non – Preferred	OTC
careone unifine pentips plus	Non – Preferred	OTC
clickfine pen needles 31g x 8 mm	Non – Preferred	OTC
crono syringe	Preferred	OTC
dropsafe safety pen needles	Non – Preferred	OTC
drug mart unifine pentips	Non – Preferred	OTC
drug mart unifine pentips plus	Non – Preferred	OTC
easy comfort insulin syringe	Non – Preferred	OTC
easy comfort pen needles	Non – Preferred	OTC
easy glide pen needles	Non – Preferred	OTC
eql insulin syringe	Non – Preferred	OTC
global ease inject pen needles	Non – Preferred	OTC
global easy glide insulin syr	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
global easy glide pen needles	Non – Preferred	OTC
global inject ease insulin syr	Non – Preferred	OTC
global insulin syringes	Non – Preferred	OTC
gnp clickfine pen needles	Non – Preferred	OTC
gnp insulin syringe	Non – Preferred	OTC
gnp insulin syringes	Non – Preferred	OTC
gnp insulin syringes 28gx1/2"	Non – Preferred	OTC
gnp insulin syringes 29gx1/2"	Non – Preferred	OTC
gnp insulin syringes 30gx5/16"	Non – Preferred	OTC
gnp insulin syringes 31gx5/16"	Non – Preferred	OTC
gnp pen needles	Non – Preferred	OTC
gnp ulticare pen needles	Non – Preferred	OTC
gnp ultra com insulin syringe	Non – Preferred	OTC
goodsense clickfine pen needle	Non – Preferred	OTC
healthwise insulin syr/needle	Non – Preferred	OTC
healthwise micron pen needles	Non – Preferred	OTC
healthwise short pen needles	Non – Preferred	OTC
h-e-b incontrol pen needles	Non – Preferred	OTC
insulin syringe	Non – Preferred	OTC
insulin syringe-needle u-100 27g x 1/2" 0.5 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 27g x 1/2" 0.5 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 27g x 1/2" 1 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 27g x 1/2" 1 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 28g x 1/2" 0.5 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 28g x 1/2" 0.5 ml (rx)	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
insulin syringe-needle u-100 28g x 1/2" 1 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 28g x 1/2" 1 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 29g x 1/2" 0.5 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 29g x 1/2" 0.5 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 29g x 1/2" 1 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 29g x 1/2" 1 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 30g x 1/2" 1 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 30g x 1/2" 1 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 30g x 5/16" 0.3 ml	Non – Preferred	OTC
insulin syringe-needle u-100 30g x 5/16" 0.5 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 30g x 5/16" 0.5 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 30g x 5/16" 1 ml	Non – Preferred	OTC
insulin syringe-needle u-100 31g x 5/16" 0.3 ml	Non – Preferred	OTC
insulin syringe-needle u-100 31g x 5/16" 0.5 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 31g x 5/16" 0.5 ml (rx)	Non – Preferred	
insulin syringe-needle u-100 31g x 5/16" 1 ml (otc)	Non – Preferred	
insulin syringe-needle u-100 31g x 5/16" 1 ml (rx)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
insupen pen needles	Non – Preferred	OTC
kinray insulin syringe	Non – Preferred	OTC
kmart valu insulin syringe 29g	Non – Preferred	OTC
kmart valu insulin syringe 30g	Non – Preferred	OTC
kroger insulin syringe	Non – Preferred	OTC
kroger pen needles	Non – Preferred	OTC
leader insulin syringe	Non – Preferred	OTC
longs insulin syringe	Non – Preferred	OTC
medic insulin syringe	Non – Preferred	OTC
medicine shoppe pen needles	Non – Preferred	OTC
meijer pen needles	Non – Preferred	OTC
mm insulin syringe/needle	Non – Preferred	OTC
ms insulin syringe	Non – Preferred	OTC
pc unifine pentips	Non – Preferred	OTC
pen needle/5-bevel tip	Non – Preferred	OTC
pen needles 29g x 12mm	Non – Preferred	OTC
pen needles 30g x 5 mm (otc)	Non – Preferred	
pen needles 30g x 5 mm (rx)	Non – Preferred	
pen needles 30g x 8 mm	Non – Preferred	OTC
pen needles 31g x 5 mm (otc)	Non – Preferred	
pen needles 31g x 5 mm (rx)	Non – Preferred	
pen needles 31g x 6 mm	Non – Preferred	OTC
pen needles 31g x 8 mm (otc)	Non – Preferred	
pen needles 31g x 8 mm (rx)	Non – Preferred	
pen needles 32g x 4 mm (otc)	Non – Preferred	
pen needles 32g x 4 mm (rx)	Non – Preferred	
pen needles 32g x 5 mm	Non – Preferred	OTC
pen needles 32g x 6 mm	Non – Preferred	OTC
pen needles 33g x 4 mm	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
pen needles 5/16"	Non – Preferred	OTC
pip pen needles 31g x 5mm	Non – Preferred	OTC
pip pen needles 32g x 4mm	Non – Preferred	OTC
preferred plus insulin syringe	Non – Preferred	OTC
preferred plus unifine pentips	Non – Preferred	OTC
pro comfort pen needles 31g x 8 mm	Non – Preferred	
pro comfort pen needles 32g x 4 mm	Non – Preferred	
pro comfort pen needles 32g x 5 mm	Non – Preferred	
pro comfort pen needles 32g x 6 mm	Non – Preferred	OTC
pure comfort pen needle	Non – Preferred	OTC
pure comfort safety pen needle	Non – Preferred	OTC
px extra short pen needles	Non – Preferred	OTC
px insulin syringe	Non – Preferred	OTC
px mini pen needles	Non – Preferred	OTC
px pen needle	Non – Preferred	OTC
qc pen needles	Non – Preferred	OTC
qc unifine pentips	Non – Preferred	OTC
ra insulin syringe	Non – Preferred	OTC
ra pen needles	Non – Preferred	OTC
raya sure pen needle	Non – Preferred	OTC
reality insulin syringe	Non – Preferred	OTC
safety pen needles	Non – Preferred	OTC
sb insulin syringe	Non – Preferred	OTC
sure comfort insulin syringe	Non – Preferred	OTC
sure comfort pen needles 29g x 12.7mm	Non – Preferred	OTC
sure comfort pen needles 30g x 8 mm	Non – Preferred	OTC
sure comfort pen needles 31g x 5 mm	Non – Preferred	OTC
sure comfort pen needles 31g x 6 mm	Non – Preferred	
sure comfort pen needles 31g x 8 mm	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sure comfort pen needles 32g x 4 mm (otc)	Non – Preferred	
sure comfort pen needles 32g x 4 mm (rx)	Non – Preferred	
sure comfort pen needles 32g x 6 mm	Non – Preferred	OTC
syringe luer lock	Preferred	OTC
syringe luer slip	Preferred	OTC
syringe/hypodermic safety	Preferred	OTC
techlite insulin syringe	Non – Preferred	OTC
todays health pen needles	Non – Preferred	OTC
todays health short pen needle	Non – Preferred	OTC
topcare clickfine pen needles	Non – Preferred	OTC
topcare ultra comfort ins syr	Non – Preferred	OTC
true comfort insulin syringe	Non – Preferred	OTC
true comfort pen needles	Non – Preferred	OTC
true comfort pro insulin syr	Non – Preferred	OTC
true comfort pro pen needles	Non – Preferred	OTC
ultra comfort insulin syringe	Non – Preferred	OTC
ultracare insulin syringe	Non – Preferred	OTC
ultracare pen needles	Non – Preferred	OTC
value health insulin syringe	Non – Preferred	OTC
vp insulin syringe	Non – Preferred	OTC
wegmans unifine pentips plus	Non – Preferred	OTC
zevrx insulin syringe	Non – Preferred	OTC
zevrx pen needles	Non – Preferred	OTC
ADVOCATE INSULIN PEN NEEDLES	Non – Preferred	OTC
ADVOCATE INSULIN SYRINGE	Non – Preferred	OTC
ASSURE ID DUO PRO PEN NEEDLES	Non – Preferred	OTC
ASSURE ID PRO PEN NEEDLES	Non – Preferred	OTC
ASSURE ID SAFETY PEN NEEDLES	Non – Preferred	OTC
AUM READYGARD DUO PEN NEEDLE	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUM SAFETY PEN NEEDLE	Non – Preferred	OTC
BD AUTOSHIELD DUO	Non – Preferred	OTC
BD ECLIPSE SYRINGE	Preferred	OTC
BD ECLIPSE SYRINGE/NEEDLE	Preferred	OTC
BD INSULIN SYR ULTRAFINE II	Non – Preferred	OTC
BD INSULIN SYRINGE 27.5G X 5/8" 2 ML	Non – Preferred	OTC
BD INSULIN SYRINGE 27G X 1/2" 1 ML	Non – Preferred	OTC
BD INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (OTC)	Non – Preferred	
BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (RX)	Non – Preferred	
BD INSULIN SYRINGE 29G X 1/2" 1 ML (OTC)	Non – Preferred	
BD INSULIN SYRINGE 29G X 1/2" 1 ML (RX)	Non – Preferred	
BD INSULIN SYRINGE HALF-UNIT	Non – Preferred	OTC
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML	Non – Preferred	OTC
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 0.5 ML	Non – Preferred	OTC
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (OTC)	Non – Preferred	
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (RX)	Non – Preferred	
BD INSULIN SYRINGE U/F	Non – Preferred	OTC
BD INSULIN SYRINGE U/F 1/2UNIT	Non – Preferred	OTC
BD INSULIN SYRINGE U-100 1 ML	Non – Preferred	OTC
BD INSULIN SYRINGE ULTRAFINE	Non – Preferred	OTC
BD INTEGRA SYRINGE	Preferred	OTC
BD LUER-LOCK SYRINGE	Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 1 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1-1/2" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 20G X 1-1/2" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1-1/2" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 21G X 1-1/2" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1" 10 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 22G X 1-1/2" 5 ML	Preferred	OTC
BD LUER-LOK SYRINGE 23G X 1" 3 ML (OTC)	Preferred	
BD LUER-LOK SYRINGE 23G X 1" 3 ML (RX)	Preferred	
BD LUER-LOK SYRINGE 23G X 1-1/2" 3 ML	Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE 25G X 1" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 25G X 1-1/2" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 25G X 5/8" 1 ML	Preferred	OTC
BD LUER-LOK SYRINGE 25G X 5/8" 3 ML	Preferred	OTC
BD LUER-LOK SYRINGE 26G X 5/8" 3 ML	Preferred	OTC
BD PEN NEEDLE MICRO U/F	Non – Preferred	OTC
BD PEN NEEDLE MINI U/F	Non – Preferred	OTC
BD PEN NEEDLE NANO 2ND GEN	Non – Preferred	OTC
BD PEN NEEDLE NANO U/F	Non – Preferred	
BD PEN NEEDLE ORIGINAL U/F	Non – Preferred	OTC
BD PEN NEEDLE SHORT U/F	Non – Preferred	OTC
BD PLASTIPAK SYRINGE	Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML	Non – Preferred	
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML	Non – Preferred	OTC
BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML	Non – Preferred	OTC
BD SAFETYGLIDE SHIELDED NEEDLE	Preferred	OTC
BD SAFETYGLIDE SYRINGE/NEEDLE	Preferred	OTC
BD SYRINGE SLIP TIP	Preferred	OTC
BD SYRINGE/NEEDLE	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD VEO INSULIN SYR U/F 1/2UNIT	Non – Preferred	OTC
BD VEO INSULIN SYRINGE U/F	Non – Preferred	
CAREFINE PEN NEEDLES	Non – Preferred	OTC
CARETOUCH INSULIN SYRINGE	Non – Preferred	OTC
CARETOUCH PEN NEEDLES	Non – Preferred	OTC
CEQUR SIMPLICITY 2U	Preferred	PA
CEQUR SIMPLICITY INSERTER	Preferred	PA
CLEVER CHOICE COMFORT EZ	Non – Preferred	OTC
CLICKFINE PEN NEEDLES 31G X 5 MM	Non – Preferred	OTC
CLICKFINE PEN NEEDLES 31G X 6 MM	Non – Preferred	OTC
CLICKFINE PEN NEEDLES 32G X 4 MM	Non – Preferred	OTC
COMFORT ASSIST INSULIN SYRINGE	Non – Preferred	OTC
COMFORT EZ INSULIN SYRINGE	Non – Preferred	OTC
COMFORT EZ MICRO PEN NEEDLES	Non – Preferred	OTC
COMFORT EZ PEN NEEDLES	Non – Preferred	OTC
COMFORT EZ PRO PEN NEEDLES	Non – Preferred	OTC
COMFORT EZ SHORT PEN NEEDLES	Non – Preferred	OTC
COMFORT TOUCH INSULIN PEN NEED	Non – Preferred	OTC
DIATHRIVE PEN NEEDLE	Non – Preferred	OTC
DROPLET INSULIN SYRINGE	Non – Preferred	OTC
DROPLET MICRON	Non – Preferred	OTC
DROPLET PEN NEEDLES	Non – Preferred	OTC
DROPSAFE SAFETY SYRINGE/NEEDLE	Non – Preferred	
EASY TOUCH FLIPLOCK INSULIN SY	Non – Preferred	OTC
EASY TOUCH FLIPLOCK SAFETY SYR	Preferred	OTC
EASY TOUCH FLURINGE	Preferred	OTC
EASY TOUCH FLURINGE FLIPLOCK	Preferred	OTC
EASY TOUCH FLURINGE SHEATHLOCK	Preferred	OTC
EASY TOUCH INSULIN SAFETY SYR	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH INSULIN SYRINGE	Non – Preferred	OTC
EASY TOUCH PEN NEEDLES	Non – Preferred	OTC
EASY TOUCH SAFETY PEN NEEDLES	Non – Preferred	OTC
EASY TOUCH SAFETY SYRINGE	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 10 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1-1/2" 5 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 10 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 22G X 1-1/2" 5 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 23G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 25G X 1" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 25G X 5/8" 3 ML	Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML	Non – Preferred	OTC
EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML	Non – Preferred	OTC
EASY TOUCH TB SHEATHLOCK SYR	Preferred	OTC
EMBECTA AUTOSHIELD DUO	Non – Preferred	OTC
EMBECTA INS SYR U/F 1/2 UNIT	Non – Preferred	OTC
EMBECTA INSULIN SYRINGE U/F	Non – Preferred	OTC
EMBECTA INSULIN SYRINGE U-100	Non – Preferred	OTC
EMBECTA PEN NEEDLE NANO	Non – Preferred	OTC
EMBECTA PEN NEEDLE NANO 2 GEN	Non – Preferred	OTC
EMBECTA PEN NEEDLE U/F	Non – Preferred	OTC
EMBRACE PEN NEEDLES	Non – Preferred	OTC
FIFTY50 PEN NEEDLES	Non – Preferred	OTC
FIFTY50 SUPERIOR COMFORT SYR	Non – Preferred	OTC
GLUCOPRO INSULIN SYRINGE	Non – Preferred	OTC
GNP ULTIGUARD SAFEPACK NEEDLE	Non – Preferred	OTC
GOODSENSE PEN NEEDLE PENFINE	Non – Preferred	OTC
H-E-B INCONTROL UNIFINE PENTIP	Non – Preferred	OTC
HM ULTICARE INSULIN SYRINGE	Non – Preferred	OTC
HM ULTICARE MINI PEN NEEDLES	Non – Preferred	OTC
HM ULTICARE SHORT PEN NEEDLES	Non – Preferred	OTC
INCONTROL ULTICARE PEN NEEDLES	Non – Preferred	OTC
LEADER UNIFINE PENTIPS	Non – Preferred	OTC
LEADER UNIFINE PENTIPS PLUS	Non – Preferred	OTC
LITETOUCH INSULIN SYRINGE	Non – Preferred	OTC
LITETOUCH PEN NEEDLES	Non – Preferred	OTC
LUER LOCK SAFETY SYRINGES	Preferred	OTC
MAGELLAN INSULIN SAFETY SYR	Non – Preferred	
MAGELLAN SYRINGE-SAFETY NEEDLE	Preferred	
MARATHON MEDICAL PENTIPS	Non – Preferred	
MAXICOMFORT II PEN NEEDLE	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs

UPPERCASE BOLD = Brand name drugs

Drug Tier

Non – Preferred = Non – Preferred

Preferred = Preferred

AL = Age Restrictions

OTC = OTC Medications

PA = Prior Authorization Applies

QL = Quantity Limits

ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAXI-COMFORT INSULIN SYRINGE	Non – Preferred	OTC
MAXI-COMFORT SAFETY PEN NEEDLE	Non – Preferred	OTC
MAXICOMFORT SYR 27G X 1/2"	Non – Preferred	OTC
MICRODOT PEN NEEDLE	Non – Preferred	OTC
MM PEN NEEDLES	Non – Preferred	OTC
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML	Non – Preferred	OTC
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)	Non – Preferred	
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)	Non – Preferred	
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	
MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (OTC)	Non – Preferred	
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)	Non – Preferred	
MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT INSULIN SYRINGE U-100 1 ML	Non – Preferred	
MONOJECT LIFESHIELD SYRINGE	Preferred	
MONOJECT MAGELLAN SYRINGE 18G X 1" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 18G X 1" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 20G X 1" 3 ML	Preferred	OTC
MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 20G X 1-1/2" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 21G X 1-1/2" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 22G X 1" 3 ML	Preferred	OTC
MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 12 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 3 ML	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT MAGELLAN SYRINGE 22G X 1-1/2" 6 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 23G X 1" 1 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 23G X 1" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 1" 1 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 1" 3 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 5/8" 1 ML	Preferred	
MONOJECT MAGELLAN SYRINGE 25G X 5/8" 3 ML	Preferred	
MONOJECT SYRINGE 18G X 1" 12 ML (OTC)	Preferred	
MONOJECT SYRINGE 18G X 1" 12 ML (RX)	Preferred	
MONOJECT SYRINGE 20G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 20G X 1-1/2" 12 ML (OTC)	Preferred	OTC
MONOJECT SYRINGE 20G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 20G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 20G X 3/4" 3 ML (RX)	Preferred	
MONOJECT SYRINGE 21G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 21G X 1" 6 ML	Preferred	
MONOJECT SYRINGE 21G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 21G X 1-1/2" 6 ML	Preferred	
MONOJECT SYRINGE 22G X 1" 3 ML	Preferred	OTC
MONOJECT SYRINGE 22G X 1-1/2" 3 ML	Preferred	
MONOJECT SYRINGE 22G X 1-1/2" 6 ML	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SYRINGE 23G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 1" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 1-1/4" 3 ML	Preferred	
MONOJECT SYRINGE 25G X 5/8" 3 ML	Preferred	
MONOJECT SYRINGE 27G X 1-1/4" 3 ML	Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (OTC)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)	Non – Preferred	
MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.3 ML	Non – Preferred	OTC
MONOJECT ULTRA COMFORT SYRINGE 31G X 5/16" 0.5 ML	Non – Preferred	OTC
NOVOFINE PEN NEEDLE	Non – Preferred	OTC
NOVOFINE PLUS PEN NEEDLE	Non – Preferred	OTC

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENTIPS 29G X 12MM (OTC)	Non – Preferred	
PENTIPS 29G X 12MM (RX)	Non – Preferred	
PENTIPS 31G X 5 MM (OTC)	Non – Preferred	
PENTIPS 31G X 5 MM (RX)	Non – Preferred	
PENTIPS 31G X 6 MM	Non – Preferred	OTC
PENTIPS 31G X 8 MM (OTC)	Non – Preferred	
PENTIPS 31G X 8 MM (RX)	Non – Preferred	
PENTIPS 32G X 4 MM (OTC)	Non – Preferred	
PENTIPS 32G X 4 MM (RX)	Non – Preferred	
PENTIPS 32G X 6 MM	Non – Preferred	OTC
PENTIPS GENERIC PEN NEEDLES	Non – Preferred	OTC
PRECISION SURE-DOSE SYRINGE	Non – Preferred	OTC
PREVENT DROPSAFE PEN NEEDLES	Non – Preferred	OTC
PREVENT SAFETY PEN NEEDLES	Non – Preferred	OTC
PRO COMFORT INSULIN SYRINGE	Non – Preferred	OTC
PRODIGY INSULIN SYRINGE	Non – Preferred	OTC
QUICK TOUCH INSULIN PEN NEEDLE	Non – Preferred	OTC
RELION INSULIN SYRINGE	Non – Preferred	OTC
RELION MINI PEN NEEDLES	Non – Preferred	OTC
RELION PEN NEEDLES	Non – Preferred	OTC
RELION SHORT PEN NEEDLES	Non – Preferred	OTC
SECURESAFE INSULIN SYRINGE	Non – Preferred	OTC
SECURESAFE SAFETY PEN NEEDLES	Non – Preferred	OTC
SECURESAFE SYRINGE/NEEDLE	Preferred	OTC
TECHLITE PEN NEEDLES	Non – Preferred	OTC
TECHLITE PLUS PEN NEEDLES	Non – Preferred	OTC
TRUEPLUS 5-BEVEL PEN NEEDLES	Preferred	OTC
TRUEPLUS INSULIN SYRINGE	Preferred	OTC
ULTICARE INSULIN SAFETY SYR	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE INSULIN SYR 1/2 UNIT	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 29G X 1/2" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (OTC)	Non – Preferred	
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)	Non – Preferred	
ULTICARE INSULIN SYRINGE 30G X 5/16" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.5 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 1/4" 1 ML	Non – Preferred	OTC
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (OTC)	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (RX)	Non – Preferred	
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (OTC)	Non – Preferred	
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (RX)	Non – Preferred	
ULTICARE INSULIN SYRINGE 31G X 5/16" 1 ML	Non – Preferred	OTC
ULTICARE MICRO PEN NEEDLES	Non – Preferred	OTC
ULTICARE MINI PEN NEEDLES	Non – Preferred	OTC
ULTICARE PEN NEEDLES 29G X 12.7MM (OTC)	Non – Preferred	
ULTICARE PEN NEEDLES 29G X 12.7MM (RX)	Non – Preferred	
ULTICARE PEN NEEDLES 31G X 5 MM	Non – Preferred	OTC
ULTICARE SHORT PEN NEEDLES 30G X 8 MM	Non – Preferred	OTC
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC)	Non – Preferred	
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX)	Non – Preferred	
ULTICARE SYRINGE	Preferred	OTC
ULTICARE TUBERCULIN SAFETY SYR	Preferred	OTC
ULTIGUARD SAFEPACK PEN NEEDLE	Non – Preferred	OTC
ULTIGUARD SAFEPACK SYR/NEEDLE	Non – Preferred	OTC
ULTILET PEN NEEDLE	Non – Preferred	OTC
ULTRA FLO INSULIN PEN NEEDLES	Non – Preferred	OTC
ULTRA FLO INSULIN SYR 1/2 UNIT	Non – Preferred	OTC
ULTRA FLO INSULIN SYRINGE	Non – Preferred	OTC
ULTRA THIN PEN NEEDLES	Non – Preferred	OTC
ULTRA-THIN II INS SYR SHORT	Non – Preferred	OTC
ULTRA-THIN II INSULIN SYRINGE	Non – Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA-THIN II MINI PEN NEEDLE	Non – Preferred	OTC
ULTRA-THIN II PEN NEEDLE SHORT	Non – Preferred	OTC
ULTRA-THIN II PEN NEEDLES	Non – Preferred	OTC
UNIFINE PENTIPS	Non – Preferred	OTC
UNIFINE PENTIPS PLUS	Non – Preferred	OTC
UNIFINE PROTECT PEN NEEDLE	Non – Preferred	OTC
UNIFINE SAFECONTROL PEN NEEDLE	Non – Preferred	OTC
UNIFINE ULTRA PEN NEEDLE	Non – Preferred	OTC
VANISHPOINT INSULIN SYRINGE	Non – Preferred	OTC
VANISHPOINT SAFETY SYRINGE	Preferred	OTC
VANISHPOINT SYRINGE	Preferred	OTC
VERIFINE INSULIN PEN NEEDLE	Non – Preferred	OTC
VERIFINE INSULIN SYRINGE	Non – Preferred	OTC
VERIFINE PLUS PEN NEEDLE	Non – Preferred	OTC
****Peak Flow Meters*** - Medical Supplies And Durable Medical Equipment***		
breathe ease peak flow meter	Preferred	OTC
lung perform peak flow meter	Preferred	OTC
peak a-i-r flow meter	Preferred	OTC
peak flow meter universal rang	Preferred	OTC
pure comfort flow meter adult	Preferred	OTC
pure comfort flow meter child	Preferred	OTC
AIRZONE PEAK FLOW METER	Preferred	OTC
ASSESS PEAK FLOW METER	Preferred	OTC
CLEVER CHOICE PEAK FLOW METER	Preferred	OTC
MICROLIFE DIGITAL PEAK FLOW	Preferred	OTC
MINI WRIGHT PEAK FLOW METER	Preferred	OTC
PEAK AIR PEAK FLOW METER	Preferred	OTC
PERSONAL BEST FULL RANGE	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PIKO 1	Preferred	OTC
POCKET PEAK FLOW METER	Preferred	OTC
POCKETPEAK PEAK FLOW METER	Preferred	OTC
TRUZONE PEAK FLOW METER	Preferred	
Respiratory Therapy Supplies - Medical Supplies And Durable Medical Equipment***		
adult aerosol mask	Preferred	OTC
adult disposable	Preferred	OTC
breathe ease neb mask/child	Preferred	
breathe ease neb mask/infant	Preferred	
co monitor replacement pieces	Preferred	
disposable full range	Preferred	
disposable low range	Preferred	
disposable low range/pediatric	Preferred	
disposable paper	Preferred	OTC
disposable universal range	Preferred	
expiratory mouthpiece	Preferred	OTC
filter air pp	Preferred	
full kit nebulizer set	Preferred	
nebulizer air tube/plugs	Preferred	
nose clip	Preferred	OTC
one-way valved expiratory	Preferred	OTC
one-way valved inspiratory	Preferred	OTC
ped disposable	Preferred	OTC
pediatric mouthpiece	Preferred	OTC
pharmacist choice mask wipes	Preferred	OTC
pillow mask/adult	Preferred	
pillow mask/child	Preferred	
pillow mask/pediatric	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
replacement air filter	Preferred	
replacement filters	Preferred	OTC
silicone mask/adult	Preferred	
silicone mask/infant	Preferred	
silicone mask/pediatric	Preferred	
sootheneb nbl 100 adult mask	Preferred	OTC
sootheneb nbl 100 child mask	Preferred	OTC
sootheneb nbl 100 med cup	Preferred	OTC
sootheneb nbl 100 mesh cap	Preferred	OTC
tubing/wing tip	Preferred	OTC
ACE AEROSOL CLOUD ENHANCER	Preferred	
ACTIVITY POUCH	Preferred	
ADAPTER PED DISPOSABLE	Preferred	OTC
AEROBIKA	Preferred	
AEROTRACH PLUS	Preferred	
AIRS PEDIATRIC AEROSOL MASK	Preferred	
ALL FLOW 1000 PFT FILTER	Preferred	
BUBBLES THE FISH II PEDI MASK	Preferred	OTC
CARETOUCH 2 CPAP HOSE HANGER	Preferred	
CARETOUCH CPAP & BIPAP HOSE	Preferred	
CARETOUCH CPAP MASK WIPES	Preferred	
CARETOUCH CPAP PRE-WASH SOLN	Preferred	
CARETOUCH CPAP TUBE BRUSH	Preferred	
CARETOUCH UNIVERSL CPAP FILTER	Preferred	
EBASE CONTROLLER KIT	Preferred	
FLYP HYPERSONIQ CARTRIDGE	Preferred	OTC
IN-CHECK INSPIRATORY FLOW MTR	Preferred	
KOKO PEAK PRO MOUTHPIECE	Preferred	OTC
LITETOUCH MASK LARGE	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONE FLOW TESTER	Preferred	OTC
PARI ALTERA NEBULIZER HANDSET	Preferred	
PARI BABY CONVERSION KIT	Preferred	
PARI ERAPID NEBULIZER HANDSET	Preferred	
PARI EXPIRATORY FILTER SET	Preferred	
PARI MASK SET	Preferred	
PARI SOFT PLASTIC ADULT MASK	Preferred	
PARI SOFT PLASTIC PED MASK	Preferred	
PRONEB ULTRA FILTER SET	Preferred	OTC
SIDESTREAM ADULT FACE MASK	Preferred	
SIDESTREAM PEDIATRIC FACE MASK	Preferred	
WINDMILL TRAINER	Preferred	
Sanitary Napkins & Tampons - Medical Supplies And Durable Medical Equipment***		
cvs maxi overnight	Preferred	OTC
eq maxi long super	Preferred	OTC
ALWAYS MAXI MAXIMUM PROTECTION	Preferred	OTC
ALWAYS PANTILINERS/THONG	Preferred	OTC
ALWAYS ULTRA OVERNIGHT/WINGS	Preferred	OTC
ALWAYS ULTRA THIN	Preferred	OTC
KOTEX CURVED MAXI	Preferred	OTC
KOTEX LIGHTDAYS PANTILINERS	Preferred	OTC
KOTEX MAXI	Preferred	OTC
KOTEX MAXI OVERNITE	Preferred	OTC
KOTEX MAXI WITH WINGS	Preferred	OTC
KOTEX OVERNITE	Preferred	OTC
KOTEX SUPER MAXI	Preferred	OTC
KOTEX THIN MAXI	Preferred	OTC
KOTEX ULTRA COMPACT MAXI	Preferred	OTC

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KOTEX ULTRA MAXI OVERNIGHT	Preferred	OTC
KOTEX ULTRA THIN MAXI	Preferred	OTC
KOTEX ULTRA THIN MAXI LONG	Preferred	OTC
Spacer/Aerosol-Holding Chambers & Supplies - Medical Supplies And Durable Medical Equipment***		
breathe ease large	Preferred	
breathe ease medium	Preferred	
breathe ease small	Preferred	
eq space chamber anti-static	Preferred	
eq space chamber anti-static l	Preferred	
eq space chamber anti-static m	Preferred	
eq space chamber anti-static s	Preferred	
AEROCHAMBER MINI CHAMBER	Preferred	
AEROCHAMBER MV	Preferred	
AEROCHAMBER PLUS FLO-VU	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE	Preferred	
AEROCHAMBER PLUS FLO-VU MEDIUM	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL	Preferred	
AEROCHAMBER PLUS FLOW VU	Preferred	
AEROCHAMBER W/FLOWSIGNAL	Preferred	
AEROCHAMBER Z-STAT PLUS	Preferred	
AEROCHAMBER Z-STAT PLUS CHAMBR	Preferred	
AEROCHAMBER Z-STAT PLUS/LARGE	Preferred	
AEROCHAMBER Z-STAT PLUS/MEDIUM	Preferred	
CLEVER CHOICE HOLDING CHAMBER	Preferred	
COMPACT SPACE CHAMBER	Preferred	
COMPACT SPACE CHAMBER/LG MASK	Preferred	
COMPACT SPACE CHAMBER/MED MASK	Preferred	
EASIVENT	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASIVENT MASK LARGE	Preferred	
EASIVENT MASK MEDIUM	Preferred	
EASIVENT MASK SMALL	Preferred	
FLEXICHAMBER	Preferred	
FLEXICHAMBER ADULT MASK/SMALL	Preferred	
FLEXICHAMBER CHILD MASK/LARGE	Preferred	
FLEXICHAMBER CHILD MASK/SMALL	Preferred	
INSPIREASE	Preferred	
MASK VORTEX/CHILD/FROG	Preferred	OTC
MASK VORTEX/TODDLER/LADYBUG	Preferred	OTC
PANDA MASK LARGE	Preferred	OTC
PANDA MASK MEDIUM	Preferred	OTC
PANDA MASK SMALL	Preferred	OTC
PARI VORTEX ADULT MASK	Preferred	OTC
PEDIATRIC PANDA MASK	Preferred	OTC
VORTEX HOLD CHMBR/MASK/CHILD	Preferred	
***Migraine Products* - Drugs For The Nervous System**		
****Calcitonin Gene-Related Peptide Receptor Antag (Cgrp)*** - Drugs For Migraine Headaches***		
NURTEC	Preferred	PA
QULIPTA	Preferred	PA
UBRELVY	Preferred	PA; QL (50 EA per 365 days)
ZAVZPRET	Non – Preferred	
****Cgrp Receptor Antagonists - Monocolonal Antibodies*** - Drugs For Migraine Headaches***		
AIMOVIG	Preferred	PA
AJOVY	Preferred	PA

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMGALITY	Preferred	PA
EMGALITY (300 MG DOSE)	Preferred	PA
VYEPTI	Non – Preferred	
Ergot Combinations - Drugs For Migraine Headaches**		
MIGERGOT	Preferred	
Migraine Products - Cyclooxygenase 2 (Cox-2) Inhibitors - Drugs For Migraine Headaches**		
ELYXYB	Non – Preferred	
Migraine Products - Nsaids - Drugs For Migraine Headaches**		
diclofenac potassium(migraine)	Non – Preferred	
Migraine Products - Drugs For Migraine Headaches**		
dihydroergotamine mesylate	Non – Preferred	
ERGOMAR	Non – Preferred	
Selective Serotonin Agonist-Nsaid Combinations - Drugs For Migraine Headaches**		
sumatriptan-naproxen sodium	Non – Preferred	
Selective Serotonin Agonists 5-Ht(1) - Drugs For Migraine Headaches**		
almotriptan malate	Non – Preferred	
eletriptan hydrobromide	Non – Preferred	
frovatriptan succinate	Non – Preferred	
naratriptan hcl	Non – Preferred	
rizatriptan benzoate	Preferred	QL (9 EA per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sumatriptan solution 20 mg/act nasal	Preferred	QL (6 EA per 30 days)
sumatriptan solution 5 mg/act nasal	Preferred	QL (6 EA per 30 days)
sumatriptan succinate refill solution cartridge 4 mg/0.5ml subcutaneous	Preferred	QL (4 VIAL per 28 days)
sumatriptan succinate refill solution cartridge 6 mg/0.5ml subcutaneous	Preferred	QL (4 VIAL per 30 days)
sumatriptan succinate solution auto-injector 4 mg/0.5ml subcutaneous	Preferred	QL (4 VIAL per 28 days)
sumatriptan succinate solution auto-injector 6 mg/0.5ml subcutaneous	Preferred	QL (2 VIAL per 30 days)
sumatriptan succinate subcutaneous solution	Preferred	QL (4 VIAL per 28 days)
sumatriptan succinate tablet 100 mg oral	Preferred	QL (9 EA per 30 days)
sumatriptan succinate tablet 25 mg oral	Preferred	QL (9 EA per 30 days)
sumatriptan succinate tablet 50 mg oral	Preferred	QL (9 EA per 30 days)
zolmitriptan	Non – Preferred	
FROVA	Non – Preferred	
IMITREX	Non – Preferred	QL (9 EA per 30 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 4 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 ML per 28 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 6 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 30 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 4 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 EA per 28 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 6 MG/0.5ML SUBCUTANEOUS	Non – Preferred	QL (4 VIAL per 30 days)
MAXALT	Non – Preferred	QL (9 EA per 30 days)
MAXALT-MLT TABLET DISPERSIBLE 10 MG ORAL	Non – Preferred	QL (9 EA per 30 days)
RELPAX	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOSYMRA	Non – Preferred	
ZEMBRACE SYMTOUCH	Non – Preferred	
ZOMIG	Non – Preferred	
Selective Serotonin Agonists 5-Ht(1F) - Drugs For Migraine Headaches***		
REYVOW	Non – Preferred	
***Minerals & Electrolytes* - Drugs For Nutrition**		
Calcium - Drugs For Nutrition***		
calcium carbonate oral tablet	Preferred	OTC
calcium carbonate oral tablet chewable	Preferred	OTC
Electrolytes Oral - Drugs For Nutrition***		
oralyte	Preferred	OTC
REHYDRALYTE	Preferred	OTC
Fluoride - Drugs For Nutrition***		
sodium fluoride	Preferred	
Magnesium - Drugs For Nutrition***		
magnesium oxide -mg supplement	Preferred	OTC
Phosphate - Drugs For Nutrition***		
PHOSPHA 250 NEUTRAL	Preferred	
PHOSPHO-TRIN 250 NEUTRAL	Preferred	
Potassium - Drugs For Nutrition***		
potassium chloride	Preferred	
potassium chloride crys er	Preferred	
potassium chloride er	Preferred	
EFFER-K	Preferred	
KLOR-CON	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KLOR-CON 10	Preferred	
KLOR-CON M10	Preferred	
KLOR-CON M15	Preferred	
KLOR-CON M20	Preferred	
KLOR-CON/EF	Preferred	
K-PRIME	Preferred	
Sodium - Drugs For Nutrition**		
sodium chloride	Preferred	
sodium chloride (pf)	Preferred	
***Miscellaneous Therapeutic Classes* - Vitamins And Minerals**		
Activated Phosphoinositide 3-Kinase Delta Syndrome Agent - Vitamins And Minerals**		
JOENJA	Non – Preferred	
Antileprotics - Vitamins And Minerals**		
THALOMID	Non – Preferred	
B-Lymphocyte Stimulator (Blys)-Specific Inhibitors - Vitamins And Minerals**		
BENLYSTA	Non – Preferred	
Chelating Agents - Vitamins And Minerals**		
penicillamine	Preferred	
trientine hcl	Preferred	
CUPRIMINE	Non – Preferred	
CUVRIOR	Non – Preferred	
DEPEN TITRATABS	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYPRINE	Non – Preferred	
***Colony Stimulating Factor-1 Receptor (Csf-1R) Antibodies** - Vitamins And Minerals**		
NIKTIMVO	Non – Preferred	
Cyclosporine Analogs - Vitamins And Minerals**		
cyclosporine	Preferred	
cyclosporine modified	Preferred	
GENGRAF	Preferred	
LUPKYNIS	Non – Preferred	
NEORAL	Non – Preferred	
SANDIMMUNE	Non – Preferred	
Immunomodulators - Combinations - Vitamins And Minerals**		
VYVGART HYTRULO	Non – Preferred	
Immunomodulators For Myelodysplastic Syndromes - Vitamins And Minerals**		
lenalidomide	Non – Preferred	QL (1 EA per 1 day)
REVLIMID	Non – Preferred	
Inosine Monophosphate Dehydrogenase Inhibitors - Vitamins And Minerals**		
mycophenolate mofetil	Preferred	
mycophenolate sodium tablet delayed release 180 mg oral	Preferred	QL (2 EA per 1 day)
mycophenolate sodium tablet delayed release 360 mg oral	Preferred	QL (4 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
mycophenolic acid tablet delayed release 180 mg oral	Preferred	
mycophenolic acid tablet delayed release 180 mg oral	Preferred	QL (2 EA per 1 day)
mycophenolic acid tablet delayed release 360 mg oral	Preferred	
mycophenolic acid tablet delayed release 360 mg oral	Preferred	QL (4 EA per 1 day)
CELLCEPT	Non – Preferred	
MYFORTIC TABLET DELAYED RELEASE 180 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
MYFORTIC TABLET DELAYED RELEASE 360 MG ORAL	Non – Preferred	QL (4 EA per 1 day)
Macrolide Immunosuppressants - Vitamins And Minerals**		
everolimus	Non – Preferred	
sirolimus	Preferred	
tacrolimus	Preferred	
ASTAGRAF XL	Non – Preferred	
ENVARSUS XR	Non – Preferred	
PROGRAF	Non – Preferred	
ZORTRESS	Non – Preferred	
Neonatal Fc Receptor (Fcrn) Antagonists - Vitamins And Minerals**		
RYSTIGGO	Non – Preferred	
VYVGART	Non – Preferred	
Potassium Removing Agents - Vitamins And Minerals**		
sodium polystyrene sulfonate	Preferred	
KIONEX	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOKELMA	Non – Preferred	
SPS (SODIUM POLYSTYRENE SULF)	Preferred	
VELTASSA	Non – Preferred	
Purine Analogs - Vitamins And Minerals**		
azathioprine tablet 100 mg oral	Non – Preferred	
azathioprine tablet 50 mg oral	Preferred	
azathioprine tablet 75 mg oral	Non – Preferred	
AZASAN	Non – Preferred	
IMURAN	Non – Preferred	
Rock Inhibitors - Vitamins And Minerals**		
REZUROCK	Non – Preferred	
***Mouth/Throat/Dental Agents* - Drugs For The Mouth And Throat**		
Anesthetics Topical Oral - Drugs For The Mouth And Throat**		
lidocaine hcl	Preferred	
lidocaine viscous hcl	Preferred	
Anti-Infectives - Throat - Drugs For The Mouth And Throat**		
clotrimazole	Preferred	
nystatin suspension 100000 unit/ml mouth/throat	Preferred	
nystatin suspension 100000 unit/ml mouth/throat	Preferred	QL (120 ML Max Qty Per Fill Retail)
ORAVIG	Non – Preferred	
Antiseptics - Mouth/Throat - Drugs For The Mouth And Throat**		
chlorhexidine gluconate	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dental Products - Combinations - Drugs For The Mouth And Throat***		
fraiche 5000 previ	Non – Preferred	
sodium fluoride 5000 enamel	Non – Preferred	
sodium fluoride 5000 sensitive	Non – Preferred	
Dry Mouth Agents And Artificial Saliva - Drugs For The Mouth And Throat***		
AQUORAL	Non – Preferred	
Fluoride Dental Products - Drugs For The Mouth And Throat***		
sodium fluoride	Non – Preferred	
sodium fluoride 5000 plus	Non – Preferred	
sodium fluoride 5000 ppm	Non – Preferred	
DENTA 5000 PLUS	Non – Preferred	
DENTAGEL	Non – Preferred	
Protectants - Mouth/Throat - Drugs For The Mouth And Throat***		
GELCLAIR	Non – Preferred	
GELX	Non – Preferred	
Saliva Stimulants - Drugs For The Mouth And Throat***		
cevimeline hcl	Non – Preferred	
pilocarpine hcl	Preferred	
EVOXAC	Non – Preferred	
Steroids - Mouth/Throat/Dental - Drugs For The Mouth And Throat***		
triamcinolone acetonide	Preferred	
ORALONE	Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Multivitamins* - Drugs For Nutrition**		
****B-Complex W/ C & Folic Acid*** - Drugs For Nutrition***		
DIALYVITE	Preferred	
RENAL	Preferred	
****Multiple Vitamins W/ Calcium*** - Drugs For Nutrition***		
essential one daily multivit	Preferred	OTC
sm one daily essential	Preferred	OTC
****Multiple Vitamins W/ Iron*** - Drugs For Nutrition***		
multi-vitamin/iron	Preferred	OTC
****Multiple Vitamins W/ Minerals*** - Drugs For Nutrition***		
i-vite	Preferred	OTC
multipro	Preferred	
KP VISION FORMULA	Preferred	OTC
MULTI COMPLETE	Preferred	OTC
****Multivitamins*** - Drugs For Nutrition***		
ONE DAILY ESSENTIAL	Preferred	OTC
****Ped Multi Vitamins W/Fl & Fe*** - Drugs For Nutrition***		
multi-vit/iron/fluoride	Preferred	OTC; AL (Max 13 Years)
multi-vitamin/fluoride/iron	Preferred	AL (Max 13 Years)
****Ped Mv W/ Fluoride*** - Drugs For Nutrition***		
multivitamin/fluoride oral solution 0.25 mg/ml	Preferred	OTC; AL (Min 13 Years)
multivitamin/fluoride oral solution 0.5 mg/ml	Preferred	OTC; AL (Max 13 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	Preferred	AL (Max 13 Years)
multivitamin/fluoride tablet chewable 0.25 mg oral (rx)	Preferred	AL (Max 13 Years)
multivitamin/fluoride tablet chewable 0.5 mg oral (rx)	Preferred	AL (Max 13 Years)
multivitamin/fluoride tablet chewable 1 mg oral (rx)	Preferred	AL (Max 13 Years)
QUFLORA PEDIATRIC	Preferred	AL (Max 13 Years)
Ped Vitamins Acd W/ Fluoride - Drugs For Nutrition**		
tri-vite/fluoride	Preferred	AL (Max 13 Years)
vitamins acd-fluoride	Preferred	OTC; AL (Max 13 Years)
Pediatric Multiple Vitamins - Drugs For Nutrition**		
childrens chewable vitamins	Preferred	OTC; AL (Max 13 Years)
Prenatal Mv & Min W/Fe-Fa - Drugs For Nutrition**		
c-nate dha	Non – Preferred	
completenate	Preferred	QL (100 EA per 90 days)
m-natal plus	Preferred	QL (100 EA per 90 days)
natal pnv	Non – Preferred	
pnv-omega	Non – Preferred	
pnv-select	Non – Preferred	
prenatal	Preferred	QL (100 EA per 90 days)
prenatal plus vitamin/mineral	Preferred	QL (100 EA per 90 days)
relnate dha	Non – Preferred	
se-natal 19	Preferred	QL (100 EA per 90 days)
thrivite rx	Preferred	
trinatal rx 1	Preferred	QL (100 EA per 90 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
wescap-c dha	Non – Preferred	QL (100 EA per 90 days)
wesnate dha	Non – Preferred	
westab plus	Preferred	QL (100 EA per 90 days)
CITRANATAL B-CALM	Non – Preferred	
DERMACINRX PRETRATE	Non – Preferred	
ELITE-OB	Preferred	
ENBRACE HR	Non – Preferred	
FOLIVANE-OB	Non – Preferred	QL (90 EA per 100 days)
NESTABS	Non – Preferred	
NESTABS DHA	Non – Preferred	
OB COMPLETE	Preferred	
OB COMPLETE ONE	Non – Preferred	
OB COMPLETE PETITE	Non – Preferred	
OB COMPLETE PREMIER	Non – Preferred	
OB COMPLETE/DHA	Non – Preferred	
PRENATE ELITE	Non – Preferred	
PRENATRIX	Non – Preferred	QL (100 EA per 90 days)
PRENATRYL	Non – Preferred	QL (100 EA per 90 days)
PRIMACARE	Non – Preferred	
SELECT-OB	Non – Preferred	
TARON-C DHA	Non – Preferred	QL (100 EA per 90 days)
VINATE DHA RF	Non – Preferred	
VITAFOL GUMMIES	Non – Preferred	
VITAFOL-OB	Preferred	QL (1 EA per 1 day)
VITAPEARL	Non – Preferred	
****Prenatal Mv & Min W/Fe-Fa-Ca-Omega 3 Fish Oil*** - Drugs For Nutrition***		
complete natal dha	Non – Preferred	QL (100 EA per 90 days)
wesnatal dha complete	Non – Preferred	QL (100 EA per 90 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prenatal Mv & Min W/Fe-Fa-Dha - Drugs For Nutrition***		
pnv-dha	Non – Preferred	
pnv-dha+docusate	Non – Preferred	
prenaissance	Non – Preferred	
prenaissance plus	Non – Preferred	
tristart dha	Non – Preferred	
wescap-pn dha	Non – Preferred	
westgel dha	Non – Preferred	
CITRANATAL 90 DHA	Non – Preferred	
CITRANATAL ASSURE	Non – Preferred	
CITRANATAL HARMONY	Non – Preferred	
CITRANATAL MEDLEY	Non – Preferred	
NESTABS ONE	Non – Preferred	
PRENATE DHA	Non – Preferred	
PRENATE ENHANCE	Non – Preferred	
PRENATE ESSENTIAL	Non – Preferred	
PRENATE MINI	Non – Preferred	
PRENATE PIXIE	Non – Preferred	
PRENATE RESTORE	Non – Preferred	
SELECT-OB+DHA	Non – Preferred	
VITAFOL FE+	Non – Preferred	
VITAFOL ULTRA	Non – Preferred	
VITAFOL-OB+DHA	Non – Preferred	
VITAFOL-ONE	Non – Preferred	
VITAMEDMD ONE RX/QUATREFOLIC	Non – Preferred	
Prenatal Mv & Minerals W/Fa Without Iron - Drugs For Nutrition***		
PRENATE	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prenatal Vitamins - Drugs For Nutrition***		
PREMESISRX	Non – Preferred	
PRENATE AM	Non – Preferred	
Specialty Vitamins Products - Drugs For Nutrition***		
biotin plus keratin	Preferred	OTC
CENTRUM SPECIALIST ENERGY	Preferred	OTC
***Musculoskeletal Therapy Agents* - Drugs For Muscles, Ligaments, Tendons, And Bones**		
Central Muscle Relaxants - Drugs For Muscles, Ligaments, Tendons, And Bones***		
baclofen oral solution	Non – Preferred	
baclofen oral suspension	Preferred	
baclofen tablet 10 mg oral	Preferred	
baclofen tablet 10 mg oral	Preferred	QL (4 EA per 1 day)
baclofen tablet 15 mg oral	Preferred	
baclofen tablet 20 mg oral	Preferred	
baclofen tablet 20 mg oral	Preferred	QL (4 EA per 1 day)
baclofen tablet 5 mg oral	Preferred	
baclofen tablet 5 mg oral	Preferred	QL (4 EA per 1 day)
carisoprodol tablet 250 mg oral	Non – Preferred	
carisoprodol tablet 350 mg oral	Non – Preferred	QL (3 EA per 1 day)
chlorzoxazone	Preferred	
cyclobenzaprine hcl er	Non – Preferred	
cyclobenzaprine hcl tablet 10 mg oral	Preferred	
cyclobenzaprine hcl tablet 10 mg oral	Preferred	QL (3 EA per 1 day)
cyclobenzaprine hcl tablet 5 mg oral	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
cyclobenzaprine hcl tablet 5 mg oral	Preferred	QL (3 EA per 1 day)
cyclobenzaprine hcl tablet 7.5 mg oral	Preferred	
cyclobenzaprine hcl tablet 7.5 mg oral	Preferred	QL (4 EA per 1 day)
metaxalone	Non – Preferred	
methocarbamol	Preferred	QL (4 EA per 1 day)
orphenadrine citrate er	Preferred	QL (2 EA per 1 day)
tizanidine hcl oral capsule	Non – Preferred	
tizanidine hcl tablet 2 mg oral	Preferred	
tizanidine hcl tablet 2 mg oral	Preferred	QL (3 EA per 1 day)
tizanidine hcl tablet 4 mg oral	Preferred	
tizanidine hcl tablet 4 mg oral	Preferred	QL (6 EA per 1 day)
AMRIX	Non – Preferred	
FEXMID	Preferred	QL (4 EA per 1 day)
FLEQSUVY	Non – Preferred	
LYVISPAH	Non – Preferred	
SOMA TABLET 250 MG ORAL	Non – Preferred	
SOMA TABLET 350 MG ORAL	Non – Preferred	QL (3 EA per 1 day)
ZANAFLEX	Non – Preferred	QL (6 EA per 1 day)
Direct Muscle Relaxants - Drugs For Muscles, Ligaments, Tendons, And Bones***		
dantrolene sodium	Preferred	QL (4 EA per 1 day)
DANTRIUM	Non – Preferred	QL (4 EA per 1 day)
Muscle Relaxant Combinations - Drugs For Muscles, Ligaments, Tendons, And Bones***		
norgesic forte	Non – Preferred	
orphenadrine-aspirin-caffeine	Preferred	
NORGESIC	Preferred	
ORPHENGESIC FORTE	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Retinoic Acid Receptor Gamma Selective Agonists - Drugs For Muscles, Ligaments, Tendons, And Bones***		
SOHONOS	Non – Preferred	
***Nasal Agents - Systemic And Topical* - Drugs For The Nose**		
Antihistamine-Steroid - Allergy***		
azelastine-fluticasone	Non – Preferred	
DYMISTA	Non – Preferred	
RYALTRIS	Non – Preferred	
Nasal Agents - Misc. - Allergy***		
saline nasal spray	Preferred	OTC
Nasal Anticholinergics - Allergy***		
ipratropium bromide solution 0.03 % nasal	Non – Preferred	
ipratropium bromide solution 0.06 % nasal	Non – Preferred	QL (15 ML per 30 days)
Nasal Antihistamines - Allergy***		
azelastine hcl solution 0.1 % nasal	Preferred	QL (30 ML per 30 days)
azelastine hcl solution 137 mcg/spray nasal	Preferred	QL (30 ML per 30 days)
olopatadine hcl	Preferred	
Nasal Mast Cell Stabilizers - Allergy***		
cromolyn sodium	Preferred	OTC
Nasal Steroids - Allergy***		
flunisolide	Preferred	QL (1.6667 ML per 1 day)
fluticasone propionate	Preferred	QL (16 GM Max Qty Per Fill Retail)
mometasone furoate	Non – Preferred	QL (1.1333 GM per 1 day)
OMNARIS	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROPEL MINI SDS	Non – Preferred	
QNASL	Non – Preferred	
QNASL CHILDRENS	Non – Preferred	
SINUVA	Non – Preferred	
XHANCE	Non – Preferred	
Systemic Decongestants - Allergy**		
phenylephrine hcl	Preferred	OTC
pseudoephedrine hcl er	Preferred	OTC
pseudoephedrine hcl oral tablet 30 mg	Preferred	OTC
pseudoephedrine hcl oral tablet 60 mg	Preferred	
SUDOGEST	Preferred	
Neuromuscular Agents* - Drugs For Nerves And Muscles		
Als Agents - Miscellaneous - Drugs For Nerves And Muscles**		
RADICAVA ORS	Non – Preferred	
RADICAVA ORS STARTER KIT	Non – Preferred	
Benzathiazoles - Drugs For Nerves And Muscles**		
riluzole	Preferred	
TEGLUTIK	Non – Preferred	
TIGLUTIK	Non – Preferred	
Rett Syndrome Agents - Glycine-Proline-Glutamate Analogs - Drugs For Nerves And Muscles**		
DAYBUE	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Nutrients* - Drugs For Nutrition**		
****Carbohydrates*** - Drugs For Nutrition***		
dextrose	Preferred	
***Ophthalmic Agents* - Drugs For The Eye**		
****Alpha Adrenergic Agonist & Carbonic Anhydrase Inhib Comb*** - Drugs For Glaucoma***		
SIMBRINZA	Non – Preferred	
****Artificial Tear And Lubricant Combinations*** - Drugs For The Eye***		
eye lubricant	Preferred	OTC
EQ RESTORE PM	Preferred	OTC
GENTEAL TEARS NIGHT-TIME	Preferred	OTC
****Artificial Tear Solutions*** - Drugs For The Eye***		
just tears eye drops	Preferred	OTC
GENTEAL TEARS	Preferred	OTC
****Artificial Tears And Lubricants*** - Drugs For The Eye***		
polyvinyl alcohol	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)
****Beta-Blockers - Ophthalmic Combinations*** - Drugs For Glaucoma***		
brimonidine tartrate-timolol	Non – Preferred	QL (10 ML per 30 days)
dorzolamide hcl-timolol mal	Preferred	QL (10 ML Max Qty Per Fill Retail)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dorzolamide hcl-timolol mal pf	Non – Preferred	
COMBIGAN	Non – Preferred	QL (10 ML per 30 days)
COSOPT	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
COSOPT PF	Non – Preferred	
Beta-Blockers - Ophthalmic - Drugs For Glaucoma***		
betaxolol hcl	Preferred	QL (10 ML per 30 days)
carteolol hcl	Preferred	QL (10 ML per 30 days)
levobunolol hcl	Preferred	QL (10 ML per 30 days)
timolol maleate (once-daily)	Preferred	
timolol maleate gel forming solution 0.25 % ophthalmic	Preferred	
timolol maleate gel forming solution 0.25 % ophthalmic	Preferred	QL (5 ML per 30 days)
timolol maleate gel forming solution 0.5 % ophthalmic	Preferred	QL (5 ML Max Qty Per Fill Retail)
timolol maleate pf	Non – Preferred	
timolol maleate solution 0.25 % ophthalmic	Preferred	QL (10 ML per 30 days)
timolol maleate solution 0.5 % ophthalmic	Preferred	
timolol maleate solution 0.5 % ophthalmic	Preferred	QL (10 ML per 30 days)
BETIMOL	Non – Preferred	
BETOPTIC-S	Non – Preferred	
ISTALOL	Non – Preferred	
TIMOLOL MALEATE OCUDOSE	Non – Preferred	
TIMOPTIC OCUDOSE	Non – Preferred	
Cycloplegic Mydriatic Combinations - Drugs For The Eye***		
CYCLOMYDRIL	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cycloplegic Mydriatics - Drugs For The Eye***		
atropine sulfate solution 1 % ophthalmic	Preferred	
atropine sulfate solution 1 % ophthalmic	Preferred	QL (5 ML per 30 days)
cyclopentolate hcl	Preferred	QL (6 ML per 30 days)
phenylephrine hcl ophthalmic solution 2.5 %	Non – Preferred	QL (2 EA per 30 days)
phenylephrine hcl solution 10 % ophthalmic	Non – Preferred	
phenylephrine hcl solution 2.5 % ophthalmic	Non – Preferred	
phenylephrine hcl solution 2.5 % ophthalmic	Non – Preferred	QL (2 EA per 30 days)
tropicamide	Preferred	QL (15 ML Max Qty Per Fill Retail)
CYCLOGYL SOLUTION 0.5 % OPHTHALMIC	Non – Preferred	
CYCLOGYL SOLUTION 1 % OPHTHALMIC	Non – Preferred	QL (6 ML per 30 days)
CYCLOGYL SOLUTION 2 % OPHTHALMIC	Non – Preferred	QL (5 ML per 30 days)
MYDRIACYL	Non – Preferred	QL (15 ML Max Qty Per Fill Retail)
Lymphocyte Function-Associated Antigen-1 (Lfa-1) Antag - Anti-Infective/Anti-Inflammatories***		
XIIDRA	Non – Preferred	
Miotics - Cholinesterase Inhibitors - Drugs For Glaucoma***		
PHOSPHOLINE IODIDE	Non – Preferred	
Miotics - Direct Acting - Drugs For Glaucoma***		
pilocarpine hcl solution 1 % ophthalmic	Preferred	QL (15 ML per 30 days)
pilocarpine hcl solution 2 % ophthalmic	Preferred	QL (15 ML per 30 days)
pilocarpine hcl solution 4 % ophthalmic	Preferred	QL (15 ML per 30 days)
VUITY	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic Antiallergic - Drugs For Itchy Eye***		
azelastine hcl	Preferred	QL (6 ML Max Qty Per Fill Retail)
bepotastine besilate	Non – Preferred	
cromolyn sodium	Preferred	QL (10 ML Max Qty Per Fill Retail)
epinastine hcl	Non – Preferred	
olopatadine hcl solution 0.1 % ophthalmic (rx)	Non – Preferred	QL (5 ML per 30 days)
olopatadine hcl solution 0.2 % ophthalmic (rx)	Non – Preferred	
BEPREVE	Non – Preferred	
ZERVIATE	Non – Preferred	
Ophthalmic Antibiotics - Anti-Infective/Anti-Inflammatories***		
bacitracin	Preferred	
ciprofloxacin hcl	Preferred	QL (5 ML per 30 days)
erythromycin	Preferred	
gatifloxacin	Non – Preferred	
gentamicin sulfate	Preferred	QL (5 ML per 30 days)
moxifloxacin hcl	Non – Preferred	
ofloxacin solution 0.3 % ophthalmic	Preferred	QL (5 ML per 30 days)
tobramycin	Preferred	QL (5 ML Max Qty Per Fill Retail)
AZASITE	Non – Preferred	
BESIVANCE	Non – Preferred	
CILOXAN	Preferred	QL (3.5 GM per 30 days)
OCUFLOX	Non – Preferred	QL (5 ML per 30 days)
TOBREX	Preferred	
VIGAMOX	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic Antifungal - Drugs For The Eye***		
NATACYN	Non – Preferred	
Ophthalmic Anti-Infective Combinations - Anti-Infective/Anti-Inflammatories***		
bacitracin-polymyxin b	Preferred	
neomycin-bacitracin zn-polymyx ointment 3.5-400-10000 ophthalmic	Preferred	
neomycin-bacitracin zn-polymyx ointment 5-400-10000 ophthalmic	Preferred	QL (7 GM per 30 days)
neomycin-polymyxin-gramicidin	Preferred	QL (10 ML Max Qty Per Fill Retail)
polymyxin b-trimethoprim	Preferred	QL (10 ML Max Qty Per Fill Retail)
NEO-POLYCIN	Preferred	QL (7 GM per 30 days)
POLYCIN	Preferred	
Ophthalmic Antiseptics - Anti-Infective/Anti-Inflammatories***		
BETADINE OPHTHALMIC PREP	Non – Preferred	
Ophthalmic Antivirals - Anti-Infective/Anti-Inflammatories***		
trifluridine	Preferred	QL (7.5 ML Max Qty Per Fill Retail)
ZIRGAN	Preferred	
Ophthalmic Carbonic Anhydrase Inhibitors - Drugs For Glaucoma***		
brinzolamide	Non – Preferred	QL (10 ML per 30 days)
dorzolamide hcl solution 2 % ophthalmic	Preferred	
dorzolamide hcl solution 2 % ophthalmic	Preferred	QL (10 ML Max Qty Per Fill Retail)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZOPT SUSPENSION 1 % OPHTHALMIC	Non – Preferred	
AZOPT SUSPENSION 1 % OPHTHALMIC	Non – Preferred	QL (10 ML per 30 days)
Ophthalmic Decongestants - Drugs For Itchy Eye***		
redness reliever eye drops	Preferred	OTC; QL (15 ML Max Qty Per Fill Retail)
Ophthalmic Diagnostic Products - Drugs For The Eye***		
fluorescein sodium/benoxinate	Non – Preferred	
GLOSTRIPS	Non – Preferred	
Ophthalmic Ectoparasiticide** - Anti-Infective/Anti-Inflammatories		
XDEMVY	Non – Preferred	
Ophthalmic Immunomodulators - Anti-Infective/Anti-Inflammatories***		
cyclosporine	Non – Preferred	
CEQUA	Non – Preferred	
RESTASIS	Non – Preferred	
RESTASIS MULTIDOSE	Non – Preferred	
VERKAZIA	Non – Preferred	
VEVYE	Non – Preferred	
Ophthalmic Kinase Inhibitors - Combinations - Drugs For Glaucoma***		
ROCKLATAN	Non – Preferred	
Ophthalmic Local Anesthetics - Drugs For The Eye***		
proparacaine hcl	Non – Preferred	
tetracaine hcl	Non – Preferred	
AKTEN	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALCAINE	Non – Preferred	
IHEEZO	Non – Preferred	
Ophthalmic Nerve Growth Factors - Drugs For The Eye***		
OXERVATE	Non – Preferred	
Ophthalmic Nonsteroidal Anti-Inflammatory Agents - Anti-Infective/Anti-Inflammatories***		
bromfenac sodium	Non – Preferred	
bromfenac sodium (once-daily)	Non – Preferred	
diclofenac sodium	Preferred	QL (5 ML Max Qty Per Fill Retail)
flurbiprofen sodium	Preferred	QL (5 ML per 25 days)
ketorolac tromethamine solution 0.4 % ophthalmic	Preferred	QL (10 ML per 30 days)
ketorolac tromethamine solution 0.5 % ophthalmic	Preferred	QL (10 ML Max Qty Per Fill Retail)
ACULAR	Non – Preferred	QL (10 ML Max Qty Per Fill Retail)
ACULAR LS	Non – Preferred	QL (10 ML per 30 days)
ACUVAIL	Non – Preferred	
BROMSITE	Non – Preferred	
ILEVRO	Non – Preferred	
NEVANAC	Non – Preferred	
PROLENSA	Non – Preferred	
Ophthalmic Rho Kinase Inhibitors - Drugs For Glaucoma***		
RHOPRESSA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic Selective Alpha Adrenergic Agonists - Drugs For Glaucoma***		
apraclonidine hcl	Non – Preferred	
brimonidine tartrate solution 0.1 % ophthalmic	Preferred	
brimonidine tartrate solution 0.15 % ophthalmic	Preferred	
brimonidine tartrate solution 0.2 % ophthalmic	Preferred	QL (10 ML per 30 days)
ALPHAGAN P	Preferred	
IOPIDINE	Non – Preferred	
Ophthalmic Steroid Combinations - Anti-Infective/Anti-Inflammatories***		
bacitra-neomycin-polymyxin-hc	Preferred	
neomycin-polymyxin-dexameth ointment 3.5-10000-0.1 ophthalmic	Preferred	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	Preferred	QL (3.5 GM per 30 days)
neomycin-polymyxin-dexameth ophthalmic suspension	Preferred	QL (5 ML Max Qty Per Fill Retail)
neomycin-polymyxin-hc	Preferred	QL (7.5 ML per 30 days)
sulfacetamide-prednisolone	Non – Preferred	QL (5 ML per 30 days)
tobramycin-dexamethasone suspension 0.3-0.1 % ophthalmic	Preferred	QL (10 ML per 30 days)
MAXITROL OINTMENT 3.5-10000-0.1 OPHTHALMIC	Non – Preferred	
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1	Preferred	QL (3.5 GM per 30 days)
MAXITROL OPHTHALMIC SUSPENSION	Non – Preferred	
NEO-POLYCIN HC	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOBRADEX	Non – Preferred	
TOBRADEX ST	Non – Preferred	
ZYLET	Non – Preferred	
Ophthalmic Steroids - Anti-Infective/Anti-Inflammatories**		
dexamethasone sodium phosphate	Preferred	QL (5 ML Max Qty Per Fill Retail)
difluprednate	Non – Preferred	
fluorometholone suspension 0.1 % ophthalmic	Preferred	QL (10 ML per 30 days)
loteprednol etabonate ophthalmic gel	Non – Preferred	
loteprednol etabonate ophthalmic suspension	Preferred	
prednisolone acetate	Preferred	QL (10 ML per 30 days)
prednisolone sodium phosphate	Preferred	QL (10 ML per 30 days)
ALREX	Preferred	
DEXTENZA	Non – Preferred	
DUREZOL	Non – Preferred	
EYSUVIS	Non – Preferred	
FLAREX	Preferred	
FML FORTE	Preferred	
FML LIQUIFILM	Non – Preferred	QL (10 ML per 30 days)
INVELTYS	Non – Preferred	
LOTEMAX	Non – Preferred	
LOTEMAX SM	Non – Preferred	
MAXIDEX	Preferred	
PRED FORTE	Non – Preferred	QL (10 ML per 30 days)
PRED MILD	Preferred	QL (10 ML per 30 days)
Ophthalmic Sulfonamides - Anti-Infective/Anti-Inflammatories**		
sulfacetamide sodium ophthalmic ointment	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sulfacetamide sodium ophthalmic solution	Preferred	QL (15 ML Max Qty Per Fill Retail)
***Ophthalmics - Cystinosis Agents** - Drugs For The Eye**		
CYSTADROPS	Non – Preferred	
CYSTARAN	Non – Preferred	
Prostaglandins - Ophthalmic - Drugs For Glaucoma**		
bimatoprost	Non – Preferred	
latanoprost solution 0.005 % ophthalmic	Preferred	QL (2.5 ML per 25 days)
tafluprost (pf)	Non – Preferred	
travoprost (bak free)	Non – Preferred	
IYUZEH	Non – Preferred	
LUMIGAN	Non – Preferred	
TRAVATAN Z	Non – Preferred	
VYZULTA	Non – Preferred	
XALATAN	Non – Preferred	QL (2.5 ML per 25 days)
XELPROS	Non – Preferred	
ZIOPTAN	Non – Preferred	
***Otic Agents* - Drugs For The Ear**		
Otic Agents - Miscellaneous - Wax Removal**		
acetic acid	Preferred	
Otic Anti-Infectives - Antibiotics**		
ciprofloxacin hcl	Non – Preferred	QL (28 EA per 30 days)
ofloxacin solution 0.3 % otic	Preferred	
ofloxacin solution 0.3 % otic	Preferred	QL (15 ML per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Otic Steroid-Anti-Infective Combinations - Anti-Infective/Anti-Inflammatories***		
ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic	Preferred	
ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic	Preferred	QL (7.5 ML per 30 days)
ciprofloxacin-fluocinolone pf	Non – Preferred	
neomycin-polymyxin-hc	Preferred	QL (10 ML per 30 days)
CIPRO HC	Non – Preferred	
CORTISPORIN-TC	Non – Preferred	
Otic Steroids - Anti-Infective/Anti-Inflammatories***		
fluocinolone acetonide	Non – Preferred	
hydrocortisone-acetic acid	Non – Preferred	
DERMOTIC	Non – Preferred	
***Oxytocics* - Hormones**		
Oxytocics - Drugs For Women***		
methylergonovine maleate	Preferred	
METHERGINE	Preferred	
***Passive Immunizing And Treatment Agents* - Biological Agents**		
Antiviral Monoclonal Antibodies - Biological Agents***		
SYNAGIS	Preferred	PA; QL (1 VIAL per 26 days)
Immune Serums - Biological Agents***		
GAMMAGARD	Preferred	PA
GAMUNEX-C	Preferred	PA
HIZENTRA	Preferred	PA

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPERRHO S/D	Preferred	
PRIVIGEN	Preferred	PA
RHOGAM ULTRA-FILTERED PLUS	Preferred	
***Penicillins* - Drugs For Infections**		
****Aminopenicillins*** - Antibiotics***		
amoxicillin	Preferred	
ampicillin	Preferred	QL (4 EA per 1 day)
ampicillin sodium	Preferred	
****Natural Penicillins*** - Antibiotics***		
penicillin g pot in dextrose	Preferred	
penicillin g potassium	Preferred	
penicillin g sodium	Preferred	
penicillin v potassium	Preferred	
BICILLIN L-A	Preferred	
PFIZERPEN	Preferred	
****Penicillin Combinations*** - Antibiotics***		
amoxicillin-pot clavulanate er	Non – Preferred	QL (28 EA Max Qty Per Fill Retail)
amoxicillin-pot clavulanate oral suspension reconstituted	Preferred	
amoxicillin-pot clavulanate oral tablet chewable	Preferred	QL (20 EA Max Qty Per Fill Retail)
amoxicillin-pot clavulanate tablet 250-125 mg oral	Preferred	
amoxicillin-pot clavulanate tablet 250-125 mg oral	Preferred	QL (30 EA Max Qty Per Fill Retail)
amoxicillin-pot clavulanate tablet 500-125 mg oral	Preferred	QL (20 EA Max Qty Per Fill Retail)
amoxicillin-pot clavulanate tablet 875-125 mg oral	Preferred	QL (20 EA Max Qty Per Fill Retail)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ampicillin-sulbactam sodium	Preferred	
piperacillin sod-tazobactam so	Preferred	
AUGMENTIN	Preferred	
AUGMENTIN ES-600	Non – Preferred	
BICILLIN C-R	Preferred	
BICILLIN C-R 900/300	Preferred	
ZOSYN	Preferred	
Penicillinase-Resistant Penicillins - Antibiotics**		
dicloxacillin sodium	Preferred	
Pharmaceutical Adjuvants		
Parenteral Vehicles*		
saline bacteriostatic	Preferred	
Semi Solid Vehicles*		
polyethylene glycol 3350	Preferred	
***Progestins* - Hormones**		
Progestins - Drugs For Women**		
medroxyprogesterone acetate	Preferred	
megestrol acetate	Non – Preferred	
norethindrone acetate	Non – Preferred	
progesterone intramuscular	Preferred	
progesterone oral	Preferred	QL (2 EA per 1 day)
PROMETRIUM	Non – Preferred	QL (2 EA per 1 day)
PROVERA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Psychotherapeutic And Neurological Agents - Misc.* - Drugs For The Nervous System**		
****Agents For Opioid Withdrawal*** - Drugs For The Nervous System***		
LUCEMYRA	Preferred	
****Alcohol Deterrents*** - Drugs For The Nervous System***		
acamprosate calcium	Preferred	
disulfiram	Preferred	
****Alzheimer's Treatment - Anti-Amyloid Antibodies*** - Drugs For Alzheimer's Disease***		
KISUNLA	Non – Preferred	
LEQEMBI	Non – Preferred	
****Anti-Cataplectic Agents*** - Drugs For Sleep Disorder***		
sodium oxybate	Non – Preferred	
XYREM	Non – Preferred	
****Anti-Cataplectic Combinations*** - Drugs For Sleep Disorder***		
XYWAV	Non – Preferred	
****Antidementia Agent Combinations*** - Drugs For Alzheimer's Disease***		
memantine hcl-donepezil hcl	Non – Preferred	
NAMZARIC	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antisense Oligonucleotide (Aso) Inhibitor Agents - Drugs For The Nervous System***		
WAINUA	Non – Preferred	
Benzodiazepines & Tricyclic Agents - Drugs For Seizures /Personality Disorder/Nerve Pain***		
chlordiazepoxide-amitriptyline	Preferred	
Cholinomimetics - Ache Inhibitors - Drugs For Alzheimer's Disease***		
donepezil hcl oral tablet dispersible	Preferred	QL (1 EA per 1 day)
donepezil hcl tablet 10 mg oral	Preferred	QL (1 EA per 1 day)
donepezil hcl tablet 23 mg oral	Preferred	
donepezil hcl tablet 5 mg oral	Preferred	QL (1 EA per 1 day)
galantamine hydrobromide er	Non – Preferred	
galantamine hydrobromide oral solution	Non – Preferred	QL (2 ML per 1 day)
galantamine hydrobromide oral tablet	Non – Preferred	
rivastigmine	Non – Preferred	
rivastigmine tartrate	Non – Preferred	
ADLARITY	Non – Preferred	
ARICEPT TABLET 10 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
ARICEPT TABLET 23 MG ORAL	Non – Preferred	
ARICEPT TABLET 5 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
EXELON	Non – Preferred	
Fibromyalgia Agent - Snris - Drugs For Seizures /Personality Disorder/Nerve Pain***		
SAVELLA	Non – Preferred	
SAVELLA TITRATION PACK	Non – Preferred	QL (55 EA per 90 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Movement Disorder Drug Therapy - Drugs For The Nervous System***		
tetrabenazine	Non – Preferred	
AUSTEDO	Preferred	PA; QL (4 EA per 1 day)
AUSTEDO XR	Preferred	PA
AUSTEDO XR PATIENT TITRATION	Preferred	PA
INGREZZA	Preferred	PA
XENAZINE	Non – Preferred	
Ms Agents - Pyrimidine Synthesis Inhibitors - Drugs For Multiple Sclerosis***		
teriflunomide	Non – Preferred	QL (1 EA per 1 day)
AUBAGIO	Non – Preferred	QL (1 EA per 1 day)
Multiple Sclerosis Agents - Antimetabolites - Drugs For Multiple Sclerosis***		
MAVENCLAD (10 TABS)	Non – Preferred	
MAVENCLAD (4 TABS)	Non – Preferred	
MAVENCLAD (5 TABS)	Non – Preferred	
MAVENCLAD (6 TABS)	Non – Preferred	
MAVENCLAD (7 TABS)	Non – Preferred	
MAVENCLAD (8 TABS)	Non – Preferred	
MAVENCLAD (9 TABS)	Non – Preferred	
Multiple Sclerosis Agents - Combinations - Drugs For Multiple Sclerosis***		
OCREVUS ZUNOVO	Non – Preferred	

Coverage Requirements and Limits

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Multiple Sclerosis Agents - Interferons - Drugs For Multiple Sclerosis***		
AVONEX PEN	Non – Preferred	QL (1 KIT per 28 days)
AVONEX PREFILLED	Non – Preferred	QL (1 SYRINGE per 28 days)
BETASERON	Preferred	QL (15 VIAL per 30 days)
PLEGRIDY	Non – Preferred	
PLEGRIDY STARTER PACK	Non – Preferred	
REBIF	Preferred	QL (12 ML per 30 days)
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS	Preferred	
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS	Preferred	QL (12 ML per 30 days)
REBIF REBIDOSE TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
REBIF TITRATION PACK	Preferred	QL (12.6 ML per 30 days)
Multiple Sclerosis Agents - Monoclonal Antibodies - Drugs For Multiple Sclerosis***		
BRIUMVI	Non – Preferred	
KESIMPTA	Non – Preferred	
LEMTRADA	Non – Preferred	
OCREVUS	Non – Preferred	
TYSABRI	Non – Preferred	
Multiple Sclerosis Agents - Nrf2 Pathway Activators - Drugs For Multiple Sclerosis***		
dimethyl fumarate capsule delayed release 120 mg oral	Non – Preferred	QL (2 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dimethyl fumarate capsule delayed release 120 mg oral	Preferred	QL (2 EA per 1 day)
dimethyl fumarate capsule delayed release 240 mg oral	Preferred	QL (2 EA per 1 day)
dimethyl fumarate starter pack capsule delayed release therapy pack 120 & 240 mg oral	Preferred	QL (60 EA per 90 days)
BAFIERTAM	Non – Preferred	
TECFIDERA ORAL CAPSULE DELAYED RELEASE	Preferred	QL (2 EA per 1 day)
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK	Preferred	QL (60 EA per 90 days)
VUMERITY	Non – Preferred	
Multiple Sclerosis Agents - Potassium Channel Blockers - Drugs For Multiple Sclerosis**		
dalfampridine er	Non – Preferred	
AMPYRA	Non – Preferred	
Multiple Sclerosis Agents - Drugs For Multiple Sclerosis**		
glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous	Non – Preferred	QL (1 ML per 1 day)
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	Non – Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Preferred	QL (1 ML per 1 day)
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Preferred	
GLATOPA SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS	Preferred	
GLATOPA SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS	Preferred	QL (12 ML per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
N-Methyl-D-Aspartate (Nmda) Receptor Antagonists - Drugs For Alzheimer's Disease***		
memantine hcl er	Non – Preferred	
memantine hcl oral solution	Non – Preferred	
memantine hcl tablet 10 mg oral	Preferred	
memantine hcl tablet 10 mg oral	Preferred	QL (2 EA per 1 day)
memantine hcl tablet 28 x 5 mg & 21 x 10 mg oral	Non – Preferred	QL (2 EA per 1 day)
memantine hcl tablet 5 mg oral	Preferred	
memantine hcl tablet 5 mg oral	Preferred	QL (2 EA per 1 day)
NAMENDA TITRATION PAK	Non – Preferred	
Phenothiazines & Tricyclic Agents - Drugs For Depression***		
perphenazine-amitriptyline	Preferred	
Postherpetic Neuralgia (Phn)/Neuropathic Pain Agents - Drugs For Seizures /Personality Disorder/Nerve Pain***		
gabapentin (once-daily)	Non – Preferred	
pregabalin er	Non – Preferred	
GRALISE	Non – Preferred	
LYRICA CR	Non – Preferred	
Premenstrual Dysphoric Disorder (Pmdd) Agents - Ssris - Drugs For Depression***		
fluoxetine hcl (pmdd)	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pseudobulbar Affect Agent Combinations - Drugs For Severe Mental Disorders***		
NUEDEXTA	Non – Preferred	
Psychotherapeutic And Neurological Agents - Misc. - Drugs For Severe Mental Disorders***		
pimozide	Preferred	
AQNEURSA	Non – Preferred	
MIPLYFFA	Non – Preferred	
Restless Leg Syndrome (Rls) Agents - Drugs For The Nervous System***		
HORIZANT	Non – Preferred	
Small Interfering Ribonucleic Acid (Sirna) Agents - Drugs For The Nervous System***		
AMVUTTRA	Non – Preferred	
Smoking Deterrents - Drugs For Depression***		
bupropion hcl er (smoking det)	Preferred	
ft nicotine lozenge 2 mg mouth/throat	Preferred	OTC
ft nicotine lozenge 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
ft nicotine mouth/throat gum	Preferred	OTC
ft nicotine transdermal	Preferred	OTC
gnp nicotine gum 2 mg mouth/throat	Preferred	OTC
gnp nicotine gum 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
gnp nicotine mini	Preferred	OTC; QL (200 EA per 30 days)
gnp nicotine patch 24 hour 14 mg/24hr transdermal	Preferred	OTC; QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
gnp nicotine patch 24 hour 21 mg/24hr transdermal	Preferred	OTC; QL (1 EA per 1 day)
gnp nicotine patch 24 hour 7 mg/24hr transdermal	Preferred	OTC
gnp nicotine polacrilex	Preferred	OTC; QL (200 EA per 30 days)
goodsense nicotine gum 2 mg mouth/throat	Preferred	OTC
goodsense nicotine gum 2 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
goodsense nicotine gum 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
goodsense nicotine lozenge 2 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
goodsense nicotine lozenge 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine mini lozenge 2 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine mini lozenge 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine patch 24 hour 14 mg/24hr transdermal (otc)	Preferred	OTC; QL (1 EA per 1 day)
nicotine patch 24 hour 21 mg/24hr transdermal (otc)	Preferred	OTC; QL (1 EA per 1 day)
nicotine patch 24 hour 7 mg/24hr transdermal (otc)	Preferred	OTC
nicotine polacrilex gum 2 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine polacrilex gum 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine polacrilex lozenge 2 mg mouth/throat	Preferred	OTC
nicotine polacrilex lozenge 2 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine polacrilex lozenge 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
nicotine polacrilex mini	Preferred	OTC; QL (200 EA per 30 days)
nicotine step 1	Preferred	OTC; QL (1 EA per 1 day)
nicotine step 2	Preferred	OTC; QL (1 EA per 1 day)
nicotine step 3	Preferred	OTC
nicotine transdermal kit	Preferred	OTC; QL (1 EA per 1 day)
sm nicotine mouth/throat	Preferred	OTC; QL (200 EA per 30 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
sm nicotine polacrilex lozenge 4 mg mouth/throat	Preferred	OTC; QL (200 EA per 30 days)
sm nicotine polacrilex mouth/throat gum	Preferred	OTC; QL (200 EA per 30 days)
sm nicotine transdermal	Preferred	OTC; QL (1 EA per 1 day)
varenicline tartrate	Preferred	
varenicline tartrate (starter)	Preferred	
varenicline tartrate(continue)	Preferred	
NICOTROL	Preferred	QL (3 INHALER per 30 days)
NICOTROL NS	Preferred	QL (120 ML per 30 days)
Sphingosine 1-Phosphate (S1p) Receptor Modulators - Drugs For Multiple Sclerosis**		
fingolimod hcl capsule 0.5 mg oral	Non – Preferred	
fingolimod hcl capsule 0.5 mg oral	Non – Preferred	PA
fingolimod hcl capsule 0.5 mg oral	Non – Preferred	PA; QL (1 EA per 1 day)
GILENYA CAPSULE 0.25 MG ORAL	Non – Preferred	
GILENYA CAPSULE 0.5 MG ORAL	Preferred	PA
MAYZENT	Non – Preferred	
MAYZENT STARTER PACK	Non – Preferred	
PONVORY	Non – Preferred	
PONVORY STARTER PACK	Non – Preferred	
TASCENSO ODT	Non – Preferred	
ZEPOSIA	Non – Preferred	
ZEPOSIA 7-DAY STARTER PACK	Non – Preferred	
ZEPOSIA STARTER KIT	Non – Preferred	
Thienbenzodiazepines & Opioid Antagonists - Drugs For Severe Mental Disorders**		
LYBALVI	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Thienbenzodiazepines & Ssris - Drugs For Severe Mental Disorders***		
olanzapine-fluoxetine hcl	Non – Preferred	QL (1 EA per 1 day)
Vasomotor Symptom Agents - Ssris - Drugs For The Nervous System***		
paroxetine mesylate	Non – Preferred	
***Respiratory Agents - Misc.* - Drugs For The Lungs**		
Cftr Potentiators - Drugs For Cystic Fibrosis***		
KALYDECO	Non – Preferred	
Cystic Fibrosis Agent - Combinations - Drugs For Cystic Fibrosis***		
ALYFTREK	Non – Preferred	
ORKAMBI	Non – Preferred	
SYMDEKO	Non – Preferred	
TRIKAFTA	Non – Preferred	
Cystic Fibrosis Agents - Miscellaneous - Drugs For Cystic Fibrosis***		
BRONCHITOL	Non – Preferred	
BRONCHITOL TOLERANCE TEST	Non – Preferred	
Hydrolytic Enzymes - Drugs For The Lungs***		
PULMOZYME	Preferred	QL (5 ML per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pulmonary Fibrosis Agents - Kinase Inhibitors - Drugs For The Lungs***		
OFEV	Non – Preferred	
Pulmonary Fibrosis Agents - Drugs For The Lungs***		
pirfenidone	Non – Preferred	
ESBRIET	Non – Preferred	
***Sulfonamides* - Drugs For Infections**		
Sulfonamides - Antibiotics***		
sulfadiazine	Preferred	
***Tetracyclines* - Drugs For Infections**		
Aminomethylcyclines - Antibiotics***		
NUZYRA	Non – Preferred	
Tetracyclines - Antibiotics***		
demeclocycline hcl	Preferred	
doxycycline hyclate intravenous	Preferred	
doxycycline hyclate oral capsule	Preferred	
doxycycline hyclate oral tablet	Preferred	
doxycycline hyclate oral tablet delayed release	Non – Preferred	
doxycycline monohydrate	Preferred	
minocycline hcl	Preferred	
minocycline hcl er	Non – Preferred	
tetracycline hcl	Preferred	
DORYX MPC	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DOXY 100	Preferred	
***Thyroid Agents* - Hormones**		
****Antithyroid Agents*** - Drugs For Thyroid***		
methimazole	Preferred	
propylthiouracil	Preferred	
****Thyroid Hormones*** - Drugs For Thyroid***		
levothyroxine sodium oral capsule	Non – Preferred	
levothyroxine sodium tablet 100 mcg oral	Preferred	
levothyroxine sodium tablet 100 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 112 mcg oral	Preferred	
levothyroxine sodium tablet 112 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 125 mcg oral	Preferred	
levothyroxine sodium tablet 125 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 137 mcg oral	Preferred	
levothyroxine sodium tablet 137 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 150 mcg oral	Preferred	
levothyroxine sodium tablet 150 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 175 mcg oral	Preferred	
levothyroxine sodium tablet 175 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 200 mcg oral	Preferred	
levothyroxine sodium tablet 200 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 25 mcg oral	Preferred	
levothyroxine sodium tablet 25 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 300 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 50 mcg oral	Preferred	
levothyroxine sodium tablet 50 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 75 mcg oral	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levothyroxine sodium tablet 75 mcg oral	Preferred	QL (1 EA per 1 day)
levothyroxine sodium tablet 88 mcg oral	Preferred	
levothyroxine sodium tablet 88 mcg oral	Preferred	QL (1 EA per 1 day)
liothyronine sodium tablet 25 mcg oral	Preferred	
liothyronine sodium tablet 25 mcg oral	Preferred	QL (2 EA per 1 day)
liothyronine sodium tablet 5 mcg oral	Preferred	
liothyronine sodium tablet 5 mcg oral	Preferred	QL (4 EA per 1 day)
liothyronine sodium tablet 50 mcg oral	Preferred	
liothyronine sodium tablet 50 mcg oral	Preferred	QL (2 EA per 1 day)
niva thyroid	Preferred	
thyroid	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 120 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 130 MG ORAL	Preferred	
ADTHYZA TABLET 15 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 16.25 MG ORAL	Preferred	
ADTHYZA TABLET 30 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 32.5 MG ORAL	Preferred	
ADTHYZA TABLET 60 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 65 MG ORAL	Preferred	
ADTHYZA TABLET 90 MG ORAL	Preferred	QL (1 EA per 1 day)
ADTHYZA TABLET 97.5 MG ORAL	Preferred	
ARMOUR THYROID	Preferred	QL (1 EA per 1 day)
CYTOMEL TABLET 25 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
CYTOMEL TABLET 5 MCG ORAL	Non – Preferred	QL (4 EA per 1 day)
CYTOMEL TABLET 50 MCG ORAL	Non – Preferred	QL (2 EA per 1 day)
ERMEZA	Non – Preferred	
EUTHYROX	Preferred	QL (1 EA per 1 day)
LEVO-T	Preferred	QL (1 EA per 1 day)
LEVOXYL	Preferred	QL (1 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NP THYROID	Preferred	QL (1 EA per 1 day)
SYNTHROID	Non – Preferred	QL (1 EA per 1 day)
THYQUIDITY	Non – Preferred	
UNITHROID	Preferred	QL (1 EA per 1 day)
***Toxoids* - Biological Agents**		
****Toxoid Combinations*** - Vaccines***		
ADACEL	Preferred	AL (Min 19 Years)
BOOSTRIX	Preferred	AL (Min 19 Years)
INFANRIX	Preferred	AL (Min 19 Years)
TDVAX	Preferred	AL (Min 19 Years)
***Ulcer Drugs/Antispasmodics/Anticholinergics* - Drugs For The Stomach**		
****Anticholinergic Combinations*** - Drugs For Stomach Cramps***		
belladonna alkaloids-opium	Preferred	
chlordiazepoxide-clidinium	Non – Preferred	
LIBRAX	Non – Preferred	
****Antispasmodics*** - Drugs For Stomach Cramps***		
dicyclomine hcl	Preferred	
****Belladonna Alkaloids*** - Drugs For Stomach Cramps***		
hyoscyamine sulfate	Preferred	
hyoscyamine sulfate er	Preferred	
oscimin	Preferred	
LEVSIN	Non – Preferred	
LEVSIN/SL	Non – Preferred	
NULEV	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
H-2 Antagonists - Drugs For Ulcers And Stomach Acid***		
cimetidine hcl	Preferred	
cimetidine tablet 200 mg oral (rx)	Preferred	
cimetidine tablet 200 mg oral (rx)	Preferred	QL (2 EA per 1 day)
cimetidine tablet 300 mg oral	Preferred	
cimetidine tablet 300 mg oral	Preferred	QL (2 EA per 1 day)
cimetidine tablet 400 mg oral	Preferred	
cimetidine tablet 400 mg oral	Preferred	QL (2 EA per 1 day)
cimetidine tablet 800 mg oral	Preferred	
cimetidine tablet 800 mg oral	Preferred	QL (2 EA per 1 day)
famotidine oral suspension reconstituted	Preferred	
famotidine tablet 20 mg oral (rx)	Preferred	
famotidine tablet 40 mg oral	Preferred	
famotidine tablet 40 mg oral	Preferred	QL (2 EA per 1 day)
nizatidine	Preferred	
PEPCID TABLET 20 MG ORAL	Non – Preferred	
PEPCID TABLET 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
Misc. Anti-Ulcer - Drugs For Ulcers And Stomach Acid***		
sucralfate	Preferred	
CARAFATE ORAL SUSPENSION	Preferred	
CARAFATE ORAL TABLET	Non – Preferred	
Ppi - Potassium-Competitive Acid Blockers (P-Cab) - Drugs For Ulcers And Stomach Acid***		
VOQUEZNA	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Proton Pump Inhibitor-Antacid Combinations - Drugs For Ulcers And Stomach Acid***		
omeprazole-sodium bicarbonate	Non – Preferred	
KONVOMEP	Non – Preferred	
Proton Pump Inhibitors - Drugs For Ulcers And Stomach Acid***		
dexlansoprazole	Non – Preferred	
esomeprazole magnesium oral capsule delayed release	Non – Preferred	QL (2 EA per 1 day)
esomeprazole magnesium oral packet	Non – Preferred	
lansoprazole capsule delayed release 15 mg oral (rx)	Non – Preferred	
lansoprazole capsule delayed release 30 mg oral	Non – Preferred	QL (2 EA per 1 day)
lansoprazole tablet delayed release dispersible 15 mg oral (rx)	Preferred	
lansoprazole tablet delayed release dispersible 15 mg oral (rx)	Preferred	AL (Max 10 Years)
lansoprazole tablet delayed release dispersible 30 mg oral	Preferred	
lansoprazole tablet delayed release dispersible 30 mg oral	Preferred	AL (Max 10 Years)
omeprazole capsule delayed release 10 mg oral	Preferred	
omeprazole capsule delayed release 10 mg oral	Preferred	QL (2 EA per 1 day)
omeprazole capsule delayed release 20 mg oral	Preferred	QL (2 EA per 1 day)
omeprazole capsule delayed release 40 mg oral	Preferred	QL (2 EA per 1 day)
pantoprazole sodium oral packet	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
pantoprazole sodium tablet delayed release 20 mg oral	Preferred	QL (1 EA per 1 day)
pantoprazole sodium tablet delayed release 40 mg oral	Preferred	QL (2 EA per 1 day)
rabeprazole sodium	Non – Preferred	QL (2 EA per 1 day)
ACIPHEX	Non – Preferred	QL (2 EA per 1 day)
DEXILANT	Non – Preferred	
NEXIUM CAPSULE DELAYED RELEASE 20 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
NEXIUM CAPSULE DELAYED RELEASE 40 MG ORAL	Non – Preferred	
NEXIUM ORAL PACKET	Non – Preferred	
PREVACID	Non – Preferred	QL (2 EA per 1 day)
PREVACID SOLUTAB	Non – Preferred	AL (Max 10 Years)
PRILOSEC	Non – Preferred	
PROTONIX ORAL PACKET	Non – Preferred	
PROTONIX TABLET DELAYED RELEASE 20 MG ORAL	Non – Preferred	QL (1 EA per 1 day)
PROTONIX TABLET DELAYED RELEASE 40 MG ORAL	Non – Preferred	QL (2 EA per 1 day)
Quaternary Anticholinergics - Drugs For Stomach Cramps**		
glycopyrrolate	Preferred	
methscopolamine bromide	Non – Preferred	
CUVPOSA	Non – Preferred	
GLYCATE	Non – Preferred	
Ulcer Anti-Infective W/ Bismuth Combinations - Drugs For Ulcers And Stomach Acid**		
bis subcit-metronid-tetracyc	Non – Preferred	
bismuth/metronidaz/tetracyclin	Non – Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PYLERA	Non – Preferred	
Ulcer Anti-Infective W/ Proton Pump Inhibitors - Drugs For Ulcers And Stomach Acid***		
amoxicill-clarithro-lansopraz	Non – Preferred	
TALICIA	Non – Preferred	
Ulcer Anti-Infective-Pcab Combinations - Drugs For The Stomach***		
VOQUEZNA DUAL PAK	Non – Preferred	
VOQUEZNA TRIPLE PAK	Non – Preferred	
Ulcer Drugs - Prostaglandins - Drugs For Ulcers And Stomach Acid***		
misoprostol	Preferred	
CYTOTEC	Non – Preferred	
***Urinary Antispasmodics* - Drugs For The Urinary System**		
Urinary Antispasmodic - Antimuscarinic (Anticholinergic) - Drugs For The Bladder***		
darifenacin hydrobromide er	Non – Preferred	
fesoterodine fumarate er	Non – Preferred	
oxybutynin chloride er tablet extended release 24 hour 10 mg oral	Preferred	QL (2 EA per 1 day)
oxybutynin chloride er tablet extended release 24 hour 15 mg oral	Preferred	QL (2 EA per 1 day)
oxybutynin chloride er tablet extended release 24 hour 5 mg oral	Preferred	QL (1 EA per 1 day)
oxybutynin chloride oral solution	Preferred	QL (20 ML per 1 day)
oxybutynin chloride tablet 2.5 mg oral	Preferred	QL (8 EA per 1 day)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxybutynin chloride tablet 5 mg oral	Preferred	QL (4 EA per 1 day)
solifenacin succinate	Preferred	QL (1 EA per 1 day)
tolterodine tartrate	Non – Preferred	
tolterodine tartrate er	Non – Preferred	
trospium chloride	Non – Preferred	
trospium chloride er	Non – Preferred	
DETROL	Non – Preferred	
OXYTROL	Non – Preferred	
TOVIAZ	Non – Preferred	
VESICARE	Non – Preferred	
VESICARE LS	Non – Preferred	
Urinary Antispasmodics - Beta-3 Adrenergic Agonists - Drugs For The Bladder***		
mirabegron er	Preferred	
GEMTESA	Preferred	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER	Preferred	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL	Preferred	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Non – Preferred	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL	Preferred	
Urinary Antispasmodics - Cholinergic Agonists - Drugs For The Bladder***		
bethanechol chloride	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Urinary Antispasmodics - Direct Muscle Relaxants - Drugs For The Bladder***		
flavoxate hcl	Non – Preferred	
***Vaccines* - Biological Agents**		
Bacterial Vaccines - Vaccines***		
BEXSERO	Preferred	AL (Min 19 Years)
MENVEO	Preferred	AL (Min 19 Years)
PNEUMOVAX 23	Preferred	AL (Min 19 Years)
PREVNAR 20	Preferred	AL (Min 19 Years)
TRUMENBA	Preferred	AL (Min 19 Years)
VAXNEUVANCE	Preferred	AL (Min 19 Years)
Viral Vaccine Combinations - Vaccines***		
TWINRIX	Preferred	AL (Min 19 Years)
Viral Vaccines - Vaccines***		
COMIRNATY	Preferred	AL (Min 3 Years)
ENGERIX-B	Preferred	AL (Min 19 Years)
FLUAD	Preferred	AL (Min 14 Years)
GARDASIL 9	Preferred	AL (Min 9 Years and Max 45 Years)
HAVRIX	Preferred	AL (Min 19 Years)
HEPLISAV-B	Preferred	AL (Min 19 Years)
RECOMBIVAX HB	Preferred	AL (Min 19 Years)
VAQTA	Preferred	AL (Min 19 Years)
VARIVAX	Preferred	AL (Min 19 Years)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
***Vaginal And Related Products* - Drugs For Women**		
****Imidazole-Related Antifungals*** - Drugs For Infections***		
clotrimazole 3	Preferred	OTC
miconazole 3	Preferred	QL (3 EA Max Qty Per Fill Retail)
terconazole	Preferred	
GYNAZOLE-1	Non – Preferred	
****Miscellaneous Vaginal Combinations*** - Drugs For Infections***		
TRIMO-SAN	Non – Preferred	
****Miscellaneous Vaginal Products*** - Drugs For Women***		
INTRAROSA	Non – Preferred	
****Vaginal Anti-Infectives*** - Drugs For Infections***		
clindamycin phosphate	Preferred	
metronidazole	Preferred	
CLEOCIN	Non – Preferred	
CLINDESSE	Non – Preferred	
NUVESSA	Non – Preferred	
VANDAZOLE	Non – Preferred	
XACIATO	Non – Preferred	
****Vaginal Contraceptive Ph Modulator - Combinations*** - Drugs For Women***		
PHEXXI	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaginal Estrogens - Drugs For Women**		
estradiol vaginal cream	Preferred	
estradiol vaginal tablet	Non – Preferred	
ESTRACE	Non – Preferred	
ESTRING	Non – Preferred	
FEMRING	Non – Preferred	
IMVEXXY MAINTENANCE PACK	Non – Preferred	
IMVEXXY STARTER PACK	Non – Preferred	
PREMARIN	Preferred	QL (60 GM per 30 days)
VAGIFEM	Non – Preferred	
YUVAFEM	Non – Preferred	
Vaginal Progestins - Drugs For Women**		
CRINONE	Non – Preferred	
ENDOMETRIN	Preferred	
***Vasopressors* - Drugs For The Heart**		
Anaphylaxis Therapy Agents - Drugs For Serious Allergic Reaction**		
epinephrine	Preferred	QL (4 UNIT per 365 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML INJECTION	Preferred	
AUVI-Q SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML INJECTION	Preferred	QL (4 EA per 365 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION	Preferred	QL (4 EA per 365 days)
EPIPEN 2-PAK	Non – Preferred	QL (4 UNIT per 365 days)
EPIPEN JR 2-PAK	Non – Preferred	QL (4 EA per 365 days)

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred

AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Neurogenic Orthostatic Hypotension (Noh) - Agents - Drugs For Serious Allergic Reaction***		
droxidopa	Non – Preferred	
NORTHERA	Non – Preferred	
Vasopressors - Drugs For Serious Allergic Reaction***		
midodrine hcl	Preferred	
***Vitamins* - Drugs For Nutrition**		
Vitamin B-3 - Drugs For Nutrition***		
niacin	Preferred	OTC
niacin er	Preferred	OTC
Vitamin D - Drugs For Nutrition***		
ergocalciferol oral capsule	Preferred	
ergocalciferol oral solution	Preferred	OTC
vitamin d	Preferred	OTC
vitamin d (ergocalciferol)	Preferred	
Vitamin K - Drugs For Nutrition***		
phytonadione	Preferred	

Coverage Requirements and Limits
lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs
Drug Tier
Non – Preferred = Non – Preferred
Preferred = Preferred
AL = Age Restrictions
OTC = OTC Medications
PA = Prior Authorization Applies
QL = Quantity Limits
ST = Step Therapy Applies

Index of Drugs