2023 Formulary List of Covered Drugs

Health Partners Medicare
Platinum and Silver (HMO-POS)

Health Partners Medicare

The plan you **need**.
The care you **deserve**.

Health Partners Medicare
Platinum and Silver (HMO-POS)
2023 Formulary

(List of Covered Drugs)

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

Formulary ID 00023466, Version 10

This formulary was updated on 3/1/2023. For more recent information or other questions, please contact Health Partners Medicare Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477) or visit www.HPPMedicare.com. From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

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

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

When this drug list (formulary) refers to "we," "us," or "our," it means Health Partners Medicare. When it refers to "plan" or "our plan," it means Health Partners Medicare Platinum and Health Partners Medicare Silver.

This document includes a list of the drugs (formulary) for our plan which is current as of 3/1/2023. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the first and last pages.

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

What is the Health Partners Medicare Platinum and Silver Formulary?

A formulary is a list of covered drugs selected by Health Partners Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Health Partners Medicare will

generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Health Partners Medicare network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

Can the Formulary (drug list) change?

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

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

- New generic drugs. We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled "How do I request an exception to the Health Partners Medicare Platinum and Silver Formulary?"
- Drugs removed from the market. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- Other changes. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled "How do I request an exception to the Health Partners Medicare Platinum and Silver Formulary?"

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

The enclosed formulary is current as of 3/1/2023. To get updated information about the drugs covered by Health Partners Medicare Platinum and Silver, please contact us. Our contact information appears on the first and last pages.

Our print formulary will be updated by reprinting in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 109. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 116. The Index provides an alphabetical list of all the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Health Partners Medicare Platinum and Silver cover both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- Prior Authorization: Health Partners Medicare Platinum and Silver require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.

- Quantity Limits: For certain drugs, Health Partners Medicare Platinum and Silver limit the amount of the drug that our plan will cover. For example, our plan provides 360 tablets per prescription for Endocet, 5-325 mg. This may be in addition to a standard one-month or three-month supply.

- Step Therapy: In some cases, Health Partners Medicare Platinum and Silver require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.HPPMedicare.com. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the first and last pages.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Health Partners Medicare Platinum and Silver Formulary?" below for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact us at 1-866-901-8000 (TTY 1-877-454-8477) and ask if your drug is covered.

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

- You can ask Member Relations for a list of similar drugs that are covered by Health Partners Medicare Platinum and Silver. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Health Partners Medicare Platinum and Silver Formulary?

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

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

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

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

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

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

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

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

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

If you are a **current member** and have a change in treatment setting due to a change in the level of care you require, you can ask us to make a formulary exception. Examples of level of care changes might include:

- Discharge from a hospital to home
- Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and you now need to use your Part D plan
- Changing from hospice status and reverting back to standard Medicare Part A and B coverage
- Ending a long-term care stay and returning to the community
- Discharges from chronic psychiatric hospitals with highly individualized drug regimens

For these unplanned transitions, you can ask us to make a formulary exception or appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis for members that have had a change in their level of care and are stabilized on drug regimens that if altered are known to have risks.

For more information

For more detailed information about your Health Partners Medicare Platinum or Silver prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Health Partners Medicare Platinum or Silver, please contact us. Our contact information, along with the date we last updated the formulary, appears on the first and last pages.

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

Health Partners Medicare Platinum and Silver's Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Health Partners Medicare Platinum and Silver. If you have trouble finding your drug in the list, turn to the Index that begins on page 116.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., ENTRESTO) and generic drugs are listed in lowercase italics (e.g., *valsartan*).

The information in the Requirements/Limits column tells you if Health Partners Medicare Platinum or Silver has any special requirements for coverage of your drug.

The table below shows the cost-sharing for each drug tier shown in this formulary.

Health Partners Medicare Platinum and Silver		
Drug Tier	**Retail Cost-Sharing** (30-day supply)	**Mail-Order Cost-Sharing** (90-day supply)
1 – Preferred Generics	$0	$0
2 – Generic	$10	$20
3 – Preferred Brand Select Insulins* Other Drugs	 $10 $47	 $20 $94
4 – Non-Preferred Drug	$100	$200
5 – Specialty	33%	Not offered

* These copays for Select Insulins apply to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

LEGEND

TIER	NAME
1	Preferred Generics
2	Generic
3	Preferred Brands
4	Non-Preferred Drug
5	Specialty

SYMBOL	NAME	DESCRIPTION
QL	Quantity Limit	There is a limit on the amount of this drug that is covered per prescription, or within a specific time frame.
PA	Prior Authorization	You (or your physician) are required to get prior authorization before you fill your prescription for this drug. Without prior approval, we may not cover this drug.
ST	Step Therapy	In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition.
SI	Select Insulin	This insulin is included in the Senior Savings Model. With this program, your copay will be the same in all phases until you reach the catastrophic coverage phase. For more information, please refer to Chapter 6 of your Evidence of Coverage (EOC).

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
butalbital-aspirin-caffeine 50-325-40 mg cap	2-Generic	PA, QL (180 PER 30 DAYS)
cataflam	2-Generic	
celecoxib (50 mg cap, 100 mg cap, 200 mg cap, 400 mg cap)	2-Generic	QL (60 PER 30 DAYS)
diclofenac potassium 50 mg tab	2-Generic	
diclofenac sodium 1 % gel	3-Preferred Brands	QL (1000 PER 30 DAYS)
diclofenac sodium 1.5 % solution	4-Non-Preferred Drug	QL (300 PER 28 DAYS)
diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)	2-Generic	
diclofenac sodium er	2-Generic	
diclofenac-misoprostol	4-Non-Preferred Drug	
diflunisal	2-Generic	
ec-naproxen	2-Generic	
etodolac (200 mg cap, 300 mg cap, 400 mg tab, 500 mg tab)	2-Generic	
etodolac er	4-Non-Preferred Drug	
flurbiprofen	2-Generic	
ibu	1-Preferred Generics	
ibuprofen 100 mg/5ml suspension	2-Generic	
ibuprofen (400 mg tab, 600 mg tab, 800 mg tab)	1-Preferred Generics	
indomethacin (25 mg cap, 50 mg cap)	2-Generic	PA
indomethacin er	2-Generic	PA
meloxicam (7.5 mg tab, 15 mg tab)	1-Preferred Generics	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nabumetone (500 mg tab, 750 mg tab)	2-Generic	
naproxen (250 mg tab, 375 mg tab, 500 mg tab)	1-Preferred Generics	
naproxen (375 mg tab dr, 500 mg tab dr)	2-Generic	
naproxen sodium (275 mg tab, 550 mg tab)	2-Generic	
oxaprozin	4-Non-Preferred Drug	
piroxicam (10 mg cap, 20 mg cap)	2-Generic	
relafen	2-Generic	
sulindac (150 mg tab, 200 mg tab)	2-Generic	
OPIOID ANALGESICS, LONG-ACTING		
buprenorphine	4-Non-Preferred Drug	QL (4 PER 28 DAYS)
fentanyl	4-Non-Preferred Drug	QL (10 PER 30 DAYS)
methadone hcl 10 mg/5ml solution	3-Preferred Brands	QL (1800 PER 30 DAYS)
methadone hcl 5 mg/5ml solution	3-Preferred Brands	QL (3600 PER 30 DAYS)
methadone hcl 10 mg tab	3-Preferred Brands	QL (240 PER 30 DAYS)
methadone hcl 5 mg tab	3-Preferred Brands	QL (480 PER 30 DAYS)
morphine sulfate er (er 15 mg tab er, er 30 mg tab er, er 60 mg tab er, er 100 mg tab er, er 200 mg tab er)	3-Preferred Brands	QL (90 PER 30 DAYS)
tramadol hcl er (er 100 mg tab er, er 200 mg tab er, er 300 mg tab er)	3-Preferred Brands	QL (30 PER 30 DAYS)
tramadol hcl er (biphasic)	3-Preferred Brands	QL (30 PER 30 DAYS)
XTAMPZA ER	3-Preferred Brands	QL (60 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-codeine 120-12 mg/5ml solution	2-Generic	QL (2700 PER 30 DAYS)
acetaminophen-codeine 300-15 mg tab	2-Generic	QL (390 PER 30 DAYS)
acetaminophen-codeine 300-30 mg tab	2-Generic	QL (360 PER 30 DAYS)
acetaminophen-codeine 300-60 mg tab	2-Generic	QL (180 PER 30 DAYS)
acetaminophen-codeine #2	2-Generic	QL (390 PER 30 DAYS)
acetaminophen-codeine #3	2-Generic	QL (360 PER 30 DAYS)
acetaminophen-codeine #4	2-Generic	QL (180 PER 30 DAYS)
butalbital-apap-caff-cod 50-325-40-30 mg cap	4-Non-Preferred Drug	PA, QL (180 PER 30 DAYS)
butorphanol tartrate 10 mg/ml solution	4-Non-Preferred Drug	QL (5 PER 30 DAYS)
endocet 10-325 mg tab	3-Preferred Brands	QL (180 PER 30 DAYS)
endocet 2.5-325 mg tab	3-Preferred Brands	QL (360 PER 30 DAYS)
endocet 5-325 mg tab	3-Preferred Brands	QL (360 PER 30 DAYS)
endocet 7.5-325 mg tab	3-Preferred Brands	QL (240 PER 30 DAYS)
fentanyl citrate (400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)	5-Specialty	PA, QL (120 PER 30 DAYS)
fentanyl citrate 200 mcg loz handle	4-Non-Preferred Drug	PA, QL (120 PER 30 DAYS)
hydrocodone-acetaminophen (2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml)	4-Non-Preferred Drug	QL (2700 PER 30 DAYS)
hydrocodone-acetaminophen 10-325 mg tab	3-Preferred Brands	QL (180 PER 30 DAYS)
hydrocodone-acetaminophen 5-325 mg tab	3-Preferred Brands	QL (360 PER 30 DAYS)
hydrocodone-acetaminophen 7.5-325 mg tab	3-Preferred Brands	QL (240 PER 30 DAYS)
hydrocodone-ibuprofen (5-200 mg tab, 10-200 mg tab)	3-Preferred Brands	QL (150 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydrocodone-ibuprofen 7.5-200 mg tab	3-Preferred Brands	QL (150 PER 30 DAYS)
hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)	3-Preferred Brands	QL (180 PER 30 DAYS)
morphine sulfate (10 mg/5ml, 20 mg/5ml)	3-Preferred Brands	QL (900 PER 30 DAYS)
morphine sulfate (15 mg tab, 30 mg tab)	3-Preferred Brands	QL (180 PER 30 DAYS)
morphine sulfate (concentrate)	3-Preferred Brands	QL (180 PER 30 DAYS)
oxycodone hcl 100 mg/5ml conc	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
oxycodone hcl 5 mg/5ml solution	3-Preferred Brands	QL (900 PER 30 DAYS)
oxycodone hcl (5 mg tab, 5 mg cap, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)	3-Preferred Brands	QL (180 PER 30 DAYS)
oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)	3-Preferred Brands	QL (360 PER 30 DAYS)
oxycodone-acetaminophen 10-325 mg tab	3-Preferred Brands	QL (180 PER 30 DAYS)
oxycodone-acetaminophen 7.5-325 mg tab	3-Preferred Brands	QL (240 PER 30 DAYS)
oxymorphone hcl	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
tramadol hcl 50 mg tab	2-Generic	QL (240 PER 30 DAYS)
tramadol-acetaminophen	2-Generic	QL (240 PER 30 DAYS)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine 5 % patch	2-Generic	PA, QL (90 PER 30 DAYS)
lidocaine 5 % ointment	4-Non-Preferred Drug	QL (50 PER 30 DAYS)
lidocaine viscous hcl	2-Generic	
lidocaine-prilocaine	2-Generic	QL (30 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium	2-Generic	
disulfiram	2-Generic	
naltrexone hcl 50 mg tab	2-Generic	
VIVITROL	5-Specialty	
OPIOID DEPENDENCE		
buprenorphine hcl 2 mg sl tab	2-Generic	QL (90 PER 30 DAYS)
buprenorphine hcl 8 mg sl tab	2-Generic	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl (2-0.5 mg, 4-1 mg, 8-2 mg)	2-Generic	QL (90 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 12-3 mg film	2-Generic	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab	2-Generic	QL (120 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 8-2 mg sl tab	2-Generic	QL (90 PER 30 DAYS)
LUCEMYRA	4-Non-Preferred Drug	PA, QL (16 PER DAY)
OPIOID REVERSAL AGENTS		
naloxone hcl (0.4 mg/ml soln cart, 0.4 mg/ml solution, 2 mg/2ml soln prsyr, 4 mg/10ml solution)	1-Preferred Generics	
naloxone hcl 4 mg/0.1ml nasal spray	2-Generic	
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det)	2-Generic	QL (60 PER 30 DAYS)
NICOTROL	4-Non-Preferred Drug	
NICOTROL NS	4-Non-Preferred Drug	
varenicline tartrate (0.5 mg x 11 & 1 mg x 42 tab thpk, 0.5 mg tab, 1 mg tab)	3-Preferred Brands	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate	2-Generic	
gentamicin in saline	1-Preferred Generics	
gentamicin sulfate (0.1 % ointment, 0.1 % cream)	2-Generic	QL (60 PER 30 DAYS)
gentamicin sulfate (10 mg/ml, 40 mg/ml)	1-Preferred Generics	
neomycin sulfate 500 mg tab	2-Generic	
paromomycin sulfate 250 mg cap	1-Preferred Generics	
streptomycin sulfate 1 gm recon soln	1-Preferred Generics	
tobramycin sulfate (1.2 gm recon soln, 1.2 gm/30ml solution, 2 gm/50ml solution, 10 mg/ml solution, 80 mg/2ml solution)	4-Non-Preferred Drug	
ANTIBACTERIALS, OTHER		
acetic acid 2 % solution	2-Generic	
aztreonam	4-Non-Preferred Drug	
clindamycin hcl (75 mg cap, 150 mg cap, 300 mg cap)	2-Generic	
clindamycin palmitate hcl	2-Generic	
clindamycin phosphate (9 gm/60ml, 300 mg/2ml, 600 mg/4ml, 900 mg/6ml, 9000 mg/60ml)	1-Preferred Generics	
clindamycin phosphate (1 % swab, 2 % cream)	2-Generic	
clindamycin phosphate in d5w	1-Preferred Generics	
colistimethate sodium (cba)	1-Preferred Generics	
daptomycin (350 mg recon soln)	5-Specialty	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fosfomycin tromethamine	4-Non-Preferred Drug	
linezolid 100 mg/5ml recon susp	5-Specialty	QL (1800 PER 30 DAYS)
linezolid 600 mg/300ml solution	4-Non-Preferred Drug	
linezolid 600 mg tab	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
methenamine hippurate	2-Generic	
metronidazole (0.75 % gel, 0.75 % cream, 0.75 % lotion, 1 % gel, 250 mg tab, 500 mg tab)	2-Generic	
metronidazole 500 mg/100ml solution	4-Non-Preferred Drug	
nitrofurantoin macrocrystal (50 mg cap, 100 mg cap)	3-Preferred Brands	
nitrofurantoin monohyd macro	3-Preferred Brands	
polymyxin b sulfate 500000 unit recon soln	1-Preferred Generics	
rosadan (0.75 % gel, 0.75 % cream)	2-Generic	
TIGECYCLINE	5-Specialty	
TRIMETHOPRIM 100 MG TAB	1-Preferred Generics	
vancomycin hcl 125 mg cap	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
vancomycin hcl 250 mg cap	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
vancomycin hcl (1 gm soln, 10 gm soln, 100 gm soln, 500 mg soln, 750 mg soln)	4-Non-Preferred Drug	
XIFAXAN 200 MG TAB	4-Non-Preferred Drug	PA
XIFAXAN 550 MG TAB	5-Specialty	PA
BETA-LACTAM, CEPHALOSPORINS		
cefaclor (250 mg cap, 500 mg cap)	2-Generic	
CEFACLOR ER	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cefadroxil (250 mg/5ml recon susp, 500 mg/5ml recon susp, 500 mg cap)	1-Preferred Generics	
cefazolin sodium (1 gm soln, 10 gm soln, 100 gm soln, 300 gm soln, 500 mg soln)	4-Non-Preferred Drug	
cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)	2-Generic	
cefepime hcl (1 gm soln, 2 gm soln)	4-Non-Preferred Drug	
cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)	2-Generic	
cefotetan disodium (1 gm soln, 2 gm soln)	4-Non-Preferred Drug	
cefoxitin sodium	4-Non-Preferred Drug	
cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg/5ml recon susp, 100 mg tab, 200 mg tab)	2-Generic	
cefprozil (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg tab, 500 mg tab)	2-Generic	
ceftazidime	4-Non-Preferred Drug	
ceftriaxone sodium (1 gm soln, 2 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln)	4-Non-Preferred Drug	
cefuroxime axetil	2-Generic	
cefuroxime sodium (1.5 gm soln, 750 mg soln)	4-Non-Preferred Drug	
cephalexin (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 500 mg cap)	2-Generic	
tazicef (1 gm soln, 2 gm soln, 6 gm soln)	4-Non-Preferred Drug	
TEFLARO	5-Specialty	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BETA-LACTAM, PENICILLINS		
amoxicillin (125 mg chew tab, 125 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 250 mg chew tab, 400 mg/5ml recon susp, 500 mg tab, 500 mg cap, 875 mg tab)	1-Preferred Generics	
amoxicillin-pot clavulanate (200-28.5 mg/5ml recon susp, 200-28.5 mg chew tab, 250-62.5 mg/5ml recon susp, 250-125 mg tab, 400-57 mg/5ml recon susp, 400-57 mg chew tab, 500-125 mg tab, 600-42.9 mg/5ml recon susp, 875-125 mg tab)	2-Generic	
amoxicillin-pot clavulanate er	2-Generic	
ampicillin	2-Generic	
ampicillin sodium	1-Preferred Generics	
ampicillin-sulbactam sodium	2-Generic	
BICILLIN L-A (600000 UNIT/ML SUSP PRSYR, 1200000 UNIT/2ML SUSP PRSYR, 2400000 UNIT/4ML SUSPENSION)	3-Preferred Brands	
dicloxacillin sodium	1-Preferred Generics	
nafcillin sodium	2-Generic	
oxacillin sodium	1-Preferred Generics	
OXACILLIN SODIUM IN DEXTROSE	1-Preferred Generics	
PENICILLIN G POT IN DEXTROSE	4-Non-Preferred Drug	
penicillin g potassium	4-Non-Preferred Drug	
PENICILLIN G PROCAINE	4-Non-Preferred Drug	
penicillin g sodium	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, 250 mg tab, 500 mg tab)	1-Preferred Generics	
pfizerpen	4-Non-Preferred Drug	
piperacillin sod-tazobactam so	2-Generic	
CARBAPENEMS		
ertapenem sodium	4-Non-Preferred Drug	
imipenem-cilastatin	2-Generic	
meropenem	2-Generic	
MACROLIDES		
azithromycin (1 gm packet, 100 mg/5ml recon susp, 200 mg/5ml recon susp, 250 mg tab, 500 mg recon soln, 500 mg tab, 600 mg tab)	1-Preferred Generics	
clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)	2-Generic	
clarithromycin er	2-Generic	
DIFICID (40 MG/ML RECON SUSP, 200 MG TAB)	5-Specialty	
e.e.s. 400	2-Generic	
ery-tab	2-Generic	
ERYTHROCIN LACTOBIONATE	4-Non-Preferred Drug	
erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)	2-Generic	
erythromycin base (250 mg tab, 250 mg cp dr part, 500 mg tab)	4-Non-Preferred Drug	
erythromycin base (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)	2-Generic	
erythromycin ethylsuccinate 400 mg tab	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
QUINOLONES		
BESIVANCE	3-Preferred Brands	
CILOXAN 0.3 % OINTMENT	4-Non-Preferred Drug	
ciprofloxacin hcl 0.3 % solution	2-Generic	
ciprofloxacin hcl (100 mg tab, 250 mg tab, 500 mg tab, 750 mg tab)	1-Preferred Generics	
ciprofloxacin in d5w	2-Generic	
levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)	2-Generic	
levofloxacin 25 mg/ml oral solution	2-Generic	
levofloxacin in d5w	2-Generic	
levofloxacin iv soln 25 mg/ml	2-Generic	
moxifloxacin hcl 400 mg tab	2-Generic	
moxifloxacin hcl in nacl	2-Generic	
ofloxacin (300 mg tab, 400 mg tab)	2-Generic	
SULFONAMIDES		
sulfacetamide sodium (acne)	2-Generic	QL (118 PER 30 DAYS)
sulfadiazine 500 mg tab	4-Non-Preferred Drug	
sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab)	1-Preferred Generics	
TETRACYCLINES		
demeclocycline hcl	1-Preferred Generics	
doxy 100	4-Non-Preferred Drug	
doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg tab, 100 mg cap)	2-Generic	
doxycycline hyclate 100 mg recon soln	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxycycline monohydrate (25 mg/5ml recon susp, 50 mg tab, 50 mg cap, 75 mg tab, 100 mg tab, 100 mg cap, 150 mg tab)	2-Generic	
minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)	2-Generic	
mondoxyne nl 100 mg cap	2-Generic	
tetracycline hcl (250 mg cap, 500 mg cap)	2-Generic	
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT 10 MG/ML SOLUTION	5-Specialty	QL (600 PER 30 DAYS)
BRIVIACT 50 MG/5ML SOLUTION	5-Specialty	
BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
DIACOMIT (250 MG CAP, 250 MG PACKET)	5-Specialty	QL (360 PER 30 DAYS)
DIACOMIT (500 MG PACKET, 500 MG CAP)	5-Specialty	QL (180 PER 30 DAYS)
divalproex sodium (125 mg cap dr, 125 mg tab dr, 250 mg tab dr, 500 mg tab dr)	2-Generic	
divalproex sodium er	2-Generic	
EPIDIOLEX	5-Specialty	PA - FOR NEW STARTS ONLY, QL (600 PER 30 DAYS)
EPRONTIA	4-Non-Preferred Drug	
felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)	4-Non-Preferred Drug	
FINTEPLA	5-Specialty	PA - FOR NEW STARTS ONLY, QL (360 PER 30 DAYS)
FYCOMPA 0.5 MG/ML SUSPENSION	5-Specialty	QL (720 PER 30 DAYS)
FYCOMPA (4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
FYCOMPA 2 MG TAB	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)	2-Generic	
levetiracetam er	2-Generic	
levetiracetam in nacl	4-Non-Preferred Drug	
roweepra	2-Generic	
roweepra xr	2-Generic	
SPRITAM 1000 MG TAB	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
SPRITAM 250 MG TAB	4-Non-Preferred Drug	QL (360 PER 30 DAYS)
SPRITAM 500 MG TAB	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
SPRITAM 750 MG TAB	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
topiramate (15 mg cap sprink, 25 mg cap sprink, 25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)	2-Generic	
valproate sodium 100 mg/ml solution	2-Generic	
valproic acid (250 mg cap, 250 mg/5ml solution)	2-Generic	
XCOPRI (150 MG TAB, 200 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
XCOPRI (50 MG TAB, 100 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
XCOPRI (14 50 MG 14 100 MG TAB, 14 150 MG 14 200 MG TAB)	5-Specialty	QL (28 PER 28 DAYS)
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	4-Non-Preferred Drug	QL (28 PER 28 DAYS)
XCOPRI (250 MG DAILY DOSE) 100 & 150 MG TAB THPK	5-Specialty	QL (56 PER 28 DAYS)
XCOPRI (350 MG DAILY DOSE)	5-Specialty	QL (56 PER 28 DAYS)
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN	3-Preferred Brands	
ethosuximide (250 mg/5ml solution, 250 mg cap)	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
clobazam 2.5 mg/ml suspension	4-Non-Preferred Drug	QL (480 PER 30 DAYS)
clobazam (10 mg tab, 20 mg tab)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)	4-Non-Preferred Drug	
gabapentin (100 mg cap, 250 mg/5ml solution, 300 mg cap, 300 mg/6ml solution, 400 mg cap, 600 mg tab, 800 mg tab)	2-Generic	
NAYZILAM	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
phenobarbital (15 mg tab, 16.2 mg tab, 20 mg/5ml elixir, 20 mg/5ml solution, 30 mg tab, 32.4 mg tab, 60 mg tab, 64.8 mg tab, 97.2 mg tab, 100 mg tab)	2-Generic	
primidone (50 mg tab, 250 mg tab)	2-Generic	
SYMPAZAN (10 MG, 20 MG)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
SYMPAZAN 5 MG FILM	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
tiagabine hcl	4-Non-Preferred Drug	
VALTOCO 10 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 15 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 20 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 5 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
vigabatrin (500 mg tab, 500 mg packet)	5-Specialty	QL (180 PER 30 DAYS)
vigadrone	5-Specialty	QL (180 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SODIUM CHANNEL AGENTS		
APTIOM (200 MG TAB, 400 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
APTIOM (600 MG TAB, 800 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)	2-Generic	
carbamazepine er (er 100 mg tab er, er 100 mg cap er, er 200 mg tab er, er 200 mg cap er, er 300 mg cap er, er 400 mg tab er)	2-Generic	
DILANTIN 30 MG CAP	3-Preferred Brands	
epitol	2-Generic	
fosphenytoin sodium	4-Non-Preferred Drug	
lacosamide 10 mg/ml solution	4-Non-Preferred Drug	QL (1200 PER 30 DAYS)
lacosamide 200 mg/20ml solution	4-Non-Preferred Drug	
lacosamide (100 mg tab, 150 mg tab, 200 mg tab)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
lacosamide 50 mg tab	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
oxcarbazepine (150 mg tab, 300 mg/5ml suspension, 300 mg tab, 600 mg tab)	2-Generic	
phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)	1-Preferred Generics	
phenytoin infatabs	1-Preferred Generics	
PHENYTOIN SODIUM 50 MG/ML SOLUTION	1-Preferred Generics	
phenytoin sodium extended	1-Preferred Generics	
rufinamide 40 mg/ml suspension	5-Specialty	QL (2760 PER 30 DAYS)
rufinamide 200 mg tab	4-Non-Preferred Drug	QL (480 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
rufinamide 400 mg tab	5-Specialty	QL (240 PER 30 DAYS)
ZONISADE	4-Non-Preferred Drug	
zonisamide (25 mg cap, 50 mg cap, 100 mg cap)	2-Generic	
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
ergoloid mesylates	2-Generic	PA
NAMZARIC (7 & 14 & 21 &28 -10 MG CP24 THPK, 7-10 MG CAP ER 24H, 14-10 MG CAP ER 24H, 21-10 MG CAP ER 24H, 28-10 MG CAP ER 24H)	4-Non-Preferred Drug	
CHOLINESTERASE INHIBITORS		
donepezil hcl (5 mg tab, 10 mg tab)	1-Preferred Generics	QL (60 PER 30 DAYS)
donepezil hcl 23 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
donepezil hcl (5 mg tab disp, 10 mg tab disp)	2-Generic	QL (60 PER 30 DAYS)
galantamine hydrobromide 4 mg/ml solution	2-Generic	QL (360 PER 30 DAYS)
galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)	2-Generic	QL (60 PER 30 DAYS)
galantamine hydrobromide er	2-Generic	QL (30 PER 30 DAYS)
rivastigmine	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
rivastigmine tartrate	2-Generic	QL (60 PER 30 DAYS)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine hcl (2 mg/ml solution, 10 mg/5ml solution, 28 x 5 mg & 21 x 10 mg tab)	2-Generic	
memantine hcl (5 mg tab, 10 mg tab)	2-Generic	QL (60 PER 30 DAYS)
memantine hcl er	2-Generic	QL (30 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
AUVELITY	5-Specialty	QL (60 PER 30 DAYS)
bupropion hcl (75 mg tab, 100 mg tab)	2-Generic	QL (120 PER 30 DAYS)
bupropion hcl er (sr)	2-Generic	QL (60 PER 30 DAYS)
bupropion hcl er (xl) 150 mg tab er 24h	2-Generic	QL (90 PER 30 DAYS)
bupropion hcl er (xl) 300 mg tab er 24h	2-Generic	QL (30 PER 30 DAYS)
chlordiazepoxide-amitriptyline	4-Non-Preferred Drug	
LYBALVI	5-Specialty	QL (30 PER 30 DAYS)
mirtazapine (15 mg tab, 15 mg tab disp)	2-Generic	QL (90 PER 30 DAYS)
mirtazapine (30 mg tab disp, 30 mg tab)	2-Generic	QL (60 PER 30 DAYS)
mirtazapine (7.5 mg tab, 45 mg tab disp, 45 mg tab)	2-Generic	QL (30 PER 30 DAYS)
olanzapine-fluoxetine hcl	4-Non-Preferred Drug	
perphenazine-amitriptyline	4-Non-Preferred Drug	
MONOAMINE OXIDASE INHIBITORS		
EMSAM	5-Specialty	QL (30 PER 30 DAYS)
MARPLAN	3-Preferred Brands	
phenelzine sulfate 15 mg tab	1-Preferred Generics	
tranylcypromine sulfate	2-Generic	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)		
citalopram hydrobromide 10 mg/5ml solution	2-Generic	QL (600 PER 30 DAYS)
citalopram hydrobromide (20 mg tab, 40 mg tab)	1-Preferred Generics	QL (45 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
citalopram hydrobromide 10 mg tab	1-Preferred Generics	QL (90 PER 30 DAYS)
desvenlafaxine succinate er	3-Preferred Brands	QL (30 PER 30 DAYS)
escitalopram oxalate 5 mg/5ml solution	2-Generic	QL (600 PER 30 DAYS)
escitalopram oxalate 10 mg tab	1-Preferred Generics	QL (45 PER 30 DAYS)
escitalopram oxalate 20 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
escitalopram oxalate 5 mg tab	1-Preferred Generics	QL (90 PER 30 DAYS)
FETZIMA	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
FETZIMA TITRATION	4-Non-Preferred Drug	
fluoxetine hcl 10 mg cap	1-Preferred Generics	QL (90 PER 30 DAYS)
fluoxetine hcl 20 mg cap	1-Preferred Generics	QL (120 PER 30 DAYS)
fluoxetine hcl 40 mg cap	1-Preferred Generics	QL (60 PER 30 DAYS)
fluoxetine hcl 90 mg cap dr	4-Non-Preferred Drug	QL (4 PER 28 DAYS)
fluoxetine hcl 20 mg/5ml solution	2-Generic	
fluoxetine hcl 10 mg tab	2-Generic	QL (90 PER 30 DAYS)
fluoxetine hcl 20 mg tab	2-Generic	QL (120 PER 30 DAYS)
fluvoxamine maleate	2-Generic	QL (90 PER 30 DAYS)
fluvoxamine maleate er	2-Generic	QL (60 PER 30 DAYS)
nefazodone hcl (50 mg tab, 100 mg tab, 250 mg tab)	2-Generic	QL (60 PER 30 DAYS)
nefazodone hcl 150 mg tab	2-Generic	QL (120 PER 30 DAYS)
nefazodone hcl 200 mg tab	2-Generic	QL (90 PER 30 DAYS)
paroxetine hcl 10 mg/5ml suspension	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
paroxetine hcl (10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)	2-Generic	
paroxetine hcl er	4-Non-Preferred Drug	
sertraline hcl 20 mg/ml conc	2-Generic	QL (300 PER 30 DAYS)
sertraline hcl (25 mg tab, 50 mg tab)	1-Preferred Generics	QL (90 PER 30 DAYS)
sertraline hcl 100 mg tab	1-Preferred Generics	QL (60 PER 30 DAYS)
trazodone hcl (50 mg tab, 100 mg tab, 150 mg tab, 300 mg tab)	1-Preferred Generics	
TRINTELLIX	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
VENLAFAXINE BESYLATE ER	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
venlafaxine hcl	2-Generic	
venlafaxine hcl er (er 37.5 mg cap er, er 75 mg cap er)	2-Generic	QL (90 PER 30 DAYS)
venlafaxine hcl er 150 mg cap er 24h	2-Generic	QL (60 PER 30 DAYS)
VIIBRYD STARTER PACK	4-Non-Preferred Drug	
vilazodone hcl	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
TRICYCLICS		
amitriptyline hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)	2-Generic	
amoxapine	3-Preferred Brands	
clomipramine hcl	4-Non-Preferred Drug	
desipramine hcl	3-Preferred Brands	
doxepin hcl (10 mg/ml conc, 10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
imipramine hcl (10 mg tab, 25 mg tab, 50 mg tab)	2-Generic	
imipramine pamoate	4-Non-Preferred Drug	
nortriptyline hcl (10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap)	2-Generic	
nortriptyline hcl 10 mg/5ml solution	4-Non-Preferred Drug	
protriptyline hcl	4-Non-Preferred Drug	
trimipramine maleate (25 mg cap, 50 mg cap, 100 mg cap)	4-Non-Preferred Drug	
ANTIEMETICS		
ANTIEMETICS, OTHER		
compro	2-Generic	
meclizine hcl (12.5 mg tab, 25 mg tab)	2-Generic	
metoclopramide hcl (5 mg/5ml solution, 5 mg tab, 10 mg/10ml solution, 10 mg tab)	1-Preferred Generics	
perphenazine (2 mg tab, 4 mg tab, 8 mg tab, 16 mg tab)	2-Generic	
phenadoz	2-Generic	
prochlorperazine	2-Generic	
prochlorperazine edisylate (10 mg/2ml, 50 mg/10ml)	4-Non-Preferred Drug	
prochlorperazine maleate (5 mg tab, 10 mg tab)	2-Generic	
promethazine hcl (12.5 mg, 25 mg)	2-Generic	
promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)	1-Preferred Generics	PA
promethegan	2-Generic	
scopolamine	4-Non-Preferred Drug	QL (10 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EMETOGENIC THERAPY ADJUNCTS		
aprepitant (40 mg cap, 80 & 125 mg misc, 80 & 125 mg cap, 80 mg cap, 125 mg cap)	2-Generic	PA - TO CONFIRM PART D COVERAGE
dronabinol	4-Non-Preferred Drug	PA, QL (60 PER 30 DAYS)
EMEND 125 MG/5ML RECON SUSP	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
granisetron hcl 1 mg tab	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
ondansetron 4 mg tab disp	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
ondansetron 8 mg tab disp	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
ondansetron hcl (4 mg/2ml soln prsyr, 40 mg/20ml solution)	2-Generic	
ondansetron hcl 4 mg/5ml solution	2-Generic	PA - TO CONFIRM PART D COVERAGE
ondansetron hcl 4 mg tab	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
ondansetron hcl 8 mg tab	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
ondansetron hcl inj 4 mg/2ml	2-Generic	
SANCUSO	5-Specialty	ST, QL (4 PER 28 DAYS)
ANTIFUNGALS		
ABELCET	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
AMBISOME	5-Specialty	PA - TO CONFIRM PART D COVERAGE
amphotericin b	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
amphotericin b liposome	5-Specialty	PA - TO CONFIRM PART D COVERAGE
caspofungin acetate	4-Non-Preferred Drug	
ciclopirox olamine 0.77 % cream	2-Generic	QL (90 PER 30 DAYS)
ciclopirox olamine 0.77 % suspension	2-Generic	QL (60 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clotrimazole 1 % cream	2-Generic	QL (90 PER 30 DAYS)
clotrimazole 1 % solution	2-Generic	QL (30 PER 30 DAYS)
clotrimazole 10 mg troche	2-Generic	
econazole nitrate	4-Non-Preferred Drug	QL (85 PER 30 DAYS)
fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)	2-Generic	
fluconazole in sodium chloride (200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%)	2-Generic	
flucytosine (250 mg cap, 500 mg cap)	5-Specialty	
griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)	2-Generic	
griseofulvin ultramicrosize	2-Generic	
itraconazole (10 mg/ml solution, 100 mg cap)	4-Non-Preferred Drug	
ketoconazole 2 % cream	2-Generic	QL (60 PER 30 DAYS)
ketoconazole 2 % shampoo	2-Generic	QL (120 PER 30 DAYS)
ketoconazole 200 mg tab	2-Generic	
micafungin sodium	5-Specialty	
naftifine hcl 1 % cream	2-Generic	QL (90 PER 30 DAYS)
naftifine hcl 2 % cream	2-Generic	QL (60 PER 30 DAYS)
NOXAFIL 300 MG PACKET	5-Specialty	PA, QL (60 PER 30 DAYS)
NOXAFIL 40 MG/ML SUSPENSION	5-Specialty	PA, QL (630 PER 30 DAYS)
nyamyc	2-Generic	QL (60 PER 30 DAYS)
nystatin (100000 unit/gm ointment, 100000 unit/gm cream, 100000 unit/gm powder)	2-Generic	QL (60 PER 30 DAYS)
nystatin (100000 unit/ml suspension, 500000 unit tab)	2-Generic	
nystop	2-Generic	QL (60 PER 30 DAYS)
posaconazole	5-Specialty	PA, QL (93 PER 30 DAYS)
terbinafine hcl 250 mg tab	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
terconazole (0.4 %, 0.8 %)	2-Generic	
terconazole 80 mg suppos	1-Preferred Generics	
voriconazole 200 mg recon soln	5-Specialty	PA
voriconazole 40 mg/ml recon susp	5-Specialty	
voriconazole (50 mg tab, 200 mg tab)	4-Non-Preferred Drug	
ANTIGOUT AGENTS		
allopurinol (100 mg tab, 300 mg tab)	1-Preferred Generics	
colchicine 0.6 mg tab	3-Preferred Brands	
colchicine-probenecid	2-Generic	
febuxostat	2-Generic	ST
MITIGARE	3-Preferred Brands	
probenecid	2-Generic	
ANTIMIGRAINE AGENTS		
ANTIMIGRAINE AGENTS, OTHER		
AIMOVIG	4-Non-Preferred Drug	PA, QL (1 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN A-INJ	4-Non-Preferred Drug	PA, QL (1.5 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN PRSYR	4-Non-Preferred Drug	PA, QL (1.5 PER 28 DAYS)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	4-Non-Preferred Drug	PA, QL (2 PER 28 DAYS)
EMGALITY (300 MG DOSE)	4-Non-Preferred Drug	PA, QL (3 PER 28 DAYS)
NURTEC	5-Specialty	ST, QL (16 PER 30 DAYS)
ERGOT ALKALOIDS		
dihydroergotamine mesylate 4 mg/ml solution	5-Specialty	PA, QL (8 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ergotamine-caffeine	2-Generic	
SEROTONIN (5-HT) RECEPTOR AGONIST		
naratriptan hcl	2-Generic	QL (9 PER 30 DAYS)
rizatriptan benzoate (5 mg tab, 5 mg tab disp, 10 mg tab disp, 10 mg tab)	2-Generic	QL (12 PER 30 DAYS)
sumatriptan (5 mg/act, 20 mg/act)	4-Non-Preferred Drug	QL (12 PER 28 DAYS)
sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)	4-Non-Preferred Drug	QL (6 PER 30 DAYS)
sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)	2-Generic	QL (9 PER 30 DAYS)
sumatriptan succinate refill	4-Non-Preferred Drug	QL (6 PER 30 DAYS)
zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)	2-Generic	QL (9 PER 30 DAYS)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
pyridostigmine bromide 60 mg tab	3-Preferred Brands	
pyridostigmine bromide er	4-Non-Preferred Drug	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone (25 mg tab, 100 mg tab)	2-Generic	
rifabutin	1-Preferred Generics	
ANTITUBERCULARS		
ethambutol hcl	2-Generic	
isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)	1-Preferred Generics	
PASER	4-Non-Preferred Drug	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PRETOMANID	3-Preferred Brands	QL (30 PER 30 DAYS)
PRIFTIN	3-Preferred Brands	
pyrazinamide 500 mg tab	2-Generic	
rifampin (150 mg cap, 300 mg cap, 600 mg recon soln)	2-Generic	
SIRTURO	5-Specialty	
TRECATOR	4-Non-Preferred Drug	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
bendamustine hcl (25 mg soln, 100 mg soln)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
busulfan	5-Specialty	
cyclophosphamide (25 mg cap, 25 mg tab, 50 mg cap, 50 mg tab)	2-Generic	PA - TO CONFIRM PART D COVERAGE
GLEOSTINE (10 MG CAP, 40 MG CAP)	4-Non-Preferred Drug	
GLEOSTINE 100 MG CAP	5-Specialty	
ifosfamide (1 gm recon soln, 1 gm/20ml solution, 3 gm/60ml solution)	4-Non-Preferred Drug	
LEUKERAN	3-Preferred Brands	
MATULANE	5-Specialty	
melphalan	5-Specialty	PA - TO CONFIRM PART D COVERAGE
melphalan hcl	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TREANDA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VALCHLOR	5-Specialty	QL (60 PER 30 DAYS)
YONDELIS	5-Specialty	
ANTIANDROGENS		
abiraterone acetate	5-Specialty	PA - FOR NEW STARTS ONLY

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bicalutamide	2-Generic	
ERLEADA	5-Specialty	PA - FOR NEW STARTS ONLY
flutamide	2-Generic	
nilutamide	5-Specialty	
NUBEQA	5-Specialty	PA - FOR NEW STARTS ONLY
XTANDI (40 MG TAB, 40 MG CAP, 80 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
YONSA	5-Specialty	PA - FOR NEW STARTS ONLY
ANTIANGIOGENIC AGENTS		
lenalidomide	5-Specialty	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)
POMALYST	5-Specialty	PA - FOR NEW STARTS ONLY
REVLIMID	5-Specialty	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)
THALOMID (150 MG CAP, 200 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
THALOMID (50 MG CAP, 100 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ANTIESTROGENS/MODIFIERS		
EMCYT	5-Specialty	
fulvestrant	5-Specialty	
SOLTAMOX	5-Specialty	
tamoxifen citrate (10 mg tab, 20 mg tab)	2-Generic	
toremifene citrate	5-Specialty	
ANTIMETABOLITES		
adrucil	2-Generic	PA - TO CONFIRM PART D COVERAGE
cladribine	5-Specialty	PA - TO CONFIRM PART D COVERAGE
clofarabine	5-Specialty	PA - TO CONFIRM PART D COVERAGE
cytarabine	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
cytarabine (pf)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DROXIA	3-Preferred Brands	
fluorouracil (1 gm/20ml, 2.5 gm/50ml, 5 gm/100ml, 500 mg/10ml)	2-Generic	PA - TO CONFIRM PART D COVERAGE
FOLOTYN 40 MG/2ML SOLUTION	5-Specialty	PA - TO CONFIRM PART D COVERAGE
gemcitabine hcl 1 gm recon soln	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
hydroxyurea 500 mg cap	2-Generic	
INQOVI	5-Specialty	PA - FOR NEW STARTS ONLY
mercaptopurine 50 mg tab	2-Generic	
NIPENT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
pemetrexed disodium (100 mg soln, 500 mg soln, 750 mg soln, 1000 mg soln)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PURIXAN	5-Specialty	
TABLOID	3-Preferred Brands	
ANTINEOPLASTICS, OTHER		
adriamycin 2 mg/ml solution	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
arsenic trioxide 10 mg/10ml solution	5-Specialty	PA - TO CONFIRM PART D COVERAGE
AYVAKIT	5-Specialty	PA - FOR NEW STARTS ONLY
azacitidine	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BESREMI	5-Specialty	
bleomycin sulfate	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
bortezomib 3.5 mg recon soln	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BRUKINSA	5-Specialty	PA - FOR NEW STARTS ONLY
carboplatin	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
cisplatin	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
dacarbazine 200 mg recon soln	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
dactinomycin	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 20 MG/4ML SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 50 MG/10ML SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
decitabine	5-Specialty	PA - TO CONFIRM PART D COVERAGE
docetaxel (20 mg/ml conc, 20 mg/2ml solution, 80 mg/4ml conc, 80 mg/8ml solution, 160 mg/16ml solution, 160 mg/8ml conc)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
doxorubicin hcl 2 mg/ml solution	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
doxorubicin hcl liposomal	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
epirubicin hcl	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ERWINAZE	5-Specialty	
EXKIVITY	5-Specialty	PA - FOR NEW STARTS ONLY
fludarabine phosphate 50 mg recon soln	4-Non-Preferred Drug	
FOTIVDA	5-Specialty	PA - FOR NEW STARTS ONLY
HALAVEN	5-Specialty	
idarubicin hcl	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IDHIFA	5-Specialty	PA - FOR NEW STARTS ONLY
irinotecan hcl	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
KISQALI FEMARA (400 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI FEMARA (600 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI FEMARA(200 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KRAZATI	5-Specialty	PA - FOR NEW STARTS ONLY
LONSURF	5-Specialty	PA - FOR NEW STARTS ONLY
LUMAKRAS	5-Specialty	PA - FOR NEW STARTS ONLY
mitomycin (5 mg soln, 20 mg soln, 40 mg soln)	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
mitoxantrone hcl	4-Non-Preferred Drug	
mutamycin	4-Non-Preferred Drug	
NINLARO	5-Specialty	PA - FOR NEW STARTS ONLY
ONUREG	5-Specialty	PA - FOR NEW STARTS ONLY
oxaliplatin (50 mg/10ml solution, 50 mg recon soln, 100 mg/20ml solution, 100 mg recon soln)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
paclitaxel	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
paclitaxel protein-bound part	5-Specialty	PA - TO CONFIRM PART D COVERAGE
paraplatin	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
QINLOCK	5-Specialty	PA - FOR NEW STARTS ONLY
RETEVMO	5-Specialty	PA - FOR NEW STARTS ONLY
romidepsin 10 mg recon soln	5-Specialty	
SYNRIBO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TABRECTA	5-Specialty	PA - FOR NEW STARTS ONLY
TAZVERIK	5-Specialty	PA - FOR NEW STARTS ONLY
vinblastine sulfate	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
vincasar pfs	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
vincristine sulfate	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
vinorelbine tartrate 50 mg/5ml solution	4-Non-Preferred Drug	
VYXEOS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
WELIREG	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (60 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (80 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
ZALTRAP 100 MG/4ML SOLUTION	5-Specialty	
ZANOSAR	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ZOLINZA	5-Specialty	PA - FOR NEW STARTS ONLY
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole 1 mg tab	2-Generic	
exemestane	2-Generic	
letrozole 2.5 mg tab	2-Generic	
ENZYME INHIBITORS		
etoposide (1 gm/50ml, 100 mg/5ml, 500 mg/25ml)	2-Generic	
toposar	2-Generic	
topotecan hcl 4 mg recon soln	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MOLECULAR TARGET INHIBITORS		
ALECENSA	5-Specialty	PA - FOR NEW STARTS ONLY
ALIQOPA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ALUNBRIG (30 MG TAB, 90 MG TAB, 90 & 180 MG TAB THPK, 180 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
BALVERSA	5-Specialty	PA - FOR NEW STARTS ONLY
BOSULIF	5-Specialty	PA - FOR NEW STARTS ONLY
BRAFTOVI	5-Specialty	PA - FOR NEW STARTS ONLY
CABOMETYX	5-Specialty	PA - FOR NEW STARTS ONLY
CALQUENCE (100 MG CAP, 100 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
CAPRELSA	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (100 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
COMETRIQ (140 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (60 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COPIKTRA	5-Specialty	PA - FOR NEW STARTS ONLY
COTELLIC	5-Specialty	PA - FOR NEW STARTS ONLY
CYRAMZA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DAURISMO	5-Specialty	PA - FOR NEW STARTS ONLY
ERIVEDGE	5-Specialty	PA - FOR NEW STARTS ONLY
erlotinib hcl	5-Specialty	PA - FOR NEW STARTS ONLY
everolimus (2 mg tab sol, 2.5 mg tab, 3 mg tab sol, 5 mg tab sol, 5 mg tab, 7.5 mg tab, 10 mg tab)	5-Specialty	PA - FOR NEW STARTS ONLY
GAVRETO	5-Specialty	PA - FOR NEW STARTS ONLY
GILOTRIF	5-Specialty	PA - FOR NEW STARTS ONLY
IBRANCE (75 MG TAB, 75 MG CAP, 100 MG CAP, 100 MG TAB, 125 MG TAB, 125 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
ICLUSIG	5-Specialty	PA - FOR NEW STARTS ONLY
imatinib mesylate	5-Specialty	PA - FOR NEW STARTS ONLY
IMBRUVICA (70 MG/ML SUSPENSION, 70 MG CAP, 140 MG TAB, 140 MG CAP, 280 MG TAB, 420 MG TAB, 560 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
INLYTA	5-Specialty	PA - FOR NEW STARTS ONLY
INREBIC	5-Specialty	PA - FOR NEW STARTS ONLY
IRESSA	5-Specialty	PA - FOR NEW STARTS ONLY
JAKAFI	5-Specialty	PA - FOR NEW STARTS ONLY
JEVTANA	5-Specialty	
KISQALI (200 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI (400 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI (600 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KOSELUGO	5-Specialty	PA - FOR NEW STARTS ONLY
KYPROLIS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
lapatinib ditosylate	5-Specialty	PA - FOR NEW STARTS ONLY

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LENVIMA (10 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (12 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (14 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (18 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (20 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (24 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (4 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (8 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LORBRENA	5-Specialty	PA - FOR NEW STARTS ONLY
LYNPARZA	5-Specialty	PA - FOR NEW STARTS ONLY
LYTGOBI (12 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LYTGOBI (16 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LYTGOBI (20 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
MEKINIST	5-Specialty	PA - FOR NEW STARTS ONLY
MEKTOVI	5-Specialty	PA - FOR NEW STARTS ONLY
NERLYNX	5-Specialty	PA - FOR NEW STARTS ONLY
ODOMZO	5-Specialty	PA - FOR NEW STARTS ONLY
PEMAZYRE	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (200 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (250 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (300 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
REZLIDHIA	5-Specialty	PA - FOR NEW STARTS ONLY
ROZLYTREK	5-Specialty	PA - FOR NEW STARTS ONLY
RUBRACA	5-Specialty	PA - FOR NEW STARTS ONLY
RYDAPT	5-Specialty	PA - FOR NEW STARTS ONLY
SCEMBLIX	5-Specialty	PA - FOR NEW STARTS ONLY
sorafenib tosylate	5-Specialty	PA - FOR NEW STARTS ONLY
SPRYCEL	5-Specialty	PA - FOR NEW STARTS ONLY
STIVARGA	5-Specialty	PA - FOR NEW STARTS ONLY
sunitinib malate	5-Specialty	PA - FOR NEW STARTS ONLY

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TAFINLAR	5-Specialty	PA - FOR NEW STARTS ONLY
TAGRISSO	5-Specialty	PA - FOR NEW STARTS ONLY
TALZENNA	5-Specialty	PA - FOR NEW STARTS ONLY
TASIGNA	5-Specialty	PA - FOR NEW STARTS ONLY
TEPMETKO	5-Specialty	PA - FOR NEW STARTS ONLY
TIBSOVO	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (100MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (125MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (50MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (75MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TUKYSA	5-Specialty	PA - FOR NEW STARTS ONLY
TURALIO	5-Specialty	PA - FOR NEW STARTS ONLY
VENCLEXTA (50 MG TAB, 100 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
VENCLEXTA 10 MG TAB	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY
VENCLEXTA STARTING PACK	5-Specialty	PA - FOR NEW STARTS ONLY
VERZENIO	5-Specialty	PA - FOR NEW STARTS ONLY
VITRAKVI (20 MG/ML SOLUTION, 25 MG CAP, 100 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
VIZIMPRO	5-Specialty	PA - FOR NEW STARTS ONLY
VONJO	5-Specialty	PA - FOR NEW STARTS ONLY
VOTRIENT	5-Specialty	PA - FOR NEW STARTS ONLY
XALKORI	5-Specialty	PA - FOR NEW STARTS ONLY
XOSPATA	5-Specialty	PA - FOR NEW STARTS ONLY
ZEJULA	5-Specialty	PA - FOR NEW STARTS ONLY
ZELBORAF	5-Specialty	PA - FOR NEW STARTS ONLY
ZYDELIG	5-Specialty	PA - FOR NEW STARTS ONLY
ZYKADIA 150 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY
MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE		
ALYMSYS	5-Specialty	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AVASTIN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BAVENCIO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DARZALEX	5-Specialty	PA - TO CONFIRM PART D COVERAGE
EMPLICITI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ERBITUX 100 MG/50ML SOLUTION	5-Specialty	
HERCEPTIN HYLECTA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
HERZUMA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IMFINZI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KADCYLA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KANJINTI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KEYTRUDA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MVASI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MYLOTARG	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OGIVRI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ONTRUZANT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OPDIVO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PERJETA	5-Specialty	
RIABNI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RITUXAN HYCELA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RUXIENCE	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TECENTRIQ	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TRAZIMERA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TRUXIMA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VECTIBIX 100 MG/5ML SOLUTION	5-Specialty	PA - TO CONFIRM PART D COVERAGE
YERVOY 50 MG/10ML SOLUTION	5-Specialty	
ZIRABEV	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RETINOIDS		
bexarotene 75 mg cap	5-Specialty	PA - FOR NEW STARTS ONLY
bexarotene 1 % gel	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PANRETIN	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
tretinoin 10 mg cap	5-Specialty	
TREATMENT ADJUNCTS		
leucovorin calcium (50 mg soln, 100 mg soln, 200 mg soln, 350 mg soln, 500 mg soln)	4-Non-Preferred Drug	
leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)	2-Generic	
levoleucovorin calcium 50 mg recon soln	5-Specialty	
levoleucovorin calcium pf	5-Specialty	
mesna	4-Non-Preferred Drug	
MESNEX 400 MG TAB	5-Specialty	
ANTIPARASITICS		
ANTHELMINTHICS		
albendazole	5-Specialty	
ivermectin 3 mg tab	3-Preferred Brands	
praziquantel 600 mg tab	2-Generic	
ANTIPROTOZOALS		
atovaquone	4-Non-Preferred Drug	
atovaquone-proguanil hcl	2-Generic	
BENZNIDAZOLE	4-Non-Preferred Drug	
chloroquine phosphate	2-Generic	
COARTEM	3-Preferred Brands	
hydroxychloroquine sulfate 200 mg tab	2-Generic	
mefloquine hcl	2-Generic	
nitazoxanide 500 mg tab	5-Specialty	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pentamidine isethionate 300 mg inject soln	2-Generic	
pentamidine isethionate for nebulization soln 300 mg	2-Generic	PA - TO CONFIRM PART D COVERAGE
primaquine phosphate	2-Generic	
pyrimethamine 25 mg tab	5-Specialty	
quinine sulfate 324 mg cap	4-Non-Preferred Drug	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)	1-Preferred Generics	
trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)	1-Preferred Generics	
ANTIPARKINSON AGENTS, OTHER		
amantadine hcl (50 mg/5ml solution, 100 mg tab, 100 mg cap)	2-Generic	
carbidopa-levodopa-entacapone	2-Generic	
entacapone	4-Non-Preferred Drug	
tolcapone	5-Specialty	
DOPAMINE AGONISTS		
APOKYN	5-Specialty	
bromocriptine mesylate (2.5 mg tab, 5 mg cap)	2-Generic	
KYNMOBI	5-Specialty	
NEUPRO	4-Non-Preferred Drug	
pramipexole dihydrochloride	1-Preferred Generics	
pramipexole dihydrochloride er	2-Generic	
ropinirole hcl	2-Generic	
ropinirole hcl er	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa	4-Non-Preferred Drug	
carbidopa-levodopa (10-100 mg tab disp, 10-100 mg tab, 25-100 mg tab disp, 25-250 mg tab, 25-250 mg tab disp, 25-100 mg tab)	2-Generic	
carbidopa-levodopa er	2-Generic	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline mesylate	4-Non-Preferred Drug	
selegiline hcl (5 mg cap, 5 mg tab)	2-Generic	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine hcl (25 mg/ml, 50 mg/2ml)	4-Non-Preferred Drug	
chlorpromazine hcl (10 mg tab, 25 mg tab, 30 mg/ml conc, 50 mg tab, 100 mg tab, 100 mg/ml conc, 200 mg tab)	2-Generic	
fluphenazine decanoate 25 mg/ml solution	4-Non-Preferred Drug	
fluphenazine hcl (1 mg tab, 2.5 mg tab, 2.5 mg/5ml elixir, 2.5 mg/ml solution, 5 mg/ml conc, 5 mg tab, 10 mg tab)	2-Generic	
haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	2-Generic	
haloperidol decanoate (50 mg/ml, 100 mg/ml)	2-Generic	
haloperidol lactate (2 mg/ml conc, 5 mg/ml solution)	2-Generic	
loxapine succinate	2-Generic	
molindone hcl	2-Generic	
pimozide	2-Generic	
thioridazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
thiothixene	2-Generic	
trifluoperazine hcl	2-Generic	
2ND GENERATION/ATYPICAL		
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG SRER, 400 MG PRSYR)	5-Specialty	QL (1 PER 28 DAYS)
aripiprazole (1 mg/ml solution, 2 mg tab, 5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)	2-Generic	
aripiprazole (10 mg tab disp, 15 mg tab disp)	4-Non-Preferred Drug	
ARISTADA 1064 MG/3.9ML PRSYR	5-Specialty	QL (3.9 PER 56 DAYS)
ARISTADA 441 MG/1.6ML PRSYR	5-Specialty	QL (1.6 PER 28 DAYS)
ARISTADA 662 MG/2.4ML PRSYR	5-Specialty	QL (2.4 PER 28 DAYS)
ARISTADA 882 MG/3.2ML PRSYR	5-Specialty	QL (3.2 PER 28 DAYS)
ARISTADA INITIO	5-Specialty	
asenapine maleate	4-Non-Preferred Drug	
CAPLYTA	5-Specialty	QL (30 PER 30 DAYS)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
FANAPT (6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
FANAPT TITRATION PACK	4-Non-Preferred Drug	
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	5-Specialty	QL (3.5 PER 180 DAYS)
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	5-Specialty	QL (5 PER 180 DAYS)
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	5-Specialty	QL (0.75 PER 28 DAYS)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	5-Specialty	QL (1 PER 28 DAYS)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	5-Specialty	QL (1.5 PER 28 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	4-Non-Preferred Drug	QL (0.25 PER 28 DAYS)
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	5-Specialty	QL (0.5 PER 28 DAYS)
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	5-Specialty	QL (0.88 PER 84 DAYS)
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	5-Specialty	QL (1.32 PER 84 DAYS)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	5-Specialty	QL (1.75 PER 84 DAYS)
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	5-Specialty	QL (2.63 PER 84 DAYS)
LATUDA (20 MG TAB, 40 MG TAB, 60 MG TAB, 120 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
LATUDA 80 MG TAB	5-Specialty	QL (60 PER 30 DAYS)
NUPLAZID (10 MG TAB, 34 MG CAP)	5-Specialty	QL (30 PER 30 DAYS)
olanzapine 10 mg recon soln	4-Non-Preferred Drug	
olanzapine (2.5 mg tab, 5 mg tab, 7.5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab)	1-Preferred Generics	
olanzapine (5 mg tab disp, 10 mg tab disp, 15 mg tab disp, 20 mg tab disp)	2-Generic	
paliperidone er 1.5 mg tab er 24h	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
paliperidone er 3 mg tab er 24h	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
paliperidone er 6 mg tab er 24h	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
paliperidone er 9 mg tab er 24h	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
PERSERIS	5-Specialty	QL (1 PER 28 DAYS)
quetiapine fumarate (25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab, 300 mg tab, 400 mg tab)	2-Generic	
quetiapine fumarate er	2-Generic	
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
RISPERDAL CONSTA (12.5 MG, 25 MG)	4-Non-Preferred Drug	QL (2 PER 28 DAYS)
RISPERDAL CONSTA (37.5 MG, 50 MG)	5-Specialty	QL (2 PER 28 DAYS)
risperidone 1 mg/ml solution	2-Generic	
risperidone (0.25 mg tab, 0.5 mg tab, 1 mg tab, 2 mg tab, 3 mg tab, 4 mg tab)	2-Generic	QL (60 PER 30 DAYS)
risperidone (0.25 mg tab disp, 2 mg tab disp, 4 mg tab disp)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
risperidone 0.5 mg tab disp	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
risperidone 1 mg tab disp	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
risperidone 3 mg tab disp	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
risperidone m-tab 0.5 mg tab disp	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
risperidone m-tab 1 mg tab disp	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
risperidone m-tab 2 mg tab disp	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
SECUADO	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	5-Specialty	QL (30 PER 30 DAYS)
VRAYLAR 1.5 & 3 MG CAP THPK	4-Non-Preferred Drug	
ziprasidone hcl	2-Generic	QL (60 PER 30 DAYS)
ziprasidone mesylate	2-Generic	
ZYPREXA RELPREVV	4-Non-Preferred Drug	
TREATMENT-RESISTANT		
clozapine (25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VERSACLOZ	5-Specialty	
ANTISPASTICITY AGENTS		
baclofen (5 mg tab, 10 mg tab, 20 mg tab)	2-Generic	
dantrolene sodium (25 mg cap, 50 mg cap, 100 mg cap)	4-Non-Preferred Drug	
tizanidine hcl (2 mg tab, 4 mg tab)	2-Generic	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
PREVYMIS (240 MG TAB, 480 MG TAB)	5-Specialty	QL (28 PER 28 DAYS)
valganciclovir hcl 50 mg/ml recon soln	5-Specialty	
valganciclovir hcl 450 mg tab	2-Generic	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil	5-Specialty	
BARACLUDE 0.05 MG/ML SOLUTION	5-Specialty	
entecavir	4-Non-Preferred Drug	
EPIVIR HBV 5 MG/ML SOLUTION	3-Preferred Brands	
lamivudine 100 mg tab	2-Generic	
VEMLIDY	5-Specialty	
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB)	5-Specialty	PA, QL (28 PER 28 DAYS)
EPCLUSA (200-50 MG TAB, 200-50 MG PACKET)	5-Specialty	PA, QL (56 PER 28 DAYS)
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	5-Specialty	PA, QL (28 PER 28 DAYS)
HARVONI (45-200 MG PACKET, 45-200 MG TAB)	5-Specialty	PA, QL (56 PER 28 DAYS)
MAVYRET 50-20 MG PACKET	5-Specialty	PA, QL (140 PER 28 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MAVYRET 100-40 MG TAB	5-Specialty	PA, QL (84 PER 28 DAYS)
ribavirin (200 mg cap, 200 mg tab)	2-Generic	
SOFOSBUVIR-VELPATASVIR	5-Specialty	PA, QL (28 PER 28 DAYS)
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY 30-120-15 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
BIKTARVY 50-200-25 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
DOVATO	5-Specialty	QL (30 PER 30 DAYS)
GENVOYA	5-Specialty	QL (30 PER 30 DAYS)
ISENTRESS (25 MG CHEW TAB, 100 MG CHEW TAB, 100 MG PACKET)	3-Preferred Brands	QL (180 PER 30 DAYS)
ISENTRESS 400 MG TAB	5-Specialty	QL (60 PER 30 DAYS)
ISENTRESS HD	5-Specialty	QL (60 PER 30 DAYS)
JULUCA	5-Specialty	QL (30 PER 30 DAYS)
STRIBILD	5-Specialty	QL (30 PER 30 DAYS)
TIVICAY (25 MG TAB, 50 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
TIVICAY 10 MG TAB	3-Preferred Brands	QL (60 PER 30 DAYS)
TIVICAY PD	5-Specialty	QL (180 PER 30 DAYS)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
COMPLERA	5-Specialty	QL (30 PER 30 DAYS)
DELSTRIGO	5-Specialty	QL (30 PER 30 DAYS)
EDURANT	5-Specialty	QL (30 PER 30 DAYS)
efavirenz 200 mg cap	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
efavirenz 50 mg cap	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
efavirenz 600 mg tab	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
efavirenz-emtricitab-tenofo df	5-Specialty	QL (30 PER 30 DAYS)
efavirenz-lamivudine-tenofovir	5-Specialty	QL (30 PER 30 DAYS)
etravirine	5-Specialty	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INTELENCE 25 MG TAB	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
nevirapine 50 mg/5ml suspension	4-Non-Preferred Drug	
nevirapine 200 mg tab	2-Generic	QL (60 PER 30 DAYS)
nevirapine er 100 mg tab er 24h	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
nevirapine er 400 mg tab er 24h	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
ODEFSEY	5-Specialty	QL (30 PER 30 DAYS)
PIFELTRO	5-Specialty	QL (60 PER 30 DAYS)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate 20 mg/ml solution	3-Preferred Brands	
abacavir sulfate 300 mg tab	3-Preferred Brands	QL (60 PER 30 DAYS)
abacavir sulfate-lamivudine	3-Preferred Brands	QL (30 PER 30 DAYS)
abacavir-lamivudine-zidovudine	1-Preferred Generics	QL (60 PER 30 DAYS)
CIMDUO	5-Specialty	QL (30 PER 30 DAYS)
DESCOVY 120-15 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
DESCOVY 200-25 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
emtricitabine	3-Preferred Brands	QL (30 PER 30 DAYS)
emtricitabine-tenofovir df	5-Specialty	QL (30 PER 30 DAYS)
EMTRIVA 10 MG/ML SOLUTION	4-Non-Preferred Drug	
lamivudine 10 mg/ml solution	3-Preferred Brands	
lamivudine 150 mg tab	3-Preferred Brands	QL (60 PER 30 DAYS)
lamivudine 300 mg tab	3-Preferred Brands	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lamivudine-zidovudine	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
TEMIXYS	5-Specialty	QL (30 PER 30 DAYS)
tenofovir disoproxil fumarate	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
TRIUMEQ	5-Specialty	QL (30 PER 30 DAYS)
TRIUMEQ PD	5-Specialty	QL (180 PER 30 DAYS)
TRIZIVIR	5-Specialty	QL (60 PER 30 DAYS)
VIREAD 40 MG/GM POWDER	5-Specialty	
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
zidovudine 100 mg cap	3-Preferred Brands	QL (180 PER 30 DAYS)
zidovudine 50 mg/5ml syrup	3-Preferred Brands	
zidovudine 300 mg tab	3-Preferred Brands	QL (60 PER 30 DAYS)
ANTI-HIV AGENTS, OTHER		
APRETUDE	5-Specialty	
CABENUVA	5-Specialty	
FUZEON	5-Specialty	QL (60 PER 30 DAYS)
maraviroc	5-Specialty	
RUKOBIA	5-Specialty	QL (60 PER 30 DAYS)
SELZENTRY (20 MG/ML SOLUTION, 75 MG TAB)	5-Specialty	
SELZENTRY 25 MG TAB	3-Preferred Brands	
SUNLENCA (4 X 300 MG TAB THPK, 5 X 300 MG TAB THPK, 463.5 MG/1.5ML SOLUTION)	5-Specialty	
TROGARZO	5-Specialty	
TYBOST	3-Preferred Brands	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)		
APTIVUS 250 MG CAP	5-Specialty	QL (120 PER 30 DAYS)
atazanavir sulfate (150 mg cap, 200 mg cap)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
atazanavir sulfate 300 mg cap	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
EVOTAZ	5-Specialty	QL (30 PER 30 DAYS)
fosamprenavir calcium	5-Specialty	
LEXIVA 50 MG/ML SUSPENSION	4-Non-Preferred Drug	
lopinavir-ritonavir (100-25 mg tab, 200-50 mg tab, 400-100 mg/5ml solution)	4-Non-Preferred Drug	
NORVIR (80 MG/ML SOLUTION, 100 MG PACKET)	4-Non-Preferred Drug	
PREZCOBIX	5-Specialty	
PREZISTA (100 MG/ML SUSPENSION, 600 MG TAB, 800 MG TAB)	5-Specialty	
PREZISTA (75 MG TAB, 150 MG TAB)	4-Non-Preferred Drug	
REYATAZ 50 MG PACKET	4-Non-Preferred Drug	
ritonavir	3-Preferred Brands	
SYMTUZA	5-Specialty	QL (30 PER 30 DAYS)
VIRACEPT 250 MG TAB	5-Specialty	QL (270 PER 30 DAYS)
VIRACEPT 625 MG TAB	5-Specialty	QL (120 PER 30 DAYS)
ANTI-INFLUENZA AGENTS		
oseltamivir phosphate (6 mg/ml recon susp, 30 mg cap, 45 mg cap, 75 mg cap)	2-Generic	
RELENZA DISKHALER	3-Preferred Brands	
rimantadine hcl	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIHERPETIC AGENTS		
acyclovir (200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab)	2-Generic	
acyclovir sodium	2-Generic	PA - TO CONFIRM PART D COVERAGE
famciclovir (125 mg tab, 250 mg tab, 500 mg tab)	2-Generic	QL (90 PER 30 DAYS)
trifluridine	2-Generic	
valacyclovir hcl (1 gm tab, 500 mg tab)	2-Generic	QL (120 PER 30 DAYS)
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl	2-Generic	
hydroxyzine pamoate (25 mg cap, 50 mg cap, 100 mg cap)	2-Generic	
BENZODIAZEPINES		
alprazolam (0.25 mg tab, 0.5 mg tab)	2-Generic	QL (120 PER 30 DAYS)
alprazolam (1 mg tab, 2 mg tab)	2-Generic	QL (150 PER 30 DAYS)
chlordiazepoxide hcl 10 mg cap	4-Non-Preferred Drug	QL (300 PER 30 DAYS)
chlordiazepoxide hcl 25 mg cap	4-Non-Preferred Drug	QL (360 PER 30 DAYS)
chlordiazepoxide hcl 5 mg cap	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
clonazepam (2 mg tab, 2 mg tab disp)	2-Generic	QL (300 PER 30 DAYS)
clonazepam (0.125 mg tab disp, 0.25 mg tab disp, 0.5 mg tab disp, 0.5 mg tab, 1 mg tab disp, 1 mg tab)	2-Generic	QL (120 PER 30 DAYS)
clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)	2-Generic	QL (90 PER 30 DAYS)
clorazepate dipotassium 15 mg tab	2-Generic	QL (180 PER 30 DAYS)
diazepam 5 mg/ml conc	2-Generic	QL (240 PER 30 DAYS)
diazepam 5 mg/5ml solution	2-Generic	QL (1200 PER 30 DAYS)
diazepam (2 mg tab, 5 mg tab, 10 mg tab)	2-Generic	QL (120 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
diazepam intensol	2-Generic	QL (240 PER 30 DAYS)
lorazepam (2 mg tab, 2 mg/ml conc)	2-Generic	QL (150 PER 30 DAYS)
lorazepam 0.5 mg tab	2-Generic	QL (600 PER 30 DAYS)
lorazepam 1 mg tab	2-Generic	QL (300 PER 30 DAYS)
lorazepam intensol	2-Generic	QL (150 PER 30 DAYS)
oxazepam	2-Generic	QL (120 PER 30 DAYS)
BIPOLAR AGENTS		
MOOD STABILIZERS		
lamotrigine (5 mg chew tab, 25 mg tab, 25 mg chew tab, 25 mg tab disp, 50 mg tab disp, 100 mg tab disp, 100 mg tab, 150 mg tab, 200 mg tab, 200 mg tab disp)	1-Preferred Generics	
lamotrigine er	4-Non-Preferred Drug	
lithium carbonate (150 mg cap, 300 mg cap, 600 mg cap)	1-Preferred Generics	
lithium carbonate 300 mg tab	2-Generic	
lithium carbonate er	2-Generic	
subvenite	1-Preferred Generics	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose	1-Preferred Generics	QL (90 PER 30 DAYS)
alogliptin benzoate	2-Generic	QL (30 PER 30 DAYS)
alogliptin-metformin hcl	2-Generic	QL (60 PER 30 DAYS)
alogliptin-pioglitazone (12.5-45 mg tab, 12.5-30 mg tab, 25-45 mg tab, 25-15 mg tab, 25-30 mg tab)	2-Generic	QL (30 PER 30 DAYS)
BYDUREON BCISE	3-Preferred Brands	QL (3.4 PER 28 DAYS)
BYETTA 10 MCG PEN	3-Preferred Brands	QL (2.4 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BYETTA 5 MCG PEN	3-Preferred Brands	QL (1.2 PER 30 DAYS)
CYCLOSET	3-Preferred Brands	
FARXIGA	3-Preferred Brands	QL (30 PER 30 DAYS)
glimepiride (1 mg tab, 2 mg tab)	1-Preferred Generics	QL (120 PER 30 DAYS)
glimepiride 4 mg tab	1-Preferred Generics	QL (60 PER 30 DAYS)
glipizide	1-Preferred Generics	QL (120 PER 30 DAYS)
glipizide er 10 mg tab er 24h	1-Preferred Generics	QL (60 PER 30 DAYS)
glipizide er 2.5 mg tab er 24h	1-Preferred Generics	QL (120 PER 30 DAYS)
glipizide er 5 mg tab er 24h	1-Preferred Generics	QL (90 PER 30 DAYS)
glipizide xl 10 mg tab er 24h	1-Preferred Generics	QL (60 PER 30 DAYS)
glipizide xl 2.5 mg tab er 24h	1-Preferred Generics	QL (120 PER 30 DAYS)
glipizide xl 5 mg tab er 24h	1-Preferred Generics	QL (90 PER 30 DAYS)
glipizide-metformin hcl	1-Preferred Generics	QL (120 PER 30 DAYS)
glyburide (1.25 mg tab, 2.5 mg tab, 5 mg tab)	1-Preferred Generics	QL (120 PER 30 DAYS)
glyburide micronized	1-Preferred Generics	QL (60 PER 30 DAYS)
glyburide-metformin	1-Preferred Generics	QL (120 PER 30 DAYS)
GLYXAMBI	3-Preferred Brands	QL (30 PER 30 DAYS)
JANUMET	3-Preferred Brands	QL (60 PER 30 DAYS)
JANUMET XR (50-1000 MG TAB ER, 50-500 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
JANUMET XR 100-1000 MG TAB ER 24H	3-Preferred Brands	QL (30 PER 30 DAYS)
JANUVIA	3-Preferred Brands	QL (30 PER 30 DAYS)
JARDIANCE	3-Preferred Brands	QL (30 PER 30 DAYS)
JENTADUETO	3-Preferred Brands	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	3-Preferred Brands	QL (60 PER 30 DAYS)
JENTADUETO XR 5-1000 MG TAB ER 24H	3-Preferred Brands	QL (30 PER 30 DAYS)
KERENDIA	4-Non-Preferred Drug	PA, QL (30 PER 30 DAYS)
metformin hcl 1000 mg tab	1-Preferred Generics	QL (75 PER 30 DAYS)
metformin hcl 500 mg tab	1-Preferred Generics	QL (150 PER 30 DAYS)
metformin hcl 850 mg tab	1-Preferred Generics	QL (90 PER 30 DAYS)
metformin hcl er 500 mg tab er 24h	1-Preferred Generics	QL (120 PER 30 DAYS)
metformin hcl er 750 mg tab er 24h	1-Preferred Generics	QL (60 PER 30 DAYS)
miglitol	1-Preferred Generics	QL (90 PER 30 DAYS)
nateglinide 120 mg tab	1-Preferred Generics	QL (90 PER 30 DAYS)
nateglinide 60 mg tab	1-Preferred Generics	QL (180 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML SOLN PEN	3-Preferred Brands	QL (1.5 PER 28 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	3-Preferred Brands	QL (3 PER 28 DAYS)
OZEMPIC (1 MG/DOSE) 4 MG/3ML SOLN PEN	3-Preferred Brands	QL (3 PER 28 DAYS)
OZEMPIC (2 MG/DOSE)	3-Preferred Brands	QL (3 PER 28 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pioglitazone hcl	1-Preferred Generics	QL (30 PER 30 DAYS)
pioglitazone hcl-glimepiride	1-Preferred Generics	QL (30 PER 30 DAYS)
pioglitazone hcl-metformin hcl	1-Preferred Generics	QL (90 PER 30 DAYS)
repaglinide (0.5 mg tab, 1 mg tab)	1-Preferred Generics	QL (120 PER 30 DAYS)
repaglinide 2 mg tab	1-Preferred Generics	QL (240 PER 30 DAYS)
RYBELSUS	3-Preferred Brands	QL (30 PER 30 DAYS)
SOLIQUA	3-Preferred Brands	QL (18 PER 30 DAYS), SI (Select Insulin)
SYMLINPEN 120	5-Specialty	QL (10.8 PER 30 DAYS)
SYMLINPEN 60	5-Specialty	QL (6 PER 30 DAYS)
SYNJARDY (5-1000 MG TAB, 12.5-500 MG TAB, 12.5-1000 MG TAB)	3-Preferred Brands	QL (60 PER 30 DAYS)
SYNJARDY 5-500 MG TAB	3-Preferred Brands	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER, 10-1000 MG TAB ER, 12.5-1000 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	3-Preferred Brands	QL (30 PER 30 DAYS)
TRADJENTA	3-Preferred Brands	QL (30 PER 30 DAYS)
TRIJARDY XR (10-5-1000 MG TAB ER, 25-5-1000 MG TAB ER)	3-Preferred Brands	QL (30 PER 30 DAYS)
TRIJARDY XR (5-2.5-1000 MG TAB ER, 12.5-2.5-1000 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
TRULICITY (0.75 MG/0.5ML SOLN, 1.5 MG/0.5ML SOLN)	3-Preferred Brands	QL (2 PER 28 DAYS)
TRULICITY (3 MG/0.5ML SOLN, 4.5 MG/0.5ML SOLN)	3-Preferred Brands	QL (2 PER 28 DAYS)
VICTOZA	3-Preferred Brands	QL (9 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XIGDUO XR (10-500 MG TAB ER, 10-1000 MG TAB ER)	3-Preferred Brands	QL (30 PER 30 DAYS)
XIGDUO XR (2.5-1000 MG TAB ER, 5-500 MG TAB ER, 5-1000 MG TAB ER)	3-Preferred Brands	QL (60 PER 30 DAYS)
GLYCEMIC AGENTS		
diazoxide	4-Non-Preferred Drug	
GLUCAGEN HYPOKIT	3-Preferred Brands	
GLUCAGON EMERGENCY (1 MG KIT, 1 MG/ML RECON SOLN)	3-Preferred Brands	
glucagon emergency 1 mg kit (generic)	3-Preferred Brands	
GVOKE HYPOPEN 1-PACK	3-Preferred Brands	
GVOKE HYPOPEN 2-PACK	3-Preferred Brands	
GVOKE KIT	3-Preferred Brands	
GVOKE PFS	3-Preferred Brands	
INSULINS		
BASAGLAR KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMALOG (100 UNIT/ML SOLUTION, 100 UNIT/ML SOLN CART)	3-Preferred Brands	SI (Select Insulin)
HUMALOG JUNIOR KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMALOG KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMALOG MIX 50/50	3-Preferred Brands	SI (Select Insulin)
HUMALOG MIX 50/50 KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMALOG MIX 75/25	3-Preferred Brands	SI (Select Insulin)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMALOG MIX 75/25 KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMULIN 70/30	3-Preferred Brands	SI (Select Insulin)
HUMULIN 70/30 KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMULIN N	3-Preferred Brands	SI (Select Insulin)
HUMULIN N KWIKPEN	3-Preferred Brands	SI (Select Insulin)
HUMULIN R	3-Preferred Brands	SI (Select Insulin)
HUMULIN R U-500 (CONCENTRATED)	3-Preferred Brands	SI (Select Insulin)
HUMULIN R U-500 KWIKPEN	3-Preferred Brands	SI (Select Insulin)
INSULIN LISPRO	3-Preferred Brands	SI (Select Insulin)
INSULIN LISPRO (1 UNIT DIAL)	3-Preferred Brands	SI (Select Insulin)
INSULIN LISPRO JUNIOR KWIKPEN	3-Preferred Brands	SI (Select Insulin)
INSULIN LISPRO PROT & LISPRO	3-Preferred Brands	SI (Select Insulin)
LANTUS	3-Preferred Brands	SI (Select Insulin)
LANTUS SOLOSTAR	3-Preferred Brands	SI (Select Insulin)
LEVEMIR	3-Preferred Brands	SI (Select Insulin)
LEVEMIR FLEXPEN	3-Preferred Brands	SI (Select Insulin)
LEVEMIR FLEXTOUCH	3-Preferred Brands	SI (Select Insulin)
LYUMJEV	3-Preferred Brands	SI (Select Insulin)
LYUMJEV KWIKPEN	3-Preferred Brands	SI (Select Insulin)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TOUJEO MAX SOLOSTAR	3-Preferred Brands	SI (Select Insulin)
TOUJEO SOLOSTAR	3-Preferred Brands	SI (Select Insulin)
TRESIBA	3-Preferred Brands	SI (Select Insulin)
TRESIBA FLEXTOUCH	3-Preferred Brands	SI (Select Insulin)
BLOOD PRODUCTS AND MODIFIERS		
ANTICOAGULANTS		
ELIQUIS	3-Preferred Brands	
ELIQUIS DVT/PE STARTER PACK	3-Preferred Brands	
enoxaparin sodium (30 mg/0.3ml soln, 40 mg/0.4ml soln, 60 mg/0.6ml soln, 80 mg/0.8ml soln, 100 mg/ml soln, 120 mg/0.8ml soln, 150 mg/ml soln)	2-Generic	
fondaparinux sodium (5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml)	5-Specialty	
fondaparinux sodium 2.5 mg/0.5ml solution	4-Non-Preferred Drug	
heparin sodium (porcine) ((porcine) 1000 unit/ml, (porcine) 5000 unit/ml, (porcine) 10000 unit/ml, (porcine) 20000 unit/ml)	1-Preferred Generics	
jantoven	1-Preferred Generics	
warfarin sodium (1 mg tab, 2 mg tab, 2.5 mg tab, 3 mg tab, 4 mg tab, 5 mg tab, 6 mg tab, 7.5 mg tab, 10 mg tab)	1-Preferred Generics	
XARELTO (1 MG/ML RECON SUSP, 2.5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB)	3-Preferred Brands	
XARELTO STARTER PACK	3-Preferred Brands	
ZONTIVITY	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BLOOD PRODUCTS AND MODIFIERS, OTHER		
anagrelide hcl	2-Generic	
LEUKINE	5-Specialty	
NYVEPRIA	5-Specialty	PA
PROCRIT (2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML)	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
PROCRIT (20000 UNIT/ML, 40000 UNIT/ML)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PROMACTA 12.5 MG PACKET	5-Specialty	PA, QL (360 PER 30 DAYS)
PROMACTA 25 MG PACKET	5-Specialty	PA, QL (180 PER 30 DAYS)
PROMACTA (12.5 MG TAB, 25 MG TAB)	5-Specialty	PA, QL (30 PER 30 DAYS)
PROMACTA (50 MG TAB, 75 MG TAB)	5-Specialty	PA, QL (60 PER 30 DAYS)
RETACRIT	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
ZARXIO	5-Specialty	PA
ZIEXTENZO	5-Specialty	PA
HEMOSTASIS AGENTS		
tranexamic acid 650 mg tab	2-Generic	
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole er	2-Generic	
BRILINTA	3-Preferred Brands	
cilostazol	2-Generic	
clopidogrel bisulfate 300 mg tab	2-Generic	
clopidogrel bisulfate 75 mg tab	1-Preferred Generics	
dipyridamole (25 mg tab, 50 mg tab, 75 mg tab)	1-Preferred Generics	PA
prasugrel hcl	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine	2-Generic	QL (4 PER 28 DAYS)
clonidine hcl (0.1 mg tab, 0.2 mg tab, 0.3 mg tab)	1-Preferred Generics	
droxidopa (200 mg cap, 300 mg cap)	5-Specialty	QL (180 PER 30 DAYS)
droxidopa 100 mg cap	5-Specialty	QL (90 PER 30 DAYS)
guanfacine hcl	1-Preferred Generics	PA
midodrine hcl	2-Generic	
ALPHA-ADRENERGIC BLOCKING AGENTS		
doxazosin mesylate	2-Generic	
phenoxybenzamine hcl 10 mg cap	5-Specialty	
prazosin hcl (1 mg cap, 2 mg cap, 5 mg cap)	2-Generic	
terazosin hcl	1-Preferred Generics	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1-Preferred Generics	
irbesartan	1-Preferred Generics	
losartan potassium (25 mg tab, 50 mg tab, 100 mg tab)	1-Preferred Generics	
olmesartan medoxomil (5 mg tab, 20 mg tab, 40 mg tab)	1-Preferred Generics	
telmisartan	1-Preferred Generics	
valsartan (40 mg tab, 80 mg tab, 160 mg tab, 320 mg tab)	1-Preferred Generics	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab)	1-Preferred Generics	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
captopril	1-Preferred Generics	
enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	1-Preferred Generics	
fosinopril sodium	1-Preferred Generics	
lisinopril (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)	1-Preferred Generics	
moexipril hcl	1-Preferred Generics	
perindopril erbumine (8 mg tab)	1-Preferred Generics	
quinapril hcl	1-Preferred Generics	
ramipril	1-Preferred Generics	
trandolapril	1-Preferred Generics	
ANTIARRHYTHMICS		
amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)	2-Generic	
disopyramide phosphate	1-Preferred Generics	PA
dofetilide	2-Generic	
flecainide acetate	2-Generic	
mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)	1-Preferred Generics	
MULTAQ	3-Preferred Brands	
pacerone	2-Generic	
propafenone hcl	2-Generic	
propafenone hcl er	4-Non-Preferred Drug	
quinidine sulfate	2-Generic	
sorine	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
sotalol hcl	2-Generic	
sotalol hcl (af)	2-Generic	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	1-Preferred Generics	
atenolol	1-Preferred Generics	
betaxolol hcl (10 mg tab, 20 mg tab)	1-Preferred Generics	
bisoprolol fumarate (5 mg tab, 10 mg tab)	2-Generic	
carvedilol	1-Preferred Generics	
carvedilol phosphate er	3-Preferred Brands	QL (30 PER 30 DAYS)
labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)	2-Generic	
metoprolol succinate er	2-Generic	
metoprolol tartrate (25 mg tab, 37.5 mg tab, 50 mg tab, 75 mg tab, 100 mg tab)	1-Preferred Generics	
nadolol (20 mg tab, 40 mg tab, 80 mg tab)	2-Generic	
nebivolol hcl (2.5 mg tab, 5 mg tab, 10 mg tab)	3-Preferred Brands	QL (30 PER 30 DAYS)
nebivolol hcl 20 mg tab	3-Preferred Brands	QL (60 PER 30 DAYS)
pindolol	2-Generic	
propranolol hcl (10 mg tab, 20 mg/5ml solution, 20 mg tab, 40 mg/5ml solution, 40 mg tab, 60 mg tab, 80 mg tab)	2-Generic	
propranolol hcl er	2-Generic	
timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)	1-Preferred Generics	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
amlodipine besylate (2.5 mg tab, 5 mg tab, 10 mg tab)	1-Preferred Generics	
felodipine er	2-Generic	
isradipine	2-Generic	
nicardipine hcl (20 mg cap, 30 mg cap)	2-Generic	
nifedipine er	2-Generic	
nifedipine er osmotic release	2-Generic	
nimodipine 30 mg cap	2-Generic	
CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES		
cartia xt	2-Generic	
dilt-xr	2-Generic	
diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)	2-Generic	
diltiazem hcl er (er 60 mg cap er 12h, er 90 mg cap er 12h, er 120 mg cap er 24h, er 120 mg cap er 12h, er 180 mg cap er 24h, er 240 mg cap er 24h)	2-Generic	
diltiazem hcl er beads	2-Generic	
diltiazem hcl er coated beads (er 120 mg cap er, er 180 mg cap er, er 180 mg tab er, er 240 mg cap er, er 240 mg tab er, er 300 mg cap er, er 300 mg tab er, er 360 mg tab er, er 360 mg cap er, er 420 mg tab er)	2-Generic	
matzim la	2-Generic	
taztia xt	2-Generic	
tiadylt er	2-Generic	
verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)	1-Preferred Generics	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
verapamil hcl er (er 100 mg cap er 24h, er 120 mg tab er, er 120 mg cap er 24h, er 180 mg cap er 24h, er 180 mg tab er, er 200 mg cap er 24h, er 240 mg tab er, er 240 mg cap er 24h, er 300 mg cap er 24h, er 360 mg cap er 24h)	2-Generic	
CARDIOVASCULAR AGENTS, OTHER		
acetazolamide (125 mg tab, 250 mg tab)	2-Generic	
aliskiren fumarate	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
amiloride-hydrochlorothiazide	2-Generic	
amlodipine besy-benazepril hcl	1-Preferred Generics	
amlodipine besylate-valsartan	1-Preferred Generics	
amlodipine-atorvastatin	1-Preferred Generics	
amlodipine-olmesartan	1-Preferred Generics	
amlodipine-valsartan-hctz	1-Preferred Generics	
atenolol-chlorthalidone	1-Preferred Generics	
benazepril-hydrochlorothiazide	1-Preferred Generics	
bisoprolol-hydrochlorothiazide	1-Preferred Generics	
candesartan cilexetil-hctz	1-Preferred Generics	
CORLANOR 5 MG/5ML SOLUTION	4-Non-Preferred Drug	QL (450 PER 30 DAYS)
CORLANOR (5 MG TAB, 7.5 MG TAB)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
digitek	2-Generic	QL (30 PER 30 DAYS)
digoxin 0.05 mg/ml solution	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
digoxin (125 mcg tab, 250 mcg tab)	2-Generic	QL (30 PER 30 DAYS)
enalapril-hydrochlorothiazide	1-Preferred Generics	
ENTRESTO	3-Preferred Brands	QL (60 PER 30 DAYS)
fosinopril sodium-hctz	1-Preferred Generics	
irbesartan-hydrochlorothiazide	1-Preferred Generics	
lisinopril-hydrochlorothiazide	1-Preferred Generics	
losartan potassium-hctz	1-Preferred Generics	
metoprolol-hydrochlorothiazide	1-Preferred Generics	
metyrosine	5-Specialty	
olmesartan medoxomil-hctz	1-Preferred Generics	
olmesartan-amlodipine-hctz	1-Preferred Generics	
pentoxifylline er	2-Generic	
quinapril-hydrochlorothiazide	1-Preferred Generics	
ranolazine er	2-Generic	
spironolactone-hctz	2-Generic	
telmisartan-amlodipine	1-Preferred Generics	
telmisartan-hctz	1-Preferred Generics	
trandolapril-verapamil hcl er	1-Preferred Generics	
triamterene-hctz (37.5-25 mg cap, 37.5-25 mg tab, 75-50 mg tab)	1-Preferred Generics	
valsartan-hydrochlorothiazide	1-Preferred Generics	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIURETICS, LOOP		
bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)	2-Generic	
furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)	1-Preferred Generics	
torsemide	1-Preferred Generics	
DIURETICS, POTASSIUM-SPARING		
amiloride hcl	2-Generic	
eplerenone	4-Non-Preferred Drug	
spironolactone (25 mg tab, 50 mg tab, 100 mg tab)	1-Preferred Generics	
DIURETICS, THIAZIDE		
chlorthalidone	2-Generic	
hydrochlorothiazide (12.5 mg tab, 12.5 mg cap, 25 mg tab, 50 mg tab)	1-Preferred Generics	
indapamide	1-Preferred Generics	
metolazone	2-Generic	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)	2-Generic	
fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)	2-Generic	
fenofibric acid (45 mg cap dr, 135 mg cap dr)	2-Generic	
gemfibrozil	1-Preferred Generics	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium (10 mg tab, 40 mg tab)	1-Preferred Generics	QL (60 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
atorvastatin calcium 20 mg tab	1-Preferred Generics	QL (90 PER 30 DAYS)
atorvastatin calcium 80 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
LIVALO	3-Preferred Brands	ST, QL (30 PER 30 DAYS)
lovastatin (10 mg tab, 20 mg tab)	1-Preferred Generics	QL (30 PER 30 DAYS)
lovastatin 40 mg tab	1-Preferred Generics	QL (60 PER 30 DAYS)
pravastatin sodium	1-Preferred Generics	QL (30 PER 30 DAYS)
rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)	1-Preferred Generics	QL (60 PER 30 DAYS)
rosuvastatin calcium 40 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
simvastatin (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)	1-Preferred Generics	QL (30 PER 30 DAYS)
DYSLIPIDEMICS, OTHER		
cholestyramine (4 gm packet, 4 gm/dose powder)	2-Generic	
cholestyramine light (4 gm packet, 4 gm/dose powder)	2-Generic	
colesevelam hcl 3.75 gm packet	4-Non-Preferred Drug	
colesevelam hcl 625 mg tab	2-Generic	
colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)	2-Generic	
ezetimibe	2-Generic	QL (30 PER 30 DAYS)
ezetimibe-simvastatin	1-Preferred Generics	QL (30 PER 30 DAYS)
niacin er (antihyperlipidemic)	4-Non-Preferred Drug	
omega-3-acid ethyl esters	3-Preferred Brands	
prevalite (4 gm packet, 4 gm/dose powder)	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
REPATHA	3-Preferred Brands	PA, QL (3 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM	3-Preferred Brands	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	3-Preferred Brands	PA, QL (3 PER 28 DAYS)
VASCEPA	3-Preferred Brands	
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	2-Generic	
minoxidil (2.5 mg tab, 10 mg tab)	2-Generic	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)	2-Generic	
isosorbide mononitrate	1-Preferred Generics	
isosorbide mononitrate er	2-Generic	
NITRO-BID	3-Preferred Brands	
nitroglycerin (0.1 mg/hr patch 24hr, 0.2 mg/hr patch 24hr, 0.3 mg sl tab, 0.4 mg/hr patch 24hr, 0.4 mg sl tab, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)	2-Generic	
nitroglycerin 0.4 mg/spray solution	4-Non-Preferred Drug	
RECTIV	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
amphetamine-dextroamphet er	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)	3-Preferred Brands	QL (90 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)	3-Preferred Brands	QL (120 PER 30 DAYS)
amphetamine-dextroamphetamine 30 mg tab	3-Preferred Brands	QL (60 PER 30 DAYS)
dextroamphetamine sulfate (5 mg tab, 10 mg tab)	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
dextroamphetamine sulfate er	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
atomoxetine hcl 18 mg cap	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
dexmethylphenidate hcl	3-Preferred Brands	QL (60 PER 30 DAYS)
guanfacine hcl er	3-Preferred Brands	QL (30 PER 30 DAYS)
methylphenidate hcl (2.5 mg tab, 5 mg tab, 10 mg tab)	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
methylphenidate hcl 10 mg/5ml solution	4-Non-Preferred Drug	QL (900 PER 30 DAYS)
methylphenidate hcl 5 mg/5ml solution	4-Non-Preferred Drug	QL (1800 PER 30 DAYS)
methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)	3-Preferred Brands	QL (90 PER 30 DAYS)
methylphenidate hcl er (er 10 mg tab er, er 20 mg tab er)	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO (9 MG TAB, 12 MG TAB)	5-Specialty	PA, QL (120 PER 30 DAYS)
AUSTEDO 6 MG TAB	5-Specialty	PA, QL (60 PER 30 DAYS)
bac	2-Generic	PA, QL (180 PER 30 DAYS)
butalbital-apap-caffeine 50-325-40 mg tab	2-Generic	PA, QL (180 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INGREZZA (40 MG CAP, 80 MG CAP)	5-Specialty	PA, QL (30 PER 30 DAYS)
INGREZZA 60 MG CAP	5-Specialty	PA, QL (30 PER 30 DAYS)
INGREZZA 40 & 80 MG CAP THPK	5-Specialty	PA, QL (28 PER 28 DAYS)
NUEDEXTA	5-Specialty	PA, QL (60 PER 30 DAYS)
riluzole	2-Generic	
tetrabenazine 12.5 mg tab	5-Specialty	PA, QL (90 PER 30 DAYS)
tetrabenazine 25 mg tab	5-Specialty	PA, QL (120 PER 30 DAYS)
FIBROMYALGIA AGENTS		
DRIZALMA SPRINKLE	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
duloxetine hcl (20 mg dr, 30 mg dr, 60 mg dr)	3-Preferred Brands	QL (60 PER 30 DAYS)
pregabalin (225 mg cap, 300 mg cap)	3-Preferred Brands	QL (60 PER 30 DAYS)
pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)	3-Preferred Brands	QL (90 PER 30 DAYS)
pregabalin 20 mg/ml solution	4-Non-Preferred Drug	QL (900 PER 30 DAYS)
pregabalin er (er 82.5 mg tab er, er 165 mg tab er)	3-Preferred Brands	PA, QL (90 PER 30 DAYS)
pregabalin er 330 mg tab er 24h	3-Preferred Brands	PA, QL (60 PER 30 DAYS)
SAVELLA	4-Non-Preferred Drug	
SAVELLA TITRATION PACK	4-Non-Preferred Drug	
MULTIPLE SCLEROSIS AGENTS		
AVONEX PEN	5-Specialty	
AVONEX PREFILLED	5-Specialty	
BAFIERTAM	5-Specialty	
BETASERON	5-Specialty	
COPAXONE 20 MG/ML SOLN PRSYR	5-Specialty	QL (30 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
COPAXONE 40 MG/ML SOLN PRSYR	5-Specialty	QL (12 PER 28 DAYS)
dalfampridine er	3-Preferred Brands	QL (60 PER 30 DAYS)
fingolimod hcl	5-Specialty	QL (30 PER 30 DAYS)
GILENYA 0.5 MG CAP	5-Specialty	QL (30 PER 30 DAYS)
KESIMPTA	5-Specialty	PA
PLEGRIDY (125 MCG/0.5ML SOLN PEN, 125 MCG/0.5ML SOLN PRSYR)	5-Specialty	
PLEGRIDY STARTER PACK (63 94 MCG/0.5ML SOLN PRSYR, 63 94 MCG/0.5ML SOLN PEN)	5-Specialty	
TECFIDERA (120 MG CAP DR, 240 MG CAP DR)	5-Specialty	QL (60 PER 30 DAYS)
TECFIDERA 120 & 240 MG MISC	5-Specialty	
VUMERITY	5-Specialty	QL (120 PER 30 DAYS)
DENTAL AND ORAL AGENTS		
cevimeline hcl	2-Generic	
chlorhexidine gluconate 0.12 % solution	1-Preferred Generics	
oralone	2-Generic	
paroex	1-Preferred Generics	
periogard	1-Preferred Generics	
pilocarpine hcl (5 mg tab, 7.5 mg tab)	2-Generic	
triamcinolone acetonide 0.1 % paste	2-Generic	
DERMATOLOGICAL AGENTS		
ACNE AND ROSACEA AGENTS		
accutane	4-Non-Preferred Drug	
acitretin	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY
amnesteem	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
avita (0.025 % cream, 0.025 % gel)	4-Non-Preferred Drug	PA, QL (45 PER 30 DAYS)
benzoyl peroxide-erythromycin	4-Non-Preferred Drug	QL (46.6 PER 30 DAYS)
claravis	4-Non-Preferred Drug	
clindamycin phos-benzoyl perox 1-5 % gel	2-Generic	QL (50 PER 30 DAYS)
clindamycin phos-benzoyl perox 1.2-5 % gel	2-Generic	QL (45 PER 30 DAYS)
isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)	4-Non-Preferred Drug	
myorisan	4-Non-Preferred Drug	
tazarotene 0.1 % cream	2-Generic	QL (60 PER 30 DAYS)
TAZORAC 0.05 % CREAM	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
tretinoin (0.01 % gel, 0.025 % gel, 0.025 % cream, 0.05 % cream, 0.1 % cream)	4-Non-Preferred Drug	PA, QL (45 PER 30 DAYS)
zenatane	4-Non-Preferred Drug	
DERMATITIS AND PRURITUS AGENTS		
ala-cort	1-Preferred Generics	
alclometasone dipropionate (0.05 % cream, 0.05 % ointment)	2-Generic	
ammonium lactate (12 % lotion, 12 % cream)	2-Generic	
betamethasone dipropionate (0.05 % lotion, 0.05 % ointment, 0.05 % cream)	2-Generic	
betamethasone dipropionate aug (0.05 % cream, 0.05 % ointment, 0.05 % gel)	2-Generic	
betamethasone valerate (0.1 % cream, 0.1 % ointment, 0.1 % lotion)	2-Generic	
clobetasol prop emollient base	2-Generic	QL (120 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clobetasol propionate 0.05 % foam	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
clobetasol propionate 0.05 % liquid	4-Non-Preferred Drug	QL (125 PER 30 DAYS)
clobetasol propionate (0.05 % lotion, 0.05 % shampoo)	4-Non-Preferred Drug	QL (118 PER 30 DAYS)
clobetasol propionate (0.05 % ointment, 0.05 % gel, 0.05 % cream)	2-Generic	QL (120 PER 30 DAYS)
clobetasol propionate 0.05 % solution	2-Generic	QL (100 PER 30 DAYS)
clobetasol propionate e	2-Generic	QL (120 PER 30 DAYS)
clobetasol propionate emulsion	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
clodan	4-Non-Preferred Drug	QL (118 PER 30 DAYS)
desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)	2-Generic	
desoximetasone (0.05 % ointment, 0.05 % cream, 0.05 % gel, 0.25 % cream, 0.25 % ointment)	2-Generic	
fluocinolone acetonide (0.01 % cream, 0.01 % solution, 0.025 % ointment, 0.025 % cream)	2-Generic	
fluocinolone acetonide body	2-Generic	
fluocinolone acetonide scalp	2-Generic	
fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)	2-Generic	QL (120 PER 30 DAYS)
fluocinonide 0.05 % solution	2-Generic	QL (60 PER 30 DAYS)
fluocinonide emulsified base	2-Generic	QL (120 PER 30 DAYS)
fluticasone propionate (0.005 % ointment, 0.05 % cream)	2-Generic	
halobetasol propionate (0.05 % ointment, 0.05 % cream)	4-Non-Preferred Drug	QL (50 PER 30 DAYS)
hydrocortisone (1 % cream, 1 % ointment, 2.5 % ointment, 2.5 % cream)	1-Preferred Generics	
hydrocortisone 2.5 % lotion	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydrocortisone (perianal)	2-Generic	
hydrocortisone butyrate (0.1 % ointment, 0.1 % solution)	2-Generic	
hydrocortisone valerate (0.2 % ointment, 0.2 % cream)	2-Generic	
mometasone furoate (0.1 % solution, 0.1 % ointment, 0.1 % cream)	2-Generic	
procto-med hc	2-Generic	
procto-pak	2-Generic	
proctosol hc	2-Generic	
proctozone-hc	2-Generic	
selenium sulfide 2.5 % lotion	2-Generic	
tacrolimus (0.03 %, 0.1 %)	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
tovet	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
triamcinolone acetonide (0.025 % ointment, 0.025 % cream, 0.025 % lotion, 0.1 % lotion, 0.1 % cream, 0.1 % ointment, 0.5 % cream, 0.5 % ointment)	2-Generic	
triderm	2-Generic	
DERMATOLOGICAL AGENTS, OTHER		
calcipotriene (0.005 % cream, 0.005 % ointment)	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
calcipotriene 0.005 % solution	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
calcitrene	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
clotrimazole-betamethasone 1-0.05 % cream	2-Generic	QL (45 PER 30 DAYS)
clotrimazole-betamethasone 1-0.05 % lotion	2-Generic	QL (60 PER 30 DAYS)
fluorouracil 0.5 % cream	5-Specialty	QL (30 PER 30 DAYS)
fluorouracil 5 % cream	2-Generic	QL (80 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
fluorouracil (2 %, 5 %)	2-Generic	QL (20 PER 30 DAYS)
imiquimod 5 % cream	2-Generic	QL (24 PER 30 DAYS)
nystatin-triamcinolone (100000-0.1 unit/gm-% ointment, 100000-0.1 unit/gm-% cream)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
podofilox 0.5 % solution	2-Generic	
REGRANEX	5-Specialty	PA, QL (30 PER 30 DAYS)
SANTYL	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
silver sulfadiazine 1 % cream	2-Generic	
ssd	2-Generic	
PEDICULICIDES/SCABICIDES		
lindane	2-Generic	
malathion	4-Non-Preferred Drug	
permethrin 5 % cream	2-Generic	
TOPICAL ANTI-INFECTIVES		
acyclovir 5 % ointment	2-Generic	QL (30 PER 30 DAYS)
ciclodan	2-Generic	QL (13.2 PER 30 DAYS)
ciclopirox 0.77 % gel	2-Generic	QL (100 PER 30 DAYS)
ciclopirox 1 % shampoo	2-Generic	QL (120 PER 30 DAYS)
ciclopirox 8 % solution	2-Generic	QL (13.2 PER 30 DAYS)
clindamycin phosphate 1 % gel	2-Generic	QL (75 PER 30 DAYS)
clindamycin phosphate (1 % lotion, 1 % solution)	2-Generic	QL (60 PER 30 DAYS)
ery	2-Generic	QL (60 PER 30 DAYS)
erythromycin 2 % gel	2-Generic	QL (60 PER 30 DAYS)
erythromycin 2 % solution	2-Generic	QL (120 PER 30 DAYS)
mupirocin 2 % ointment	2-Generic	QL (66 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
carglumic acid	5-Specialty	
CLINIMIX E/DEXTROSE (2.75/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/10)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/15)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/20)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
clinisol sf	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINOLIPID	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
dextrose (5 %, 10 %, 50 %, 70 %, 250 mg/ml)	2-Generic	
dextrose-nacl (2.5-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.9 %, 5-0.45 %, 10-0.45 %, 10-0.2 %)	2-Generic	
dextrose-sodium chloride (2.5-0.45 %, 5-0.45 %, 5-0.9 %)	2-Generic	
FREAMINE III	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
INTRALIPID	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ISOLYTE-P IN D5W	4-Non-Preferred Drug	
ISOLYTE-S	4-Non-Preferred Drug	
ISOLYTE-S PH 7.4	4-Non-Preferred Drug	
kcl in dextrose-nacl (10-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%)	2-Generic	
KCL-LACTATED RINGERS-D5W	2-Generic	
klor-con (8 tab er, 20 packet)	2-Generic	
klor-con 10	2-Generic	
klor-con m10	2-Generic	
klor-con m15	2-Generic	
klor-con m20	2-Generic	
klor-con sprinkle	2-Generic	
levocarnitine (1 gm/10ml solution, 330 mg tab)	2-Generic	
levocarnitine sf	2-Generic	
magnesium sulfate 50 % solution	1-Preferred Generics	
NUTRILIPID	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
PLASMA-LYTE 148	4-Non-Preferred Drug	
PLASMA-LYTE A	4-Non-Preferred Drug	
plenamine	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
potassium chloride (0.4 meq/ml solution, 2 meq/ml solution, 10 % solution, 10 meq/50ml solution, 10 meq/100ml solution, 20 meq packet, 20 meq/100ml solution, 20 meq/15ml (10%) solution, 20 meq/50ml solution, 40 meq/100ml solution, 40 meq/15ml (20%) solution)	2-Generic	
potassium chloride crys er	2-Generic	
potassium chloride er (er 8 tab er, er 8 cap er, er 10 tab er, er 10 cap er, er 20 tab er)	2-Generic	
potassium chloride in dextrose 20-5 meq/l-% solution	2-Generic	
potassium chloride in nacl (20-0.9 meq/l-%, 20-0.45 meq/l-%, 40-0.9 meq/l-%)	4-Non-Preferred Drug	
potassium citrate er	2-Generic	
PREMASOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
PROSOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
sodium chloride (0.45 %, 0.9 %, 3 %, 5 %)	2-Generic	
sodium chloride (pf)	2-Generic	
sodium fluoride (0.55 (0.25 f) mg chew tab, 1.1 (0.5 f) mg/ml solution, 1.1 (0.5 f) mg chew tab, 2.2 (1 f) mg chew tab)	1-Preferred Generics	
TPN ELECTROLYTES	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE 10 % SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ELECTROLYTE/MINERAL/METAL MODIFIERS		
CHEMET	3-Preferred Brands	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
deferasirox (90 mg packet, 125 mg tab sol, 180 mg tab, 180 mg packet, 250 mg tab sol, 360 mg packet, 360 mg tab, 500 mg tab sol)	5-Specialty	PA
deferasirox 90 mg tab	4-Non-Preferred Drug	PA
deferasirox granules	5-Specialty	PA
deferiprone	5-Specialty	
FERRIPROX 100 MG/ML SOLUTION	5-Specialty	
FERRIPROX TWICE-A-DAY	5-Specialty	
trientine hcl	5-Specialty	QL (240 PER 30 DAYS)
PHOSPHATE BINDERS		
calcium acetate 667 mg tab	2-Generic	
calcium acetate (phos binder) (binder) 667 mg tab, binder) 667 mg cap)	2-Generic	
sevelamer carbonate (0.8 gm, 2.4 gm)	4-Non-Preferred Drug	
sevelamer carbonate 800 mg tab	2-Generic	
POTASSIUM BINDERS		
LOKELMA	3-Preferred Brands	
sodium polystyrene sulfonate	3-Preferred Brands	
sps	3-Preferred Brands	
VELTASSA	3-Preferred Brands	
VITAMINS		
prenatal vitamin oral tablet	3-Preferred Brands	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
constulose	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
enulose	2-Generic	
generlac	2-Generic	
lactulose (10 gm/15ml, 20 gm/30ml)	2-Generic	
lactulose encephalopathy	2-Generic	
LINZESS	3-Preferred Brands	QL (30 PER 30 DAYS)
lubiprostone	2-Generic	QL (60 PER 30 DAYS)
MOVANTIK	3-Preferred Brands	QL (30 PER 30 DAYS)
RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION, 150 MG TAB)	5-Specialty	
ANTI-DIARRHEAL AGENTS		
alosetron hcl	5-Specialty	QL (60 PER 30 DAYS)
diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)	2-Generic	
loperamide hcl 2 mg cap	2-Generic	
VIBERZI	5-Specialty	QL (60 PER 30 DAYS)
XERMELO	5-Specialty	PA, QL (84 PER 28 DAYS)
ANTISPASMODICS, GASTROINTESTINAL		
dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)	2-Generic	
glycopyrrolate (1 mg tab, 2 mg tab)	2-Generic	
methscopolamine bromide (2.5 mg tab, 5 mg tab)	2-Generic	
GASTROINTESTINAL AGENTS, OTHER		
GATTEX	5-Specialty	PA
gavilyte-c	1-Preferred Generics	
gavilyte-g	1-Preferred Generics	
gavilyte-n with flavor pack	1-Preferred Generics	
MYALEPT	5-Specialty	PA

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
na sulfate-k sulfate-mg sulf	4-Non-Preferred Drug	
OCALIVA	5-Specialty	PA
peg 3350-kcl-na bicarb-nacl	1-Preferred Generics	
peg-3350/electrolytes	1-Preferred Generics	
peg-3350/electrolytes/ascorbat	2-Generic	
peg-kcl-nacl-nasulf-na asc-c	2-Generic	
SUPREP BOWEL PREP KIT	4-Non-Preferred Drug	
ursodiol (250 mg tab, 300 mg cap, 500 mg tab)	2-Generic	
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
cimetidine	2-Generic	
cimetidine hcl	2-Generic	
famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)	2-Generic	
nizatidine (150 mg cap, 300 mg cap)	3-Preferred Brands	
PROTECTANTS		
misoprostol (100 mcg tab, 200 mcg tab)	2-Generic	
sucralfate 1 gm/10ml suspension	4-Non-Preferred Drug	
sucralfate 1 gm tab	2-Generic	
PROTON PUMP INHIBITORS		
esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
lansoprazole (15 mg cap dr, 30 mg cap dr)	3-Preferred Brands	QL (60 PER 30 DAYS)
omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)	1-Preferred Generics	QL (60 PER 30 DAYS)
pantoprazole sodium (20 mg tab dr, 40 mg tab dr)	1-Preferred Generics	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
rabeprazole sodium 20 mg tab dr	2-Generic	QL (30 PER 30 DAYS)
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
ARALAST NP	5-Specialty	PA
betaine	5-Specialty	
CREON	3-Preferred Brands	
cromolyn sodium 100 mg/5ml conc	1-Preferred Generics	
CYSTAGON	3-Preferred Brands	
CYSTARAN	5-Specialty	PA
ENDARI	5-Specialty	PA, QL (180 PER 30 DAYS)
GLASSIA	5-Specialty	PA
javygtor (100 mg tab, 100 mg packet, 500 mg packet)	5-Specialty	
miglustat	5-Specialty	QL (90 PER 30 DAYS)
nitisinone	5-Specialty	
NITYR	5-Specialty	
PANCREAZE	3-Preferred Brands	
PROLASTIN-C (1000 MG/20ML SOLUTION, 1000 MG RECON SOLN)	5-Specialty	PA
RAVICTI	5-Specialty	PA, QL (525 PER 30 DAYS)
sapropterin dihydrochloride (100 mg packet, 100 mg tab, 500 mg packet)	5-Specialty	
sodium phenylbutyrate 500 mg tab	5-Specialty	
ZEMAIRA	5-Specialty	PA
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin hydrobromide er	2-Generic	QL (30 PER 30 DAYS)
fesoterodine fumarate er	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
flavoxate hcl	2-Generic	
GEMTESA	3-Preferred Brands	
MYRBETRIQ (25 MG TAB ER, 50 MG TAB ER)	3-Preferred Brands	QL (30 PER 30 DAYS)
MYRBETRIQ 8 MG/ML SRER	3-Preferred Brands	QL (300 PER 30 DAYS)
oxybutynin chloride (5 mg/5ml syrup, 5 mg tab)	2-Generic	
oxybutynin chloride er	2-Generic	QL (60 PER 30 DAYS)
solifenacin succinate	2-Generic	QL (30 PER 30 DAYS)
tolterodine tartrate	2-Generic	QL (60 PER 30 DAYS)
tolterodine tartrate er	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
trospium chloride	2-Generic	QL (60 PER 30 DAYS)
trospium chloride er	2-Generic	QL (30 PER 30 DAYS)
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er	2-Generic	QL (30 PER 30 DAYS)
dutasteride 0.5 mg cap	2-Generic	QL (30 PER 30 DAYS)
dutasteride-tamsulosin hcl	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
finasteride 5 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
silodosin	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
tamsulosin hcl	2-Generic	QL (60 PER 30 DAYS)
GENITOURINARY AGENTS, OTHER		
bethanechol chloride	2-Generic	
ELMIRON	3-Preferred Brands	
penicillamine 250 mg tab	5-Specialty	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ACTHAR	5-Specialty	PA
betamethasone dipropionate aug 0.05 % lotion	2-Generic	
CORTROPHIN	5-Specialty	PA
dexamethasone (0.5 mg tab, 0.5 mg/5ml elixir, 0.5 mg/5ml solution, 0.75 mg tab, 1 mg tab, 1.5 mg tab, 2 mg tab, 4 mg tab, 6 mg tab)	2-Generic	
dexamethasone sod phosphate pf 10 mg/ml solution	4-Non-Preferred Drug	
dexamethasone sodium phosphate (4 mg/ml, 10 mg/ml, 20 mg/5ml, 100 mg/10ml, 120 mg/30ml)	4-Non-Preferred Drug	
fludrocortisone acetate	2-Generic	
KORLYM	5-Specialty	PA
methylprednisolone (4 mg tab thpk, 4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)	2-Generic	
methylprednisolone acetate (40 mg/ml, 80 mg/ml)	2-Generic	
methylprednisolone sodium succ	4-Non-Preferred Drug	
prednisolone 15 mg/5ml solution	2-Generic	
prednisolone sodium phosphate (6.7 (5 base) mg/5ml, 15 mg/5ml, 25 mg/5ml)	2-Generic	
prednisone (1 mg tab, 2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 50 mg tab)	1-Preferred Generics	
prednisone (5 mg/5ml solution, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 10 mg (48) tab thpk, 10 mg (21) tab thpk)	2-Generic	
PREDNISONE INTENSOL	4-Non-Preferred Drug	
SOLU-MEDROL 2 GM RECON SOLN	4-Non-Preferred Drug	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
desmopressin ace spray refrig	4-Non-Preferred Drug	
desmopressin acetate 4 mcg/ml solution	4-Non-Preferred Drug	
desmopressin acetate (0.1 mg tab, 0.2 mg tab)	2-Generic	
desmopressin acetate pf	4-Non-Preferred Drug	
desmopressin acetate spray	4-Non-Preferred Drug	
INCRELEX	5-Specialty	
NORDITROPIN FLEXPRO	5-Specialty	PA
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
oxandrolone 10 mg tab	2-Generic	PA, QL (60 PER 30 DAYS)
oxandrolone 2.5 mg tab	2-Generic	PA, QL (240 PER 30 DAYS)
ANDROGENS		
danazol	4-Non-Preferred Drug	
testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)	4-Non-Preferred Drug	PA, QL (300 PER 30 DAYS)
testosterone cypionate (100 mg/ml, 200 mg/ml)	2-Generic	PA - FOR NEW STARTS ONLY
testosterone enanthate	2-Generic	PA - FOR NEW STARTS ONLY
testosterone td gel pump 20.25 mg/act (1.62%)	4-Non-Preferred Drug	PA, QL (150 PER 30 DAYS)
ESTROGENS		
afirmelle	2-Generic	
altavera	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
alyacen 1/35	2-Generic	
alyacen 7/7/7	2-Generic	
amabelz	2-Generic	
apri	2-Generic	
aranelle	2-Generic	
aubra	2-Generic	
aubra eq	2-Generic	
aurovela 1.5/30	2-Generic	
aurovela 1/20	2-Generic	
aurovela fe 1.5/30	2-Generic	
aurovela fe 1/20	2-Generic	
aviane	2-Generic	
ayuna	2-Generic	
azurette	2-Generic	
balziva	2-Generic	
bekyree	2-Generic	
blisovi fe 1.5/30	2-Generic	
blisovi fe 1/20	2-Generic	
briellyn	2-Generic	
camrese lo	2-Generic	
caziant	2-Generic	
chateal	2-Generic	
chateal eq	2-Generic	
cryselle-28	2-Generic	
cyclafem 1/35	2-Generic	
cyclafem 7/7/7	2-Generic	
cyred	2-Generic	
cyred eq	2-Generic	
dasetta 1/35	2-Generic	
dasetta 7/7/7	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
delyla	2-Generic	
desogestrel-ethinyl estradiol	2-Generic	
dotti	2-Generic	
drospirenone-ethinyl estradiol	2-Generic	
elinest	2-Generic	
eluryng	2-Generic	
emoquette	2-Generic	
enpresse-28	2-Generic	
enskyce	2-Generic	
estarylla	2-Generic	
estradiol (0.025 mg/24hr patch tw, 0.025 mg/24hr patch wk, 0.0375 mg/24hr patch tw, 0.0375 mg/24hr patch wk, 0.05 mg/24hr patch tw, 0.05 mg/24hr patch wk, 0.06 mg/24hr patch wk, 0.075 mg/24hr patch tw, 0.075 mg/24hr patch wk, 0.1 mg/gm cream, 0.1 mg/24hr patch tw, 0.1 mg/24hr patch wk, 0.5 mg tab, 1 mg tab, 2 mg tab, 10 mcg tab)	2-Generic	
estradiol valerate (20 mg/ml, 40 mg/ml)	2-Generic	
estradiol-norethindrone acet	2-Generic	
ethynodiol diac-eth estradiol	2-Generic	
etonogestrel-ethinyl estradiol	2-Generic	
falmina	2-Generic	
femynor	2-Generic	
hailey 1.5/30	2-Generic	
hailey fe 1.5/30	2-Generic	
hailey fe 1/20	2-Generic	
haloette	2-Generic	
iclevia	2-Generic	
introvale	2-Generic	
isibloom	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
jasmiel	2-Generic	
jolessa	2-Generic	
juleber	2-Generic	
junel 1.5/30	2-Generic	
junel 1/20	2-Generic	
junel fe 1.5/30	2-Generic	
junel fe 1/20	2-Generic	
kalliga	2-Generic	
kariva	2-Generic	
kelnor 1/35	2-Generic	
kelnor 1/50	2-Generic	
kurvelo	2-Generic	
larin 1.5/30	2-Generic	
larin 1/20	2-Generic	
larin fe 1.5/30	2-Generic	
larin fe 1/20	2-Generic	
larissia	2-Generic	
leena	2-Generic	
lessina	2-Generic	
levonest	2-Generic	
levonorg-eth estrad triphasic	2-Generic	
levonorgest-eth estrad 91-day (0.1-0.02 & 0.01 mg tab, 0.15-0.03 mg tab)	2-Generic	
levonorgestrel-ethinyl estrad (0.1-20 tab, 0.15-30 tab)	2-Generic	
levora 0.15/30 (28)	2-Generic	
lillow	2-Generic	
lo-zumandimine	2-Generic	
loestrin 1.5/30 (21)	2-Generic	
loestrin 1/20 (21)	2-Generic	
loestrin fe 1.5/30	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
loestrin fe 1/20	2-Generic	
lojaimiess	2-Generic	
lopreeza	2-Generic	
loryna	2-Generic	
low-ogestrel	2-Generic	
lutera	2-Generic	
lyllana	2-Generic	
marlissa	2-Generic	
microgestin 1.5/30	2-Generic	
microgestin 1/20	2-Generic	
microgestin fe 1.5/30	2-Generic	
microgestin fe 1/20	2-Generic	
mili	2-Generic	
mimvey	2-Generic	
mono-linyah	2-Generic	
myzilra	2-Generic	
necon 0.5/35 (28)	2-Generic	
nikki	2-Generic	
norethin ace-eth estrad-fe (1-20 tab, 1.5-30 tab)	2-Generic	
norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab	2-Generic	
norethindron-ethinyl estrad-fe	2-Generic	
norethindrone acet-ethinyl est (1-20 tab, 1.5-30 tab)	2-Generic	
norgestim-eth estrad triphasic	2-Generic	
norgestimate-eth estradiol	2-Generic	
nortrel 0.5/35 (28)	2-Generic	
nortrel 1/35 (21)	2-Generic	
nortrel 1/35 (28)	2-Generic	
nortrel 7/7/7	2-Generic	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nylia 1/35	2-Generic	
nylia 7/7/7	2-Generic	
nymyo	2-Generic	
ocella	2-Generic	
orsythia	2-Generic	
philith	2-Generic	
pimtrea	2-Generic	
pirmella 1/35	2-Generic	
pirmella 7/7/7	2-Generic	
portia-28	2-Generic	
PREMARIN (0.3 MG TAB, 0.45 MG TAB, 0.625 MG/GM CREAM, 0.625 MG TAB, 0.9 MG TAB, 1.25 MG TAB)	3-Preferred Brands	
PREMPHASE	3-Preferred Brands	
PREMPRO	3-Preferred Brands	
reclipsen	2-Generic	
setlakin	2-Generic	
simliya	2-Generic	
sprintec 28	2-Generic	
sronyx	2-Generic	
syeda	2-Generic	
tarina fe 1/20	2-Generic	
tarina fe 1/20 eq	2-Generic	
tilia fe	2-Generic	
tri femynor	2-Generic	
tri-estarylla	2-Generic	
tri-legest fe	2-Generic	
tri-linyah	2-Generic	
tri-lo-estarylla	2-Generic	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tri-lo-marzia	2-Generic	
tri-lo-mili	2-Generic	
tri-lo-sprintec	2-Generic	
tri-mili	2-Generic	
tri-nymyo	2-Generic	
tri-previfem	2-Generic	
tri-sprintec	2-Generic	
tri-vylibra	2-Generic	
tri-vylibra lo	2-Generic	
trivora (28)	2-Generic	
velivet	2-Generic	
vestura	2-Generic	
vienva	2-Generic	
viorele	2-Generic	
volnea	2-Generic	
vyfemla	2-Generic	
vylibra	2-Generic	
wera	2-Generic	
wymzya fe	2-Generic	
xulane	2-Generic	
yuvafem	2-Generic	
zafemy	2-Generic	
zarah	2-Generic	
zovia 1/35 (28)	2-Generic	
zovia 1/35e (28)	2-Generic	
zumandimine	2-Generic	
PROGESTINS		
camila	2-Generic	
deblitane	2-Generic	
DEPO-SUBQ PROVERA 104	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
errin	2-Generic	
heather	2-Generic	
incassia	2-Generic	
jencycla	2-Generic	
jolivette	2-Generic	
lyleq	2-Generic	
lyza	2-Generic	
medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml suspension, 150 mg/ml susp prsyr)	2-Generic	
megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension, 800 mg/20ml suspension)	2-Generic	
nora-be	2-Generic	
norethindrone 0.35 mg tab	2-Generic	
norethindrone acetate 5 mg tab	2-Generic	
norlyda	2-Generic	
norlyroc	2-Generic	
progesterone (100 mg cap, 200 mg cap)	2-Generic	
sharobel	2-Generic	
tulana	2-Generic	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
DUAVEE	3-Preferred Brands	
raloxifene hcl	2-Generic	QL (30 PER 30 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
euthyrox	1-Preferred Generics	
levo-t	1-Preferred Generics	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
levothyroxine sodium (25 mcg tab, 50 mcg tab, 75 mcg tab, 88 mcg tab, 100 mcg tab, 112 mcg tab, 125 mcg tab, 137 mcg tab, 150 mcg tab, 175 mcg tab, 200 mcg tab, 300 mcg tab)	1-Preferred Generics	
levoxyl	1-Preferred Generics	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	2-Generic	
SYNTHROID	3-Preferred Brands	
unithroid	1-Preferred Generics	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN	5-Specialty	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
cabergoline	2-Generic	
ELIGARD	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FIRMAGON	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (240 MG DOSE)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
leuprolide acetate 1 mg/0.2ml kit	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (1-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (3-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (4-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (6-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (1-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (3-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
octreotide acetate (50 mcg/ml solution, 50 mcg/ml soln prsyr, 100 mcg/ml soln prsyr, 100 mcg/ml solution, 200 mcg/ml solution, 500 mcg/ml solution, 500 mcg/ml soln prsyr, 1000 mcg/ml solution)	4-Non-Preferred Drug	
ORGOVYX	5-Specialty	PA - FOR NEW STARTS ONLY
SIGNIFOR	5-Specialty	
SOMATULINE DEPOT	5-Specialty	
SOMAVERT	5-Specialty	
SYNAREL	5-Specialty	
TRELSTAR MIXJECT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole (5 mg tab, 10 mg tab)	1-Preferred Generics	
propylthiouracil 50 mg tab	2-Generic	
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
CINRYZE	5-Specialty	PA
icatibant acetate	5-Specialty	PA, QL (27 PER 30 DAYS)
sajazir	5-Specialty	PA, QL (27 PER 30 DAYS)
IMMUNOGLOBULINS		
ATGAM	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BIVIGAM	5-Specialty	PA
FLEBOGAMMA DIF	5-Specialty	PA
GAMMAGARD	5-Specialty	PA
GAMMAGARD S/D LESS IGA	5-Specialty	PA
GAMMAKED	5-Specialty	PA
GAMMAPLEX	5-Specialty	PA
GAMUNEX-C	5-Specialty	PA

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OCTAGAM	5-Specialty	PA
PANZYGA	5-Specialty	PA
PRIVIGEN	5-Specialty	PA
THYMOGLOBULIN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST	5-Specialty	
BENLYSTA (120 MG SOLN, 400 MG SOLN)	5-Specialty	PA
BENLYSTA (200 MG/ML SOLN PRSYR, 200 MG/ML SOLN A-INJ)	5-Specialty	PA, QL (8 PER 28 DAYS)
DUPIXENT (100 MG/0.67ML SOLN PRSYR, 200 MG/1.14ML SOLN PEN, 200 MG/1.14ML SOLN PRSYR, 300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	5-Specialty	PA
OTEZLA (10 20 30 MG TAB THPK, 30 MG TAB)	5-Specialty	PA
RIDAURA	5-Specialty	
SIMULECT 20 MG RECON SOLN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
SKYRIZI (150 MG/ML SOLN PRSYR, 180 MG/1.2ML SOLN CART, 360 MG/2.4ML SOLN CART, 600 MG/10ML SOLUTION)	5-Specialty	PA
SKYRIZI (150 MG DOSE)	5-Specialty	PA
SKYRIZI PEN	5-Specialty	PA
TALTZ (80 MG/ML SOLN A-INJ, 80 MG/ML SOLN PRSYR)	5-Specialty	PA
XELJANZ (1 MG/ML SOLUTION, 5 MG TAB, 10 MG TAB)	5-Specialty	PA
XELJANZ XR	5-Specialty	PA
XOLAIR (75 MG/0.5ML SOLN PRSYR, 150 MG/ML SOLN PRSYR, 150 MG RECON SOLN)	5-Specialty	PA
IMMUNOSTIMULANTS		
ACTIMMUNE	5-Specialty	PA

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INTRON A (6000000 UNIT/ML SOLUTION, 10000000 UNIT/ML SOLUTION, 10000000 UNIT RECON SOLN, 18000000 UNIT RECON SOLN, 50000000 UNIT RECON SOLN)	5-Specialty	
PEGASYS (180 MCG/0.5ML SOLN PRSYR, 180 MCG/ML SOLUTION)	5-Specialty	
IMMUNOSUPPRESSANTS		
ASTAGRAF XL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
AVSOLA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
azathioprine 50 mg tab	2-Generic	PA - TO CONFIRM PART D COVERAGE
AZATHIOPRINE SODIUM	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
cyclosporine (25 mg cap, 50 mg/ml solution, 100 mg cap)	2-Generic	PA - TO CONFIRM PART D COVERAGE
cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)	2-Generic	PA - TO CONFIRM PART D COVERAGE
ENBREL (25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION, 25 MG RECON SOLN, 50 MG/ML SOLN PRSYR)	5-Specialty	PA
ENBREL MINI	5-Specialty	PA
ENBREL SURECLICK	5-Specialty	PA
ENVARSUS XR	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
everolimus (0.5 mg tab, 0.75 mg tab, 1 mg tab)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
everolimus 0.25 mg tab	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
gengraf (25 mg cap, 100 mg/ml solution, 100 mg cap)	2-Generic	PA - TO CONFIRM PART D COVERAGE
HUMIRA	5-Specialty	PA
HUMIRA PEDIATRIC CROHNS START	5-Specialty	PA
HUMIRA PEN	5-Specialty	PA
HUMIRA PEN-CD/UC/HS STARTER	5-Specialty	PA

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMIRA PEN-PEDIATRIC UC START	5-Specialty	PA
HUMIRA PEN-PS/UV/ADOL HS START	5-Specialty	PA
HUMIRA PEN-PSOR/UVEIT STARTER	5-Specialty	PA
INFLECTRA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
leflunomide 10 mg tab	2-Generic	QL (30 PER 30 DAYS)
leflunomide 20 mg tab	2-Generic	QL (150 PER 30 DAYS)
methotrexate 2.5 mg tab	2-Generic	
methotrexate sodium 1 gm recon soln	4-Non-Preferred Drug	
methotrexate sodium (2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution, 1000 mg/40ml solution)	2-Generic	
methotrexate sodium (pf)	2-Generic	
mycophenolate mofetil 200 mg/ml recon susp	5-Specialty	PA - TO CONFIRM PART D COVERAGE
mycophenolate mofetil (250 mg cap, 500 mg recon soln, 500 mg tab)	2-Generic	PA - TO CONFIRM PART D COVERAGE
mycophenolate mofetil hcl	2-Generic	PA - TO CONFIRM PART D COVERAGE
mycophenolate sodium	2-Generic	PA - TO CONFIRM PART D COVERAGE
NULOJIX	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OTREXUP	4-Non-Preferred Drug	
PROGRAF (0.2 MG, 1 MG)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
RASUVO	4-Non-Preferred Drug	
RENFLEXIS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
REZUROCK	5-Specialty	PA
RINVOQ	5-Specialty	PA
SANDIMMUNE 100 MG/ML SOLUTION	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
sirolimus 1 mg/ml solution	5-Specialty	PA - TO CONFIRM PART D COVERAGE
sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)	2-Generic	PA - TO CONFIRM PART D COVERAGE
temsirolimus	5-Specialty	
TREXALL	4-Non-Preferred Drug	
XATMEP	4-Non-Preferred Drug	
VACCINES		
ACTHIB	3-Preferred Brands	
ADACEL	1-Preferred Generics	
BCG VACCINE	3-Preferred Brands	
BEXSERO	3-Preferred Brands	
BOOSTRIX (5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR, 5-2.5-18.5 LF-MCG/0.5 SUSPENSION)	1-Preferred Generics	
DAPTACEL	1-Preferred Generics	
DIPHTHERIA-TETANUS TOXOIDS DT	1-Preferred Generics	
ENGERIX-B (10 MCG/0.5ML SUSP PRSYR, 20 MCG/ML SUSP PRSYR, 20 MCG/ML SUSPENSION)	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
GARDASIL 9 (9SUSPPRSYR, 9SUSPENSION)	1-Preferred Generics	
HAVRIX	1-Preferred Generics	
HIBERIX	3-Preferred Brands	
IMOVAX RABIES	3-Preferred Brands	
INFANRIX	1-Preferred Generics	
IPOL	3-Preferred Brands	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IXIARO	3-Preferred Brands	
JYNNEOS	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
KINRIX	1-Preferred Generics	
M-M-R II	1-Preferred Generics	
MENACTRA	3-Preferred Brands	
MENQUADFI	3-Preferred Brands	
MENVEO (RECONSOLN, SOLUTION)	3-Preferred Brands	
PEDIARIX	3-Preferred Brands	
PEDVAX HIB	3-Preferred Brands	
PENTACEL	1-Preferred Generics	
PREHEVBRIO	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
PRIORIX	1-Preferred Generics	
PROQUAD	1-Preferred Generics	
QUADRACEL (0.5MLSUSPPRSYR, SUSPENSION)	1-Preferred Generics	
RABAVERT	3-Preferred Brands	
RECOMBIVAX HB (5 MCG/0.5ML SUSP PRSYR, 5 MCG/0.5ML SUSPENSION, 10 MCG/ML SUSP PRSYR, 10 MCG/ML SUSPENSION, 40 MCG/ML SUSPENSION)	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
ROTARIX RECON SUSP	3-Preferred Brands	
ROTATEQ	3-Preferred Brands	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SHINGRIX	1-Preferred Generics	
TDVAX	1-Preferred Generics	
TENIVAC	1-Preferred Generics	
TICOVAC	3-Preferred Brands	
TRUMENBA	3-Preferred Brands	
TWINRIX	1-Preferred Generics	
TYPHIM VI (25 MCG/0.5ML SOLN PRSYR, 25 MCG/0.5ML SOLUTION)	3-Preferred Brands	
VAQTA	1-Preferred Generics	
VARIVAX	3-Preferred Brands	
YF-VAX	3-Preferred Brands	
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
balsalazide disodium	2-Generic	
mesalamine (4 gm enema, 1000 mg suppos)	4-Non-Preferred Drug	
mesalamine (1.2 gm tab dr, 400 mg cap dr, 800 mg tab dr)	2-Generic	
mesalamine er 0.375 gm cap er 24h	2-Generic	
mesalamine-cleanser	4-Non-Preferred Drug	
sulfasalazine (500 mg tab dr, 500 mg tab)	2-Generic	
GLUCOCORTICOIDS		
budesonide 3 mg cp dr part	4-Non-Preferred Drug	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
budesonide er	5-Specialty	
hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab, 100 mg/60ml enema)	2-Generic	
METABOLIC BONE DISEASE AGENTS		
alendronate sodium 70 mg/75ml solution	1-Preferred Generics	
alendronate sodium (35 mg tab, 70 mg tab)	1-Preferred Generics	QL (4 PER 28 DAYS)
alendronate sodium 10 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
calcitonin (salmon) 200 unit/act solution	2-Generic	
calcitriol (0.25 mcg cap, 0.5 mcg cap, 1 mcg/ml solution)	2-Generic	
cinacalcet hcl 30 mg tab	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
cinacalcet hcl 60 mg tab	5-Specialty	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
cinacalcet hcl 90 mg tab	5-Specialty	PA - TO CONFIRM PART D COVERAGE, QL (120 PER 30 DAYS)
doxercalciferol (0.5 mcg cap, 1 mcg cap, 2.5 mcg cap)	2-Generic	
FORTEO	5-Specialty	PA
ibandronate sodium 150 mg tab	2-Generic	QL (1 PER 30 DAYS)
NATPARA	5-Specialty	PA
paricalcitol (1 mcg cap, 2 mcg cap, 4 mcg cap)	4-Non-Preferred Drug	
PROLIA	4-Non-Preferred Drug	
RAYALDEE	5-Specialty	
risedronate sodium (5 mg tab, 30 mg tab, 35 mg tab dr, 35 mg tab, 150 mg tab)	4-Non-Preferred Drug	
TERIPARATIDE (RECOMBINANT)	5-Specialty	PA
XGEVA	5-Specialty	PA

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL PADS	2-Generic	
GAUZE PADS & DRESSINGS - PADS 2 X 2	2-Generic	
INSULIN PEN NEEDLE (Novo/BD/Ultimed/Owen/Trividia)	2-Generic	
INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
INSULIN SYRINGE (DISP) U-100 1 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
NEEDLES, INSULIN DISP., SAFETY	2-Generic	
sterile water for irrigation	4-Non-Preferred Drug	
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
ak-poly-bac	2-Generic	
ATROPINE SULFATE 1 % SOLUTION	2-Generic	
bacitra-neomycin-polymyxin-hc	2-Generic	
bacitracin-polymyxin b	2-Generic	
BLEPHAMIDE S.O.P.	3-Preferred Brands	
COMBIGAN	3-Preferred Brands	
cyclopentolate hcl	2-Generic	
dorzolamide hcl-timolol mal	2-Generic	
dorzolamide hcl-timolol mal pf	2-Generic	
ISOPTO ATROPINE	2-Generic	
neo-polycin	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
neo-polycin hc	2-Generic	
neomycin-bacitracin zn-polymyx	2-Generic	
neomycin-polymyxin-dexameth (3.5-10000-0.1suspension, 3.5-10000-0.1ointment)	2-Generic	
neomycin-polymyxin-gramicidin	2-Generic	
neomycin-polymyxin-hc 3.5-10000-1 suspension	2-Generic	
OXERVATE	5-Specialty	PA
polycin	2-Generic	
proparacaine hcl 0.5 % solution	2-Generic	
RESTASIS	3-Preferred Brands	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	3-Preferred Brands	QL (5.5 PER 28 DAYS)
sulfacetamide-prednisolone	2-Generic	
TOBRADEX 0.3-0.1 % OINTMENT	3-Preferred Brands	
tobramycin-dexamethasone	4-Non-Preferred Drug	
XIIDRA	3-Preferred Brands	QL (60 PER 30 DAYS)
ZYLET	4-Non-Preferred Drug	
OPHTHALMIC ANTI-ALLERGY AGENTS		
ALOCRIL	3-Preferred Brands	
ALOMIDE	3-Preferred Brands	
azelastine hcl 0.05 % solution	2-Generic	
bepotastine besilate	4-Non-Preferred Drug	
cromolyn sodium 4 % solution	1-Preferred Generics	
epinastine hcl	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
olopatadine hcl (0.1 %, 0.2 %)	2-Generic	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE	3-Preferred Brands	
bacitracin 500 unit/gm ointment	2-Generic	
erythromycin 5 mg/gm ointment	2-Generic	
gatifloxacin 0.5 % solution	2-Generic	
gentak	2-Generic	
gentamicin sulfate 0.3 % solution	2-Generic	
levofloxacin 0.5 % solution	2-Generic	
moxifloxacin hcl 0.5 % solution	2-Generic	
moxifloxacin hcl (2x day)	4-Non-Preferred Drug	
NATACYN	3-Preferred Brands	
ofloxacin 0.3 % solution	2-Generic	
polymyxin b-trimethoprim	1-Preferred Generics	
sulfacetamide sodium 10 % ointment	1-Preferred Generics	
sulfacetamide sodium 10 % solution	2-Generic	
tobramycin 0.3 % solution	1-Preferred Generics	
ZIRGAN	3-Preferred Brands	
OPHTHALMIC ANTI-INFLAMMATORIES		
bromfenac sodium (once-daily)	4-Non-Preferred Drug	
dexamethasone sodium phosphate 0.1 % solution	2-Generic	
diclofenac sodium 0.1 % solution	2-Generic	
difluprednate	3-Preferred Brands	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FLAREX	3-Preferred Brands	
fluorometholone	2-Generic	
flurbiprofen sodium	2-Generic	
FML	3-Preferred Brands	
ILEVRO	3-Preferred Brands	
ketorolac tromethamine (0.4 %, 0.5 %)	2-Generic	
LOTEMAX 0.5 % OINTMENT	4-Non-Preferred Drug	
loteprednol etabonate (0.5 % gel, 0.5 % suspension)	4-Non-Preferred Drug	
prednisolone acetate 1 % suspension	2-Generic	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	2-Generic	
PROLENSA	4-Non-Preferred Drug	
OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS		
betaxolol hcl 0.5 % solution	2-Generic	
carteolol hcl	2-Generic	
levobunolol hcl	2-Generic	
timolol maleate (0.25 % gel f soln, 0.5 % gel f soln, 0.5 % (daily) solution)	2-Generic	
timolol maleate (0.25 %, 0.5 %)	1-Preferred Generics	
OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER		
acetazolamide er	2-Generic	
ALPHAGAN P 0.1 % SOLUTION	3-Preferred Brands	
apraclonidine hcl	2-Generic	
AZOPT	3-Preferred Brands	
brimonidine tartrate (0.15 %, 0.2 %)	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
dorzolamide hcl	2-Generic	
methazolamide (25 mg tab, 50 mg tab)	4-Non-Preferred Drug	
pilocarpine hcl (1 %, 2 %, 4 %)	2-Generic	
RHOPRESSA	3-Preferred Brands	
SIMBRINZA	3-Preferred Brands	
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
bimatoprost 0.03% ophth solution	2-Generic	
latanoprost 0.005 % solution	1-Preferred Generics	
LUMIGAN	3-Preferred Brands	
travoprost (bak free)	2-Generic	
OTIC AGENTS		
CIPRODEX	3-Preferred Brands	
ciprofloxacin hcl 0.2 % solution	2-Generic	
flac	2-Generic	
fluocinolone acetonide 0.01 % oil	2-Generic	
hydrocortisone-acetic acid	2-Generic	
neomycin-polymyxin-hc (1 %, 3.5-10000-1)	2-Generic	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ARNUITY ELLIPTA	3-Preferred Brands	QL (30 PER 30 DAYS)
budesonide (0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FLOVENT DISKUS	3-Preferred Brands	QL (80 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FLOVENT HFA (110 MCG/ACT, 220 MCG/ACT)	3-Preferred Brands	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG/ACT AEROSOL	3-Preferred Brands	QL (22 PER 30 DAYS)
flunisolide	2-Generic	QL (50 PER 30 DAYS)
fluticasone propionate 50 mcg/act suspension	1-Preferred Generics	QL (16 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA (110 MCG/ACT, 220 MCG/ACT)	3-Preferred Brands	QL (24 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA 44 MCG/ACT AEROSOL	3-Preferred Brands	QL (22 PER 30 DAYS)
mometasone furoate 50 mcg/act suspension	4-Non-Preferred Drug	QL (34 PER 30 DAYS)
PULMICORT FLEXHALER	3-Preferred Brands	QL (2 PER 30 DAYS)
ANTIHISTAMINES		
azelastine hcl (0.1 %, 0.15 %, 137 mcg/spray)	2-Generic	
cetirizine hcl (1 mg/ml, 5 mg/5ml)	2-Generic	
cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)	2-Generic	
desloratadine 5 mg tab	2-Generic	
diphenhydramine hcl 50 mg/ml solution	2-Generic	
hydroxyzine hcl 10 mg/5ml syrup	3-Preferred Brands	
hydroxyzine hcl (10 mg tab, 25 mg tab, 50 mg tab)	2-Generic	
levocetirizine dihydrochloride 2.5 mg/5ml solution	4-Non-Preferred Drug	
levocetirizine dihydrochloride 5 mg tab	1-Preferred Generics	
olopatadine hcl 0.6 % solution	2-Generic	
promethazine hcl (6.25 mg/5ml solution, 6.25 mg/5ml syrup)	1-Preferred Generics	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTILEUKOTRIENES		
montelukast sodium (4 mg chew tab, 4 mg packet, 5 mg chew tab)	2-Generic	QL (30 PER 30 DAYS)
montelukast sodium 10 mg tab	1-Preferred Generics	QL (30 PER 30 DAYS)
zafirlukast 10 mg tab	2-Generic	QL (120 PER 30 DAYS)
zafirlukast 20 mg tab	2-Generic	QL (60 PER 30 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	4-Non-Preferred Drug	QL (25.8 PER 30 DAYS)
INCRUSE ELLIPTA	3-Preferred Brands	QL (30 PER 30 DAYS)
ipratropium bromide (0.03 %, 0.06 %)	2-Generic	
ipratropium bromide 0.02 % solution	2-Generic	PA - TO CONFIRM PART D COVERAGE
SPIRIVA HANDIHALER	3-Preferred Brands	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
YUPELRI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BRONCHODILATORS, SYMPATHOMIMETIC		
albuterol sulfate (0.63 mg/3ml soln, 1.25 mg/3ml soln, 2.5 mg/0.5ml soln, (2.5 mg/3ml) 0.083% soln, (5 mg/ml) 0.5% soln)	2-Generic	PA - TO CONFIRM PART D COVERAGE
albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab)	2-Generic	
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)	1-Preferred Generics	QL (17 PER 30 DAYS)
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)	1-Preferred Generics	QL (13.4 PER 30 DAYS)
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)	1-Preferred Generics	QL (36 PER 30 DAYS)
arformoterol tartrate	5-Specialty	PA - TO CONFIRM PART D COVERAGE
epinephrine (0.15 mg/0.15ml soln, 0.15 mg/0.3ml soln, 0.3 mg/0.3ml soln)	2-Generic	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
formoterol fumarate	5-Specialty	PA - TO CONFIRM PART D COVERAGE
levalbuterol hcl (0.31 mg/3ml soln, 0.63 mg/3ml soln, 1.25 mg/3ml soln, 1.25 mg/0.5ml soln)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
levalbuterol tartrate	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
SEREVENT DISKUS	3-Preferred Brands	QL (60 PER 30 DAYS)
STRIVERDI RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
terbutaline sulfate (2.5 mg tab, 5 mg tab)	2-Generic	
CYSTIC FIBROSIS AGENTS		
CAYSTON	5-Specialty	
KALYDECO (25 MG, 50 MG)	5-Specialty	PA, QL (56 PER 28 DAYS)
KALYDECO (75 MG PACKET, 150 MG TAB)	5-Specialty	PA, QL (60 PER 30 DAYS)
ORKAMBI (75-94 MG, 100-125 MG, 150-188 MG)	5-Specialty	PA, QL (56 PER 28 DAYS)
ORKAMBI 100-125 MG TAB	5-Specialty	PA, QL (112 PER 28 DAYS)
ORKAMBI 200-125 MG TAB	5-Specialty	PA, QL (120 PER 30 DAYS)
PULMOZYME	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TOBI PODHALER	5-Specialty	QL (240 PER 30 DAYS)
tobramycin 300 mg/5ml nebu soln	5-Specialty	PA - TO CONFIRM PART D COVERAGE, QL (300 PER 30 DAYS)
MAST CELL STABILIZERS		
cromolyn sodium 20 mg/2ml nebu soln	1-Preferred Generics	PA - TO CONFIRM PART D COVERAGE
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
DALIRESP	4-Non-Preferred Drug	
elixophyllin	2-Generic	
roflumilast	4-Non-Preferred Drug	

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
THEO-24	4-Non-Preferred Drug	
theophylline (80 mg/15ml solution, 80 mg/15ml elixir)	2-Generic	
theophylline er (er 300 mg tab er 12h, er 400 mg tab er 24h, er 450 mg tab er 12h, er 600 mg tab er 24h)	2-Generic	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	5-Specialty	PA, QL (90 PER 30 DAYS)
alyq	5-Specialty	PA, QL (60 PER 30 DAYS)
ambrisentan	5-Specialty	PA, QL (30 PER 30 DAYS)
bosentan	5-Specialty	PA, QL (60 PER 30 DAYS)
OPSUMIT	5-Specialty	PA, QL (30 PER 30 DAYS)
sildenafil citrate 20 mg tab	2-Generic	PA, QL (90 PER 30 DAYS)
tadalafil (pah)	5-Specialty	PA, QL (60 PER 30 DAYS)
TRACLEER 32 MG TAB SOL	5-Specialty	PA, QL (120 PER 30 DAYS)
UPTRAVI (200 & 800 MCG TAB THPK, 200 MCG TAB, 400 MCG TAB, 600 MCG TAB, 800 MCG TAB, 1000 MCG TAB, 1200 MCG TAB, 1400 MCG TAB, 1600 MCG TAB)	5-Specialty	PA
PULMONARY FIBROSIS AGENTS		
OFEV	5-Specialty	PA, QL (60 PER 30 DAYS)
pirfenidone (267 mg tab, 267 mg cap)	5-Specialty	PA, QL (270 PER 30 DAYS)
pirfenidone (534 mg tab, 801 mg tab)	5-Specialty	PA, QL (90 PER 30 DAYS)
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine (10 %, 20 %)	2-Generic	PA - TO CONFIRM PART D COVERAGE
ADVAIR DISKUS	2-Generic	QL (60 PER 30 DAYS)
ADVAIR HFA	3-Preferred Brands	QL (12 PER 30 DAYS)
ANORO ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)
BEVESPI AEROSPHERE	3-Preferred Brands	QL (10.7 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BREO ELLIPTA 100-25 MCG/ACT AER POW BA	3-Preferred Brands	QL (60 PER 30 DAYS)
BREO ELLIPTA 200-25 MCG/ACT AER POW BA	3-Preferred Brands	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE	3-Preferred Brands	QL (10.7 PER 30 DAYS)
COMBIVENT RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
FASENRA	5-Specialty	PA
FASENRA PEN	5-Specialty	PA
FLUTICASONE FUROATE-VILANTEROL	3-Preferred Brands	QL (60 PER 30 DAYS)
ipratropium-albuterol	2-Generic	PA - TO CONFIRM PART D COVERAGE
NUCALA (40 MG/0.4ML SOLN PRSYR, 100 MG RECON SOLN, 100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR)	5-Specialty	PA
SYMBICORT	3-Preferred Brands	QL (10.2 PER 30 DAYS)
TRELEGY ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)
SKELETAL MUSCLE RELAXANTS		
BOTOX	4-Non-Preferred Drug	PA
carisoprodol 350 mg tab	2-Generic	PA, QL (120 PER 30 DAYS)
cyclobenzaprine hcl 10 mg tab	2-Generic	PA, QL (90 PER 30 DAYS)
cyclobenzaprine hcl 5 mg tab	2-Generic	PA, QL (180 PER 30 DAYS)
methocarbamol (500 mg tab, 750 mg tab)	2-Generic	PA
vanadom	2-Generic	PA, QL (120 PER 30 DAYS)
XEOMIN	4-Non-Preferred Drug	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SLEEP DISORDER AGENTS		
SLEEP PROMOTING AGENTS		
doxepin hcl (3 mg tab, 6 mg tab)	2-Generic	QL (30 PER 30 DAYS)
eszopiclone	2-Generic	PA, QL (30 PER 30 DAYS)
HETLIOZ	5-Specialty	PA, QL (30 PER 30 DAYS)
HETLIOZ LQ	5-Specialty	PA, QL (158 PER 30 DAYS)
ramelteon	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
tasimelteon	5-Specialty	PA, QL (30 PER 30 DAYS)
temazepam (15 mg cap, 30 mg cap)	2-Generic	QL (30 PER 30 DAYS)
zaleplon	2-Generic	PA, QL (30 PER 30 DAYS)
zolpidem tartrate 10 mg tab	2-Generic	PA, QL (30 PER 30 DAYS)
zolpidem tartrate 5 mg tab	2-Generic	QL (30 PER 30 DAYS)
zolpidem tartrate er	2-Generic	PA, QL (30 PER 30 DAYS)
WAKEFULNESS PROMOTING AGENTS		
armodafinil	3-Preferred Brands	PA, QL (30 PER 30 DAYS)
modafinil 100 mg tab	4-Non-Preferred Drug	PA, QL (30 PER 30 DAYS)
modafinil 200 mg tab	4-Non-Preferred Drug	PA, QL (60 PER 30 DAYS)
XYREM	5-Specialty	PA, QL (540 PER 30 DAYS)
XYWAV	5-Specialty	PA, QL (540 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page 1.

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H9207_HPM-540RX-4246-013-014_C

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