2023 Formulary List of Covered Drugs

Health Partners Medicare Special (HMO SNP)

Health Partners Medicare

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

Health Partners Medicare Special (HMO SNP) 2023 Formulary

(List of Covered Drugs)

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

Formulary ID 00023467, Version 14

This formulary was updated on 8/1/2023. 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 $0 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 Special.

This document includes a list of the drugs (formulary) for our plan, which is current as of 8/1/2023. 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 Special 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 Special Formulary?"
- Drugs removed from the market. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- Other changes. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary; or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or 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 Special 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 8/1/2023. To get updated information about the drugs covered by Health Partners Medicare Special, 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, Other." If you know what your drug is used for, look for the category name in the list that begins on page 101. 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 108. 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 Special covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

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

- Quantity Limits: For certain drugs, Health Partners Medicare Special limits 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 Special requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 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 Special 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 Special. 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 Special 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 Special prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Health Partners Medicare Special, 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 Special's Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Health Partners Medicare Special. If you have trouble finding your drug in the list, turn to the Index that begins on page 108.

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 Special has any special requirements for coverage of your drug.

LEGEND

TIER	NAME
1	Covered

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.
NDS	Non-Extended Day Supply	You cannot obtain an extended day supply for this type of drug. We will cover up to a 30-day supply per prescription only.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
butalbital-aspirin-caffeine 50-325-40 mg cap	1-Covered	PA, QL (180 PER 30 DAYS)
cataflam	1-Covered	
celecoxib	1-Covered	QL (60 PER 30 DAYS)
diclofenac potassium 50 mg tab	1-Covered	
diclofenac sodium 1 % gel	1-Covered	QL (1000 PER 30 DAYS)
diclofenac sodium 1.5 % solution	1-Covered	QL (300 PER 28 DAYS)
diclofenac sodium (25 mg tab dr, 50 mg tab dr, 75 mg tab dr)	1-Covered	
diclofenac sodium er	1-Covered	
diclofenac-misoprostol	1-Covered	
diflunisal	1-Covered	
ec-naproxen	1-Covered	
etodolac (200 mg cap, 300 mg cap, 400 mg tab, 500 mg tab)	1-Covered	
etodolac er	1-Covered	
flurbiprofen	1-Covered	
ibu	1-Covered	
ibuprofen (100 mg/5ml suspension, 400 mg tab, 600 mg tab, 800 mg tab)	1-Covered	
indomethacin (25 mg cap, 50 mg cap)	1-Covered	PA
indomethacin er	1-Covered	PA
meloxicam (7.5 mg tab, 15 mg tab)	1-Covered	
nabumetone	1-Covered	
naproxen (250 mg tab, 375 mg tab dr, 375 mg tab, 500 mg tab, 500 mg tab dr)	1-Covered	
naproxen sodium	1-Covered	
oxaprozin	1-Covered	

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
piroxicam (10 mg cap, 20 mg cap)	1-Covered	
relafen	1-Covered	
sulindac	1-Covered	
OPIOID ANALGESICS, LONG-ACTING		
buprenorphine	1-Covered	QL (4 PER 28 DAYS)
fentanyl	1-Covered	QL (10 PER 30 DAYS)
methadone hcl 10 mg/5ml solution	1-Covered	QL (1800 PER 30 DAYS)
methadone hcl 5 mg/5ml solution	1-Covered	QL (3600 PER 30 DAYS)
methadone hcl 10 mg tab	1-Covered	QL (240 PER 30 DAYS)
methadone hcl 5 mg tab	1-Covered	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)	1-Covered	QL (90 PER 30 DAYS)
tramadol hcl er (er 100 mg tab er, er 200 mg tab er, er 300 mg tab er)	1-Covered	QL (30 PER 30 DAYS)
tramadol hcl er (biphasic)	1-Covered	QL (30 PER 30 DAYS)
XTAMPZA ER	1-Covered	QL (60 PER 30 DAYS)
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-codeine 120-12 mg/5ml solution	1-Covered	QL (2700 PER 30 DAYS)
acetaminophen-codeine 300-15 mg tab	1-Covered	QL (390 PER 30 DAYS)
acetaminophen-codeine 300-30 mg tab	1-Covered	QL (360 PER 30 DAYS)
acetaminophen-codeine 300-60 mg tab	1-Covered	QL (180 PER 30 DAYS)
butalbital-apap-caff-cod 50-325-40-30 mg cap	1-Covered	PA, QL (180 PER 30 DAYS)
butorphanol tartrate 10 mg/ml solution	1-Covered	QL (5 PER 30 DAYS)
endocet 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
endocet 2.5-325 mg tab	1-Covered	QL (360 PER 30 DAYS)
endocet 5-325 mg tab	1-Covered	QL (360 PER 30 DAYS)
endocet 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
fentanyl citrate (400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)

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
fentanyl citrate 200 mcg loz handle	1-Covered	PA, QL (120 PER 30 DAYS)
hydrocodone-acetaminophen (2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml)	1-Covered	QL (2700 PER 30 DAYS)
hydrocodone-acetaminophen 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
hydrocodone-acetaminophen 5-325 mg tab	1-Covered	QL (360 PER 30 DAYS)
hydrocodone-acetaminophen 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
hydrocodone-ibuprofen (5-200 mg tab, 10-200 mg tab)	1-Covered	QL (150 PER 30 DAYS)
hydrocodone-ibuprofen 7.5-200 mg tab	1-Covered	QL (150 PER 30 DAYS)
hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)	1-Covered	QL (180 PER 30 DAYS)
morphine sulfate (10 mg/5ml, 20 mg/5ml)	1-Covered	QL (900 PER 30 DAYS)
morphine sulfate (15 mg tab, 30 mg tab)	1-Covered	QL (180 PER 30 DAYS)
morphine sulfate (concentrate)	1-Covered	QL (180 PER 30 DAYS)
oxycodone hcl 5 mg/5ml solution	1-Covered	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, 100 mg/5ml conc)	1-Covered	QL (180 PER 30 DAYS)
oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)	1-Covered	QL (360 PER 30 DAYS)
oxycodone-acetaminophen 10-325 mg tab	1-Covered	QL (180 PER 30 DAYS)
oxycodone-acetaminophen 7.5-325 mg tab	1-Covered	QL (240 PER 30 DAYS)
oxymorphone hcl	1-Covered	QL (180 PER 30 DAYS)
tramadol hcl 50 mg tab	1-Covered	QL (240 PER 30 DAYS)
tramadol-acetaminophen	1-Covered	QL (240 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine 5 % patch	1-Covered	PA, QL (90 PER 30 DAYS)
lidocaine 5 % ointment	1-Covered	QL (50 PER 30 DAYS)
lidocaine viscous hcl	1-Covered	
lidocaine-prilocaine	1-Covered	QL (30 PER 30 DAYS)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium	1-Covered	
disulfiram	1-Covered	
naltrexone hcl 50 mg tab	1-Covered	
VIVITROL	1-Covered	NDS (Non-Extended Day Supply)
OPIOID DEPENDENCE		
buprenorphine hcl 2 mg sl tab	1-Covered	QL (90 PER 30 DAYS)
buprenorphine hcl 8 mg sl tab	1-Covered	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl (2-0.5 mg, 4-1 mg, 8-2 mg)	1-Covered	QL (90 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 12-3 mg film	1-Covered	QL (60 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab	1-Covered	QL (120 PER 30 DAYS)
buprenorphine hcl-naloxone hcl 8-2 mg sl tab	1-Covered	QL (90 PER 30 DAYS)
LUCEMYRA	1-Covered	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-Covered	
naloxone hcl 4 mg/0.1ml nasal spray	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SMOKING CESSATION AGENTS		
bupropion hcl er (smoking det)	1-Covered	QL (60 PER 30 DAYS)
NICOTROL	1-Covered	
NICOTROL NS	1-Covered	
varenicline tartrate (0.5 mg x 11 & 1 mg x 42 tab thpk, 0.5 mg tab, 1 mg tab)	1-Covered	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate	1-Covered	
gentamicin in saline	1-Covered	
gentamicin sulfate (0.1 % ointment, 0.1 % cream)	1-Covered	QL (60 PER 30 DAYS)
gentamicin sulfate (10 mg/ml, 40 mg/ml)	1-Covered	
neomycin sulfate	1-Covered	
paromomycin sulfate	1-Covered	
streptomycin sulfate	1-Covered	
tobramycin sulfate (1.2 gm recon soln, 1.2 gm/30ml solution, 2 gm/50ml solution, 10 mg/ml solution, 80 mg/2ml solution)	1-Covered	
ANTIBACTERIALS, OTHER		
acetic acid 2 % solution	1-Covered	
aztreonam	1-Covered	
clindamycin hcl	1-Covered	
clindamycin palmitate hcl	1-Covered	
clindamycin phosphate (1 % swab, 2 % cream, 9 gm/60ml solution, 300 mg/2ml solution, 600 mg/4ml solution, 900 mg/6ml solution, 9000 mg/60ml solution)	1-Covered	
clindamycin phosphate in d5w	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
colistimethate sodium (cba)	1-Covered	
daptomycin (350 mg recon soln)	1-Covered	NDS (Non-Extended Day Supply)
fosfomycin tromethamine	1-Covered	
linezolid 100 mg/5ml recon susp	1-Covered	QL (1800 PER 30 DAYS), NDS (Non-Extended Day Supply)
linezolid 600 mg/300ml solution	1-Covered	
linezolid 600 mg tab	1-Covered	QL (60 PER 30 DAYS)
linezolid in sodium chloride	1-Covered	
methenamine hippurate	1-Covered	
metronidazole (0.75 % gel, 0.75 % cream, 0.75 % lotion, 1 % gel, 250 mg tab, 500 mg/100ml solution, 500 mg tab)	1-Covered	
nitrofurantoin macrocrystal (50 mg cap, 100 mg cap)	1-Covered	
nitrofurantoin monohyd macro	1-Covered	
polymyxin b sulfate	1-Covered	
TIGECYCLINE	1-Covered	NDS (Non-Extended Day Supply)
trimethoprim	1-Covered	
vancomycin hcl 125 mg cap	1-Covered	QL (120 PER 30 DAYS)
vancomycin hcl 250 mg cap	1-Covered	QL (240 PER 30 DAYS)
vancomycin hcl (1 gm soln, 10 gm soln, 100 gm soln, 500 mg soln, 750 mg soln)	1-Covered	
XIFAXAN 200 MG TAB	1-Covered	PA
XIFAXAN 550 MG TAB	1-Covered	PA, NDS (Non-Extended Day Supply)
BETA-LACTAM, CEPHALOSPORINS		
cefaclor (250 mg cap, 500 mg cap)	1-Covered	
CEFACLOR ER	1-Covered	
cefadroxil (250 mg/5ml recon susp, 500 mg/5ml recon susp, 500 mg cap)	1-Covered	
cefazolin sodium (1 gm soln, 10 gm soln, 100 gm soln, 300 gm soln, 500 mg soln)	1-Covered	

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
cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)	1-Covered	
cefepime hcl (1 gm soln, 2 gm soln)	1-Covered	
cefepime hcl for iv soln 2 gm	1-Covered	
cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)	1-Covered	
cefotetan disodium (1 gm soln, 2 gm soln)	1-Covered	
cefoxitin sodium	1-Covered	
cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg/5ml recon susp, 100 mg tab, 200 mg tab)	1-Covered	
cefprozil (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg tab, 500 mg tab)	1-Covered	
ceftazidime	1-Covered	
ceftriaxone sodium (1 gm soln, 2 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln)	1-Covered	
ceftriaxone sodium in dextrose	1-Covered	
cefuroxime axetil	1-Covered	
cefuroxime sodium	1-Covered	
cephalexin (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 500 mg cap)	1-Covered	
tazicef	1-Covered	
TEFLARO	1-Covered	NDS (Non-Extended Day Supply)
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-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	1-Covered	
amoxicillin-pot clavulanate er	1-Covered	
ampicillin	1-Covered	
ampicillin sodium	1-Covered	
ampicillin-sulbactam sodium	1-Covered	
BICILLIN L-A	1-Covered	
dicloxacillin sodium	1-Covered	
nafcillin sodium	1-Covered	
oxacillin sodium	1-Covered	
OXACILLIN SODIUM IN DEXTROSE	1-Covered	
PENICILLIN G POT IN DEXTROSE	1-Covered	
penicillin g potassium	1-Covered	
PENICILLIN G PROCAINE	1-Covered	
penicillin g sodium	1-Covered	
penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, 250 mg tab, 500 mg tab)	1-Covered	
pfizerpen	1-Covered	
piperacillin sod-tazobactam so	1-Covered	
CARBAPENEMS		
ertapenem sodium	1-Covered	
imipenem-cilastatin	1-Covered	
meropenem	1-Covered	
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-Covered	

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
clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)	1-Covered	
clarithromycin er	1-Covered	
DIFICID (40 MG/ML RECON SUSP, 200 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
e.e.s. 400	1-Covered	
ery-tab	1-Covered	
ERYTHROCIN LACTOBIONATE	1-Covered	
erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)	1-Covered	
erythromycin base (250 mg tab dr, 250 mg tab, 250 mg cp dr part, 333 mg tab dr, 500 mg tab, 500 mg tab dr)	1-Covered	
erythromycin ethylsuccinate 400 mg tab	1-Covered	
QUINOLONES		
ciprofloxacin hcl (0.3 % solution, 100 mg tab, 250 mg tab, 500 mg tab, 750 mg tab)	1-Covered	
ciprofloxacin in d5w	1-Covered	
levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)	1-Covered	
levofloxacin 25 mg/ml oral solution	1-Covered	
levofloxacin in d5w	1-Covered	
levofloxacin iv soln 25 mg/ml	1-Covered	
moxifloxacin hcl 400 mg tab	1-Covered	
moxifloxacin hcl in nacl	1-Covered	
ofloxacin (300 mg tab, 400 mg tab)	1-Covered	
SULFONAMIDES		
sulfacetamide sodium (acne)	1-Covered	QL (118 PER 30 DAYS)
sulfadiazine	1-Covered	
sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TETRACYCLINES		
demeclocycline hcl	1-Covered	
doxy 100	1-Covered	
doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg recon soln, 100 mg tab, 100 mg cap)	1-Covered	
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)	1-Covered	
minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)	1-Covered	
mondoxyne nl	1-Covered	
tetracycline hcl (250 mg cap, 500 mg cap)	1-Covered	
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT 10 MG/ML SOLUTION	1-Covered	QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
BRIVIACT 50 MG/5ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
DIACOMIT (250 MG CAP, 250 MG PACKET)	1-Covered	QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
DIACOMIT (500 MG PACKET, 500 MG CAP)	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
divalproex sodium (125 mg cap dr, 125 mg tab dr, 250 mg tab dr, 500 mg tab dr)	1-Covered	
divalproex sodium er	1-Covered	
EPIDIOLEX	1-Covered	PA - FOR NEW STARTS ONLY, QL (600 PER 30 DAYS), NDS (Non-Extended Day Supply)
EPRONTIA	1-Covered	
felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)	1-Covered	

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
FINTEPLA	1-Covered	PA - FOR NEW STARTS ONLY, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
FYCOMPA 0.5 MG/ML SUSPENSION	1-Covered	QL (720 PER 30 DAYS), NDS (Non-Extended Day Supply)
FYCOMPA (4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
FYCOMPA 2 MG TAB	1-Covered	QL (30 PER 30 DAYS)
levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)	1-Covered	
levetiracetam er	1-Covered	
levetiracetam in nacl	1-Covered	
roweepra	1-Covered	
roweepra xr	1-Covered	
SPRITAM 1000 MG TAB	1-Covered	QL (90 PER 30 DAYS)
SPRITAM 250 MG TAB	1-Covered	QL (360 PER 30 DAYS)
SPRITAM 500 MG TAB	1-Covered	QL (180 PER 30 DAYS)
SPRITAM 750 MG TAB	1-Covered	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)	1-Covered	
valproate sodium 100 mg/ml solution	1-Covered	
valproic acid (250 mg cap, 250 mg/5ml solution)	1-Covered	
XCOPRI (150 MG TAB, 200 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (50 MG TAB, 100 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
XCOPRI (14 50 MG 14 100 MG TAB, 14 150 MG 14 200 MG TAB)	1-Covered	QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	1-Covered	QL (28 PER 28 DAYS)
XCOPRI (250 MG DAILY DOSE)	1-Covered	QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)

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
XCOPRI (350 MG DAILY DOSE)	1-Covered	QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
ZTALMY	1-Covered	PA - FOR NEW STARTS ONLY, QL (1100 PER 30 DAYS), NDS (Non-Extended Day Supply)
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN	1-Covered	
ethosuximide (250 mg/5ml solution, 250 mg cap)	1-Covered	
methsuximide	1-Covered	
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
clobazam 2.5 mg/ml suspension	1-Covered	QL (480 PER 30 DAYS)
clobazam (10 mg tab, 20 mg tab)	1-Covered	QL (60 PER 30 DAYS)
diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)	1-Covered	
gabapentin (100 mg cap, 250 mg/5ml solution, 300 mg cap, 300 mg/6ml solution, 400 mg cap, 600 mg tab, 800 mg tab)	1-Covered	
NAYZILAM	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
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)	1-Covered	
primidone (50 mg tab, 125 mg tab, 250 mg tab)	1-Covered	
SYMPAZAN (10 MG, 20 MG)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SYMPAZAN 5 MG FILM	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
tiagabine hcl	1-Covered	
VALTOCO 10 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)

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
VALTOCO 15 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 20 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
VALTOCO 5 MG DOSE	1-Covered	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS), NDS (Non-Extended Day Supply)
vigabatrin (500 mg tab, 500 mg packet)	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
vigadrone 500 mg packet	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
SODIUM CHANNEL AGENTS		
APTIOM (200 MG TAB, 400 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
APTIOM (600 MG TAB, 800 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)	1-Covered	
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)	1-Covered	
DILANTIN 30 MG CAP	1-Covered	
epitol	1-Covered	
fosphenytoin sodium	1-Covered	
lacosamide 10 mg/ml solution	1-Covered	QL (1200 PER 30 DAYS)
lacosamide 200 mg/20ml solution	1-Covered	
lacosamide (100 mg tab, 150 mg tab, 200 mg tab)	1-Covered	QL (60 PER 30 DAYS)
lacosamide 50 mg tab	1-Covered	QL (120 PER 30 DAYS)
oxcarbazepine (150 mg tab, 300 mg/5ml suspension, 300 mg tab, 600 mg tab)	1-Covered	
phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
phenytoin infatabs	1-Covered	
phenytoin sodium 50 mg/ml solution	1-Covered	
phenytoin sodium extended	1-Covered	
rufinamide 40 mg/ml suspension	1-Covered	QL (2760 PER 30 DAYS), NDS (Non-Extended Day Supply)
rufinamide 200 mg tab	1-Covered	QL (480 PER 30 DAYS)
rufinamide 400 mg tab	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
ZONISADE	1-Covered	
zonisamide (25 mg cap, 50 mg cap, 100 mg cap)	1-Covered	
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
ergoloid mesylates	1-Covered	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)	1-Covered	
CHOLINESTERASE INHIBITORS		
donepezil hcl 23 mg tab	1-Covered	QL (30 PER 30 DAYS)
donepezil hcl (5 mg tab, 5 mg tab disp, 10 mg tab, 10 mg tab disp)	1-Covered	QL (60 PER 30 DAYS)
galantamine hydrobromide 4 mg/ml solution	1-Covered	QL (360 PER 30 DAYS)
galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)	1-Covered	QL (60 PER 30 DAYS)
galantamine hydrobromide er	1-Covered	QL (30 PER 30 DAYS)
rivastigmine	1-Covered	QL (30 PER 30 DAYS)
rivastigmine tartrate	1-Covered	QL (60 PER 30 DAYS)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine hcl (2 mg/ml solution, 28 5 mg & 21 10 mg tab)	1-Covered	
memantine hcl (5 mg tab, 10 mg tab)	1-Covered	QL (60 PER 30 DAYS)

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

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
citalopram hydrobromide 10 mg tab	1-Covered	QL (90 PER 30 DAYS)
desvenlafaxine succinate er	1-Covered	QL (30 PER 30 DAYS)
escitalopram oxalate 5 mg/5ml solution	1-Covered	QL (600 PER 30 DAYS)
escitalopram oxalate 10 mg tab	1-Covered	QL (45 PER 30 DAYS)
escitalopram oxalate 20 mg tab	1-Covered	QL (30 PER 30 DAYS)
escitalopram oxalate 5 mg tab	1-Covered	QL (90 PER 30 DAYS)
FETZIMA	1-Covered	QL (30 PER 30 DAYS)
FETZIMA TITRATION	1-Covered	
fluoxetine hcl 40 mg cap	1-Covered	QL (60 PER 30 DAYS)
fluoxetine hcl 90 mg cap dr	1-Covered	QL (4 PER 28 DAYS)
fluoxetine hcl 20 mg/5ml solution	1-Covered	
fluoxetine hcl (10 mg tab, 10 mg cap)	1-Covered	QL (90 PER 30 DAYS)
fluoxetine hcl (20 mg cap, 20 mg tab)	1-Covered	QL (120 PER 30 DAYS)
fluvoxamine maleate	1-Covered	QL (90 PER 30 DAYS)
fluvoxamine maleate er	1-Covered	QL (60 PER 30 DAYS)
nefazodone hcl (50 mg tab, 100 mg tab, 250 mg tab)	1-Covered	QL (60 PER 30 DAYS)
nefazodone hcl 150 mg tab	1-Covered	QL (120 PER 30 DAYS)
nefazodone hcl 200 mg tab	1-Covered	QL (90 PER 30 DAYS)
paroxetine hcl (10 mg/5ml suspension, 10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)	1-Covered	
paroxetine hcl er	1-Covered	
sertraline hcl 20 mg/ml conc	1-Covered	QL (300 PER 30 DAYS)
sertraline hcl (25 mg tab, 50 mg tab)	1-Covered	QL (90 PER 30 DAYS)
sertraline hcl 100 mg tab	1-Covered	QL (60 PER 30 DAYS)
trazodone hcl	1-Covered	
TRINTELLIX	1-Covered	QL (30 PER 30 DAYS)
VENLAFAXINE BESYLATE ER	1-Covered	QL (60 PER 30 DAYS)
venlafaxine hcl	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
venlafaxine hcl er (er 37.5 mg cap er, er 75 mg cap er)	1-Covered	QL (90 PER 30 DAYS)
venlafaxine hcl er 150 mg cap er 24h	1-Covered	QL (60 PER 30 DAYS)
VIIBRYD STARTER PACK	1-Covered	
vilazodone hcl	1-Covered	QL (30 PER 30 DAYS)
TRICYCLICS		
amitriptyline hcl	1-Covered	
amoxapine	1-Covered	
clomipramine hcl	1-Covered	
desipramine hcl	1-Covered	
doxepin hcl (10 mg/ml conc, 10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)	1-Covered	
imipramine hcl	1-Covered	
imipramine pamoate	1-Covered	
nortriptyline hcl (10 mg cap, 10 mg/5ml solution, 25 mg cap, 50 mg cap, 75 mg cap)	1-Covered	
protriptyline hcl	1-Covered	
trimipramine maleate	1-Covered	
ANTIEMETICS		
ANTIEMETICS, OTHER		
compro	1-Covered	
meclizine hcl (12.5 mg tab, 25 mg tab)	1-Covered	
metoclopramide hcl (5 mg/5ml solution, 5 mg tab, 10 mg/10ml solution, 10 mg tab)	1-Covered	
perphenazine	1-Covered	
phenadoz	1-Covered	
prochlorperazine	1-Covered	
prochlorperazine edisylate	1-Covered	
prochlorperazine maleate	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
promethazine hcl (12.5 mg, 25 mg)	1-Covered	
promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)	1-Covered	PA
promethegan	1-Covered	
scopolamine	1-Covered	QL (10 PER 30 DAYS)
EMETOGENIC THERAPY ADJUNCTS		
aprepitant (40 mg cap, 80 & 125 mg misc, 80 & 125 mg cap, 80 mg cap, 125 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
dronabinol	1-Covered	PA, QL (60 PER 30 DAYS)
EMEND 125 MG/5ML RECON SUSP	1-Covered	PA - TO CONFIRM PART D COVERAGE
granisetron hcl 1 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
ondansetron 4 mg tab disp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
ondansetron 8 mg tab disp	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
ondansetron hcl (4 mg/2ml soln prsyr, 40 mg/20ml solution)	1-Covered	
ondansetron hcl 4 mg/5ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
ondansetron hcl 4 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
ondansetron hcl 8 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
ondansetron hcl inj 4 mg/2ml	1-Covered	
SANCUSO	1-Covered	ST, QL (4 PER 28 DAYS), NDS (Non-Extended Day Supply)
ANTIFUNGALS		
ABELCET	1-Covered	PA - TO CONFIRM PART D COVERAGE
AMBISOME	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
amphotericin b	1-Covered	PA - TO CONFIRM PART D COVERAGE
amphotericin b liposome	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
caspofungin acetate	1-Covered	
ciclopirox olamine 0.77 % cream	1-Covered	QL (90 PER 30 DAYS)
ciclopirox olamine 0.77 % suspension	1-Covered	QL (60 PER 30 DAYS)
clotrimazole 1 % cream	1-Covered	QL (90 PER 30 DAYS)
clotrimazole 1 % solution	1-Covered	QL (30 PER 30 DAYS)
clotrimazole 10 mg troche	1-Covered	
econazole nitrate	1-Covered	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)	1-Covered	
fluconazole in sodium chloride (200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%)	1-Covered	
flucytosine	1-Covered	NDS (Non-Extended Day Supply)
griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)	1-Covered	
griseofulvin ultramicrosize	1-Covered	
itraconazole (10 mg/ml solution, 100 mg cap)	1-Covered	
ketoconazole 2 % cream	1-Covered	QL (60 PER 30 DAYS)
ketoconazole 2 % shampoo	1-Covered	QL (120 PER 30 DAYS)
ketoconazole 200 mg tab	1-Covered	
micafungin sodium	1-Covered	NDS (Non-Extended Day Supply)
naftifine hcl 1 % cream	1-Covered	QL (90 PER 30 DAYS)
naftifine hcl 2 % cream	1-Covered	QL (60 PER 30 DAYS)
NOXAFIL 300 MG PACKET	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
NOXAFIL 40 MG/ML SUSPENSION	1-Covered	PA, QL (630 PER 30 DAYS), NDS (Non-Extended Day Supply)
nyamyc	1-Covered	QL (60 PER 30 DAYS)
nystatin (100000 unit/gm ointment, 100000 unit/gm cream, 100000 unit/gm powder)	1-Covered	QL (60 PER 30 DAYS)
nystatin (100000 unit/ml suspension, 500000 unit tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nystop	1-Covered	QL (60 PER 30 DAYS)
posaconazole 40 mg/ml suspension	1-Covered	PA, QL (630 PER 30 DAYS), NDS (Non-Extended Day Supply)
posaconazole 100 mg tab dr	1-Covered	PA, QL (93 PER 30 DAYS), NDS (Non-Extended Day Supply)
terbinafine hcl 250 mg tab	1-Covered	
terconazole (0.4 % cream, 0.8 % cream, 80 mg suppos)	1-Covered	
voriconazole 200 mg recon soln	1-Covered	PA, NDS (Non-Extended Day Supply)
voriconazole 40 mg/ml recon susp	1-Covered	NDS (Non-Extended Day Supply)
voriconazole (50 mg tab, 200 mg tab)	1-Covered	
ANTIGOUT AGENTS		
allopurinol (100 mg tab, 300 mg tab)	1-Covered	
colchicine 0.6 mg tab	1-Covered	
colchicine-probenecid	1-Covered	
febuxostat	1-Covered	ST
MITIGARE	1-Covered	
probenecid	1-Covered	
ANTIMIGRAINE AGENTS		
ANTIMIGRAINE AGENTS, OTHER		
AIMOVIG	1-Covered	PA, QL (1 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN A-INJ	1-Covered	PA, QL (1.5 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN PRSYR	1-Covered	PA, QL (1.5 PER 28 DAYS)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	1-Covered	PA, QL (2 PER 28 DAYS)
EMGALITY (300 MG DOSE)	1-Covered	PA, QL (3 PER 28 DAYS)
NURTEC	1-Covered	ST, QL (16 PER 30 DAYS), NDS (Non-Extended Day Supply)
ERGOT ALKALOIDS		
dihydroergotamine mesylate 4 mg/ml solution	1-Covered	PA, QL (8 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ergotamine-caffeine	1-Covered	
SEROTONIN (5-HT) RECEPTOR AGONIST		
naratriptan hcl	1-Covered	QL (9 PER 30 DAYS)
rizatriptan benzoate (5 mg tab, 5 mg tab disp, 10 mg tab disp, 10 mg tab)	1-Covered	QL (12 PER 30 DAYS)
sumatriptan (5 mg/act, 20 mg/act)	1-Covered	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)	1-Covered	QL (6 PER 30 DAYS)
sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	QL (9 PER 30 DAYS)
sumatriptan succinate refill	1-Covered	QL (6 PER 30 DAYS)
zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)	1-Covered	QL (9 PER 30 DAYS)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
pyridostigmine bromide 60 mg tab	1-Covered	
pyridostigmine bromide er	1-Covered	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone (25 mg tab, 100 mg tab)	1-Covered	
rifabutin	1-Covered	
ANTITUBERCULARS		
ethambutol hcl	1-Covered	
isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)	1-Covered	
PRETOMANID	1-Covered	QL (30 PER 30 DAYS)
PRIFTIN	1-Covered	
pyrazinamide	1-Covered	
rifampin (150 mg cap, 300 mg cap, 600 mg recon soln)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SIRTURO	1-Covered	NDS (Non-Extended Day Supply)
TRECATOR	1-Covered	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
bendamustine hcl (25 mg soln, 100 mg soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
busulfan	1-Covered	NDS (Non-Extended Day Supply)
cyclophosphamide (25 mg cap, 25 mg tab, 50 mg cap, 50 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GLEOSTINE (10 MG CAP, 40 MG CAP)	1-Covered	
GLEOSTINE 100 MG CAP	1-Covered	NDS (Non-Extended Day Supply)
ifosfamide (1 gm recon soln, 1 gm/20ml solution, 3 gm/60ml solution)	1-Covered	
LEUKERAN	1-Covered	
MATULANE	1-Covered	NDS (Non-Extended Day Supply)
melphalan	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
melphalan hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TREANDA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VALCHLOR	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
YONDELIS	1-Covered	NDS (Non-Extended Day Supply)
ANTIANDROGENS		
abiraterone acetate	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
bicalutamide	1-Covered	
ERLEADA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
flutamide	1-Covered	
nilutamide	1-Covered	NDS (Non-Extended Day Supply)

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
NUBEQA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ORSERDU 345 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ORSERDU 86 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
XTANDI (40 MG TAB, 40 MG CAP, 80 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
YONSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ANTIANGIOGENIC AGENTS		
lenalidomide	1-Covered	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
POMALYST	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
REVLIMID	1-Covered	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
THALOMID (150 MG CAP, 200 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
THALOMID (50 MG CAP, 100 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTIESTROGENS/MODIFIERS		
EMCYT	1-Covered	NDS (Non-Extended Day Supply)
fulvestrant	1-Covered	NDS (Non-Extended Day Supply)
SOLTAMOX	1-Covered	NDS (Non-Extended Day Supply)
tamoxifen citrate	1-Covered	
toremifene citrate	1-Covered	NDS (Non-Extended Day Supply)
ANTIMETABOLITES		
adrucil	1-Covered	PA - TO CONFIRM PART D COVERAGE
cladribine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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
clofarabine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
cytarabine	1-Covered	PA - TO CONFIRM PART D COVERAGE
cytarabine (pf)	1-Covered	PA - TO CONFIRM PART D COVERAGE
DROXIA	1-Covered	
fluorouracil (1 gm/20ml, 2.5 gm/50ml, 5 gm/100ml, 500 mg/10ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
FOLOTYN 40 MG/2ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
gemcitabine hcl 1 gm recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE
hydroxyurea	1-Covered	
INQOVI	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
mercaptopurine	1-Covered	
NIPENT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
pemetrexed disodium (100 mg soln, 500 mg soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
pemetrexed disodium (750 mg soln, 1000 mg soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
PURIXAN	1-Covered	NDS (Non-Extended Day Supply)
TABLOID	1-Covered	
ANTINEOPLASTICS, OTHER		
adriamycin 2 mg/ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
arsenic trioxide 10 mg/10ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
AYVAKIT	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
azacitidine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BESREMI	1-Covered	NDS (Non-Extended Day Supply)
bleomycin sulfate	1-Covered	PA - TO CONFIRM PART D COVERAGE
bortezomib 3.5 mg recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BRUKINSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
carboplatin	1-Covered	PA - TO CONFIRM PART D COVERAGE
cisplatin (50 mg/50ml solution)	1-Covered	PA - TO CONFIRM PART D COVERAGE
dacarbazine 200 mg recon soln	1-Covered	
dactinomycin	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
DAUNORUBICIN HCL 20 MG/4ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 50 MG/10ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
decitabine	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
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)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
doxorubicin hcl 2 mg/ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
doxorubicin hcl liposomal	1-Covered	PA - TO CONFIRM PART D COVERAGE
epirubicin hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
EXKIVITY	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
fludarabine phosphate 50 mg recon soln	1-Covered	
FOTIVDA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
HALAVEN	1-Covered	NDS (Non-Extended Day Supply)
idarubicin hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
IDHIFA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
irinotecan hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
KISQALI FEMARA (400 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
KISQALI FEMARA (600 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)

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
KISQALI FEMARA(200 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
KRAZATI	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LONSURF	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LUMAKRAS	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
mitomycin (5 mg soln, 20 mg soln, 40 mg soln)	1-Covered	
mitoxantrone hcl	1-Covered	
mutamycin	1-Covered	
NINLARO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ONUREG	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
oxaliplatin (50 mg/10ml solution, 50 mg recon soln, 100 mg/20ml solution, 100 mg recon soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
paclitaxel	1-Covered	PA - TO CONFIRM PART D COVERAGE
paclitaxel protein-bound part	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
paraplatin	1-Covered	PA - TO CONFIRM PART D COVERAGE
QINLOCK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
RETEVMO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
romidepsin 10 mg recon soln	1-Covered	NDS (Non-Extended Day Supply)
SYNRIBO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TABRECTA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TAZVERIK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
vinblastine sulfate	1-Covered	PA - TO CONFIRM PART D COVERAGE
vincasar pfs	1-Covered	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
vincristine sulfate	1-Covered	PA - TO CONFIRM PART D COVERAGE
vinorelbine tartrate 50 mg/5ml solution	1-Covered	
VYXEOS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
WELIREG	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (60 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XPOVIO (80 MG TWICE WEEKLY)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ZALTRAP 100 MG/4ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
ZANOSAR	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZOLINZA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole	1-Covered	
exemestane	1-Covered	
letrozole	1-Covered	
ENZYME INHIBITORS		
etoposide	1-Covered	
JAYPIRCA 100 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
toposar	1-Covered	
topotecan hcl 4 mg recon soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
MOLECULAR TARGET INHIBITORS		
ALECENSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ALIQOPA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ALUNBRIG (30 MG TAB, 90 MG TAB, 90 & 180 MG TAB THPK, 180 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
BALVERSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
BOSULIF	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
BRAFTOVI	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
CABOMETYX	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
CALQUENCE (100 MG CAP, 100 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
CAPRELSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
COMETRIQ (100 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
COMETRIQ (140 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
COMETRIQ (60 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
COPIKTRA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
COTELLIC	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
CYRAMZA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
DAURISMO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ERIVEDGE	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
erlotinib hcl	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
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)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
GAVRETO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
gefitinib	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
GILOTRIF	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
IBRANCE (75 MG TAB, 75 MG CAP, 100 MG CAP, 100 MG TAB, 125 MG TAB, 125 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ICLUSIG	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
imatinib mesylate	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
IMBRUVICA (70 MG/ML SUSPENSION, 70 MG CAP, 140 MG TAB, 140 MG CAP, 280 MG TAB, 420 MG TAB, 560 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
INLYTA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
INREBIC	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
IRESSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
JAKAFI	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
JEVTANA	1-Covered	NDS (Non-Extended Day Supply)
KISQALI (200 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
KISQALI (400 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
KISQALI (600 MG DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
KOSELUGO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
KYPROLIS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
lapatinib ditosylate	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (10 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (12 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (14 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (18 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (20 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (24 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (4 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LENVIMA (8 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LORBRENA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LYNPARZA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LYTGOBI (12 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LYTGOBI (16 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
LYTGOBI (20 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
MEKINIST (0.05 MG/ML RECON SOLN, 0.5 MG TAB, 2 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
MEKTOVI	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
NERLYNX	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ODOMZO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
PEMAZYRE	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
PIQRAY (200 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
PIQRAY (250 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
PIQRAY (300 MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
REZLIDHIA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ROZLYTREK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
RUBRACA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
RYDAPT	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
SCEMBLIX	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
sorafenib tosylate	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
SPRYCEL	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
STIVARGA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
sunitinib malate	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TAFINLAR (10 MG TAB SOL, 50 MG CAP, 75 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TAGRISSO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TALZENNA (0.25 MG CAP, 0.5 MG CAP, 0.75 MG CAP, 1 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TASIGNA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TEPMETKO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TIBSOVO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TRUSELTIQ (100MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TRUSELTIQ (125MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TRUSELTIQ (50MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TRUSELTIQ (75MG DAILY DOSE)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TUKYSA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
TURALIO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VENCLEXTA (50 MG TAB, 100 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VENCLEXTA 10 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY
VENCLEXTA STARTING PACK	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VERZENIO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VITRAKVI (20 MG/ML SOLUTION, 25 MG CAP, 100 MG CAP)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VIZIMPRO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VONJO	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
VOTRIENT	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XALKORI	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
XOSPATA	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ZEJULA (100 MG CAP, 100 MG TAB, 200 MG TAB, 300 MG TAB)	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ZELBORAF	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZYDELIG	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
ZYKADIA 150 MG TAB	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE		
ALYMSYS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
AVASTIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BAVENCIO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
DARZALEX	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
EMPLICITI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ERBITUX 100 MG/50ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
HERCEPTIN HYLECTA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
HERZUMA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
IMFINZI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
KADCYLA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
KANJINTI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
KEYTRUDA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
MVASI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
MYLOTARG	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
OGIVRI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
ONTRUZANT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPDIVO	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
PERJETA	1-Covered	NDS (Non-Extended Day Supply)
RIABNI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
RITUXAN HYCELA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
RUXIENCE	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TECENTRIQ	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TRAZIMERA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TRUXIMA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
VECTIBIX 100 MG/5ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
YERVOY 50 MG/10ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
ZIRABEV	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
RETINOIDS		
bexarotene 75 mg cap	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
bexarotene 1 % gel	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
PANRETIN	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
tretinoin 10 mg cap	1-Covered	NDS (Non-Extended Day Supply)
TREATMENT ADJUNCTS		
leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab, 50 mg recon soln, 100 mg recon soln, 200 mg recon soln, 350 mg recon soln, 500 mg recon soln)	1-Covered	
levoleucovorin calcium	1-Covered	NDS (Non-Extended Day Supply)

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
levoleucovorin calcium pf	1-Covered	NDS (Non-Extended Day Supply)
mesna	1-Covered	
MESNEX 400 MG TAB	1-Covered	NDS (Non-Extended Day Supply)
ANTIPARASITICS		
ANTHELMINTHICS		
albendazole	1-Covered	NDS (Non-Extended Day Supply)
ivermectin 3 mg tab	1-Covered	
praziquantel	1-Covered	
ANTIPROTOZOALS		
atovaquone	1-Covered	
atovaquone-proguanil hcl	1-Covered	
BENZNIDAZOLE	1-Covered	
chloroquine phosphate	1-Covered	
COARTEM	1-Covered	
hydroxychloroquine sulfate 200 mg tab	1-Covered	
mefloquine hcl	1-Covered	
nitazoxanide	1-Covered	NDS (Non-Extended Day Supply)
pentamidine isethionate	1-Covered	PA - TO CONFIRM PART D COVERAGE
pentamidine isethionate 300 mg inject soln	1-Covered	
pentamidine isethionate for nebulization soln 300 mg	1-Covered	PA - TO CONFIRM PART D COVERAGE
primaquine phosphate	1-Covered	
pyrimethamine	1-Covered	NDS (Non-Extended Day Supply)
quinine sulfate	1-Covered	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)	1-Covered	
ANTIPARKINSON AGENTS, OTHER		
amantadine hcl (50 mg/5ml solution, 100 mg tab, 100 mg cap)	1-Covered	
carbidopa-levodopa-entacapone	1-Covered	
entacapone	1-Covered	
tolcapone	1-Covered	NDS (Non-Extended Day Supply)
DOPAMINE AGONISTS		
APOKYN	1-Covered	NDS (Non-Extended Day Supply)
bromocriptine mesylate (2.5 mg tab, 5 mg cap)	1-Covered	
KYNMOBI	1-Covered	NDS (Non-Extended Day Supply)
NEUPRO	1-Covered	
pramipexole dihydrochloride	1-Covered	
pramipexole dihydrochloride er	1-Covered	
ropinirole hcl	1-Covered	
ropinirole hcl er	1-Covered	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa	1-Covered	
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)	1-Covered	
carbidopa-levodopa er	1-Covered	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline mesylate	1-Covered	
selegiline hcl (5 mg cap, 5 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine hcl (10 mg tab, 25 mg tab, 25 mg/ml solution, 30 mg/ml conc, 50 mg tab, 50 mg/2ml solution, 100 mg tab, 100 mg/ml conc, 200 mg tab)	1-Covered	
fluphenazine decanoate	1-Covered	
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)	1-Covered	
haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
haloperidol decanoate	1-Covered	
haloperidol lactate (2 mg/ml conc, 5 mg/ml solution)	1-Covered	
loxapine succinate	1-Covered	
molindone hcl	1-Covered	
pimozide	1-Covered	
thioridazine hcl	1-Covered	
thiothixene	1-Covered	
trifluoperazine hcl	1-Covered	
2ND GENERATION/ATYPICAL		
ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 56 DAYS), NDS (Non-Extended Day Supply)
ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 56 DAYS), NDS (Non-Extended Day Supply)
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG SRER, 400 MG PRSYR)	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
aripiprazole (1 mg/ml solution, 2 mg tab, 5 mg tab, 10 mg tab, 10 mg tab disp, 15 mg tab, 15 mg tab disp, 20 mg tab, 30 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ARISTADA 1064 MG/3.9ML PRSYR	1-Covered	QL (3.9 PER 56 DAYS), NDS (Non-Extended Day Supply)
ARISTADA 441 MG/1.6ML PRSYR	1-Covered	QL (1.6 PER 28 DAYS), NDS (Non-Extended Day Supply)
ARISTADA 662 MG/2.4ML PRSYR	1-Covered	QL (2.4 PER 28 DAYS), NDS (Non-Extended Day Supply)
ARISTADA 882 MG/3.2ML PRSYR	1-Covered	QL (3.2 PER 28 DAYS), NDS (Non-Extended Day Supply)
ARISTADA INITIO	1-Covered	NDS (Non-Extended Day Supply)
asenapine maleate	1-Covered	
CAPLYTA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
FANAPT (6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
FANAPT TITRATION PACK	1-Covered	
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	1-Covered	QL (3.5 PER 180 DAYS), NDS (Non-Extended Day Supply)
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	1-Covered	QL (5 PER 180 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	1-Covered	QL (0.75 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	1-Covered	QL (1.5 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	1-Covered	QL (0.25 PER 28 DAYS)
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	1-Covered	QL (0.5 PER 28 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	1-Covered	QL (0.88 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	1-Covered	QL (1.32 PER 84 DAYS), NDS (Non-Extended Day Supply)
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	1-Covered	QL (1.75 PER 84 DAYS), NDS (Non-Extended Day Supply)

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
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	1-Covered	QL (2.63 PER 84 DAYS), NDS (Non-Extended Day Supply)
LATUDA (20 MG TAB, 40 MG TAB, 60 MG TAB, 120 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
LATUDA 80 MG TAB	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
lurasidone hcl (20 mg tab, 40 mg tab, 60 mg tab, 120 mg tab)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
lurasidone hcl 80 mg tab	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
NUPLAZID (10 MG TAB, 34 MG CAP)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
olanzapine (2.5 mg tab, 5 mg tab disp, 5 mg tab, 7.5 mg tab, 10 mg tab disp, 10 mg tab, 10 mg recon soln, 15 mg tab, 15 mg tab disp, 20 mg tab, 20 mg tab disp)	1-Covered	
paliperidone er 1.5 mg tab er 24h	1-Covered	QL (240 PER 30 DAYS)
paliperidone er 3 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
paliperidone er 6 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
paliperidone er 9 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
PERSERIS	1-Covered	QL (1 PER 28 DAYS), NDS (Non-Extended Day Supply)
quetiapine fumarate	1-Covered	
quetiapine fumarate er	1-Covered	
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
REXULTI (2 MG TAB, 3 MG TAB, 4 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
RISPERDAL CONSTA (12.5 MG, 25 MG)	1-Covered	QL (2 PER 28 DAYS)
RISPERDAL CONSTA (37.5 MG, 50 MG)	1-Covered	QL (2 PER 28 DAYS), NDS (Non-Extended Day Supply)
risperidone 1 mg/ml solution	1-Covered	
risperidone (0.25 mg tab, 0.25 mg tab disp, 0.5 mg tab, 1 mg tab, 2 mg tab, 2 mg tab disp, 3 mg tab, 4 mg tab disp, 4 mg tab)	1-Covered	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
risperidone 0.5 mg tab disp	1-Covered	QL (120 PER 30 DAYS)
risperidone 1 mg tab disp	1-Covered	QL (30 PER 30 DAYS)
risperidone 3 mg tab disp	1-Covered	QL (90 PER 30 DAYS)
SECUADO	1-Covered	QL (30 PER 30 DAYS)
UZEDY 100 MG/0.28ML SUSP PRSYR	1-Covered	QL (0.28 PER 28 DAYS), NDS (Non-Extended Day Supply)
UZEDY 125 MG/0.35ML SUSP PRSYR	1-Covered	QL (0.35 PER 28 DAYS), NDS (Non-Extended Day Supply)
UZEDY 150 MG/0.42ML SUSP PRSYR	1-Covered	QL (0.42 PER 28 DAYS), NDS (Non-Extended Day Supply)
UZEDY 200 MG/0.56ML SUSP PRSYR	1-Covered	QL (0.56 PER 56 DAYS), NDS (Non-Extended Day Supply)
UZEDY 250 MG/0.7ML SUSP PRSYR	1-Covered	QL (0.7 PER 56 DAYS), NDS (Non-Extended Day Supply)
UZEDY 50 MG/0.14ML SUSP PRSYR	1-Covered	QL (0.14 PER 28 DAYS), NDS (Non-Extended Day Supply)
UZEDY 75 MG/0.21ML SUSP PRSYR	1-Covered	QL (0.21 PER 28 DAYS), NDS (Non-Extended Day Supply)
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VRAYLAR 1.5 & 3 MG CAP THPK	1-Covered	
ziprasidone hcl	1-Covered	QL (60 PER 30 DAYS)
ziprasidone mesylate	1-Covered	
ZYPREXA RELPREVV	1-Covered	
TREATMENT-RESISTANT		
clozapine (12.5 mg tab disp, 25 mg tab disp, 25 mg tab, 50 mg tab, 100 mg tab disp, 100 mg tab, 150 mg tab disp, 200 mg tab disp, 200 mg tab)	1-Covered	
VERSACLOZ	1-Covered	NDS (Non-Extended Day Supply)
ANTISPASTICITY AGENTS		
baclofen (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
dantrolene sodium	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tizanidine hcl (2 mg tab, 4 mg tab)	1-Covered	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
PREVYMIS (240 MG TAB, 480 MG TAB)	1-Covered	QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
valganciclovir hcl 50 mg/ml recon soln	1-Covered	NDS (Non-Extended Day Supply)
valganciclovir hcl 450 mg tab	1-Covered	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil	1-Covered	NDS (Non-Extended Day Supply)
BARACLUDE 0.05 MG/ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
entecavir	1-Covered	
EPIVIR HBV 5 MG/ML SOLUTION	1-Covered	
lamivudine 100 mg tab	1-Covered	
VEMLIDY	1-Covered	NDS (Non-Extended Day Supply)
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
EPCLUSA (200-50 MG TAB, 200-50 MG PACKET)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
HARVONI (45-200 MG PACKET, 45-200 MG TAB)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
MAVYRET 50-20 MG PACKET	1-Covered	PA, QL (140 PER 28 DAYS), NDS (Non-Extended Day Supply)
MAVYRET 100-40 MG TAB	1-Covered	PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
ribavirin (200 mg cap, 200 mg tab)	1-Covered	
SOFOSBUVIR-VELPATASVIR	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY 30-120-15 MG TAB	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
BIKTARVY 50-200-25 MG TAB	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DOVATO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
GENVOYA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS (25 MG CHEW TAB, 100 MG CHEW TAB, 100 MG PACKET)	1-Covered	QL (180 PER 30 DAYS)
ISENTRESS 400 MG TAB	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ISENTRESS HD	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
JULUCA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
STRIBILD	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIVICAY (25 MG TAB, 50 MG TAB)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
TIVICAY 10 MG TAB	1-Covered	QL (60 PER 30 DAYS)
TIVICAY PD	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
COMPLERA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DELSTRIGO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EDURANT	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EFAVIRENZ 200 MG CAP	1-Covered	QL (90 PER 30 DAYS)
EFAVIRENZ 50 MG CAP	1-Covered	QL (240 PER 30 DAYS)
efavirenz 600 mg tab	1-Covered	QL (30 PER 30 DAYS)
efavirenz-emtricitab-tenofo df	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
efavirenz-lamivudine-tenofovir	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
etravirine	1-Covered	NDS (Non-Extended Day Supply)
INTELENCE 25 MG TAB	1-Covered	QL (120 PER 30 DAYS)
nevirapine 50 mg/5ml suspension	1-Covered	
nevirapine 200 mg tab	1-Covered	QL (60 PER 30 DAYS)
nevirapine er 100 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
nevirapine er 400 mg tab er 24h	1-Covered	QL (30 PER 30 DAYS)
ODEFSEY	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PIFELTRO	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate 20 mg/ml solution	1-Covered	
abacavir sulfate 300 mg tab	1-Covered	QL (60 PER 30 DAYS)
abacavir sulfate-lamivudine	1-Covered	QL (30 PER 30 DAYS)
abacavir-lamivudine-zidovudine	1-Covered	QL (60 PER 30 DAYS)
CIMDUO	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DESCOVY 120-15 MG TAB	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
DESCOVY 200-25 MG TAB	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
emtricitabine	1-Covered	QL (30 PER 30 DAYS)
emtricitabine-tenofovir df	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
EMTRIVA 10 MG/ML SOLUTION	1-Covered	
lamivudine 10 mg/ml solution	1-Covered	
lamivudine 150 mg tab	1-Covered	QL (60 PER 30 DAYS)
lamivudine 300 mg tab	1-Covered	QL (30 PER 30 DAYS)
lamivudine-zidovudine	1-Covered	QL (60 PER 30 DAYS)
TEMIXYS	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tenofovir disoproxil fumarate	1-Covered	QL (30 PER 30 DAYS)
TRIUMEQ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
TRIUMEQ PD	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
TRIZIVIR	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIREAD 40 MG/GM POWDER	1-Covered	NDS (Non-Extended Day Supply)
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
zidovudine 100 mg cap	1-Covered	QL (180 PER 30 DAYS)
zidovudine 50 mg/5ml syrup	1-Covered	
zidovudine 300 mg tab	1-Covered	QL (60 PER 30 DAYS)
ANTI-HIV AGENTS, OTHER		
APRETUDE	1-Covered	NDS (Non-Extended Day Supply)
CABENUVA	1-Covered	NDS (Non-Extended Day Supply)
FUZEON	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
maraviroc	1-Covered	NDS (Non-Extended Day Supply)
RUKOBIA	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
SELZENTRY (20 MG/ML SOLUTION, 75 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
SELZENTRY 25 MG TAB	1-Covered	
SUNLENCA (4 X 300 MG TAB THPK, 5 X 300 MG TAB THPK, 463.5 MG/1.5ML SOLUTION)	1-Covered	NDS (Non-Extended Day Supply)
TROGARZO	1-Covered	NDS (Non-Extended Day Supply)
TYBOST	1-Covered	QL (30 PER 30 DAYS)
ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)		
APTIVUS	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
atazanavir sulfate (150 mg cap, 200 mg cap)	1-Covered	QL (60 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
atazanavir sulfate 300 mg cap	1-Covered	QL (30 PER 30 DAYS)
darunavir	1-Covered	NDS (Non-Extended Day Supply)
EVOTAZ	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
fosamprenavir calcium	1-Covered	NDS (Non-Extended Day Supply)
LEXIVA 50 MG/ML SUSPENSION	1-Covered	
lopinavir-ritonavir (100-25 mg tab, 200-50 mg tab, 400-100 mg/5ml solution)	1-Covered	
NORVIR 100 MG PACKET	1-Covered	
PREZCOBIX	1-Covered	NDS (Non-Extended Day Supply)
PREZISTA (100 MG/ML SUSPENSION, 600 MG TAB, 800 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)
PREZISTA (75 MG TAB, 150 MG TAB)	1-Covered	
REYATAZ 50 MG PACKET	1-Covered	
ritonavir	1-Covered	
SYMTUZA	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIRACEPT 250 MG TAB	1-Covered	QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply)
VIRACEPT 625 MG TAB	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
ANTI-INFLUENZA AGENTS		
oseltamivir phosphate (6 mg/ml recon susp, 30 mg cap, 45 mg cap, 75 mg cap)	1-Covered	
RELENZA DISKHALER	1-Covered	
rimantadine hcl	1-Covered	
ANTIHERPETIC AGENTS		
acyclovir (200 mg cap, 200 mg/5ml suspension, 400 mg tab, 800 mg tab)	1-Covered	
acyclovir sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE
famciclovir	1-Covered	QL (90 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
trifluridine	1-Covered	
valacyclovir hcl (1 gm tab, 500 mg tab)	1-Covered	QL (120 PER 30 DAYS)
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl	1-Covered	
hydroxyzine pamoate	1-Covered	
BENZODIAZEPINES		
alprazolam (0.25 mg tab, 0.5 mg tab)	1-Covered	QL (120 PER 30 DAYS)
alprazolam (1 mg tab, 2 mg tab)	1-Covered	QL (150 PER 30 DAYS)
chlordiazepoxide hcl 10 mg cap	1-Covered	QL (300 PER 30 DAYS)
chlordiazepoxide hcl 25 mg cap	1-Covered	QL (360 PER 30 DAYS)
chlordiazepoxide hcl 5 mg cap	1-Covered	QL (240 PER 30 DAYS)
clonazepam (2 mg tab, 2 mg tab disp)	1-Covered	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)	1-Covered	QL (120 PER 30 DAYS)
clorazepate dipotassium (3.75 mg tab, 7.5 mg tab)	1-Covered	QL (90 PER 30 DAYS)
clorazepate dipotassium 15 mg tab	1-Covered	QL (180 PER 30 DAYS)
diazepam 5 mg/ml conc	1-Covered	QL (240 PER 30 DAYS)
diazepam 5 mg/5ml solution	1-Covered	QL (1200 PER 30 DAYS)
diazepam (2 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (120 PER 30 DAYS)
diazepam intensol	1-Covered	QL (240 PER 30 DAYS)
lorazepam (2 mg tab, 2 mg/ml conc)	1-Covered	QL (150 PER 30 DAYS)
lorazepam 0.5 mg tab	1-Covered	QL (600 PER 30 DAYS)
lorazepam 1 mg tab	1-Covered	QL (300 PER 30 DAYS)
lorazepam intensol	1-Covered	QL (150 PER 30 DAYS)
oxazepam	1-Covered	QL (120 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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-Covered	
lamotrigine er	1-Covered	
lithium carbonate (150 mg cap, 300 mg tab, 300 mg cap, 600 mg cap)	1-Covered	
lithium carbonate er	1-Covered	
subvenite	1-Covered	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose	1-Covered	QL (90 PER 30 DAYS)
alogliptin benzoate	1-Covered	QL (30 PER 30 DAYS)
alogliptin-metformin hcl	1-Covered	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)	1-Covered	QL (30 PER 30 DAYS)
BYDUREON BCISE	1-Covered	QL (3.4 PER 28 DAYS)
BYETTA 10 MCG PEN	1-Covered	QL (2.4 PER 30 DAYS)
BYETTA 5 MCG PEN	1-Covered	QL (1.2 PER 30 DAYS)
CYCLOSET	1-Covered	
FARXIGA	1-Covered	QL (30 PER 30 DAYS)
glimepiride (1 mg tab, 2 mg tab)	1-Covered	QL (120 PER 30 DAYS)
glimepiride 4 mg tab	1-Covered	QL (60 PER 30 DAYS)
glipizide	1-Covered	QL (120 PER 30 DAYS)
glipizide er 10 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
glipizide er 2.5 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
glipizide er 5 mg tab er 24h	1-Covered	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
glipizide xl 10 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
glipizide xl 2.5 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
glipizide xl 5 mg tab er 24h	1-Covered	QL (90 PER 30 DAYS)
glipizide-metformin hcl	1-Covered	QL (120 PER 30 DAYS)
glyburide	1-Covered	QL (120 PER 30 DAYS)
glyburide micronized	1-Covered	QL (60 PER 30 DAYS)
glyburide-metformin	1-Covered	QL (120 PER 30 DAYS)
GLYXAMBI	1-Covered	QL (30 PER 30 DAYS)
JANUMET	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR (50-1000 MG TAB ER, 50-500 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
JANUMET XR 100-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
JANUVIA	1-Covered	QL (30 PER 30 DAYS)
JARDIANCE	1-Covered	QL (30 PER 30 DAYS)
JENTADUETO	1-Covered	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	1-Covered	QL (60 PER 30 DAYS)
JENTADUETO XR 5-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
KERENDIA	1-Covered	PA, QL (30 PER 30 DAYS)
metformin hcl 1000 mg tab	1-Covered	QL (75 PER 30 DAYS)
metformin hcl 500 mg tab	1-Covered	QL (150 PER 30 DAYS)
metformin hcl 850 mg tab	1-Covered	QL (90 PER 30 DAYS)
metformin hcl er 500 mg tab er 24h	1-Covered	QL (120 PER 30 DAYS)
metformin hcl er 750 mg tab er 24h	1-Covered	QL (60 PER 30 DAYS)
miglitol	1-Covered	QL (90 PER 30 DAYS)
nateglinide 120 mg tab	1-Covered	QL (90 PER 30 DAYS)
nateglinide 60 mg tab	1-Covered	QL (180 PER 30 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML SOLN PEN	1-Covered	QL (1.5 PER 28 DAYS)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	1-Covered	QL (3 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
OZEMPIC (1 MG/DOSE)	1-Covered	QL (3 PER 28 DAYS)
OZEMPIC (2 MG/DOSE)	1-Covered	QL (3 PER 28 DAYS)
pioglitazone hcl	1-Covered	QL (30 PER 30 DAYS)
pioglitazone hcl-glimepiride	1-Covered	QL (30 PER 30 DAYS)
pioglitazone hcl-metformin hcl	1-Covered	QL (90 PER 30 DAYS)
repaglinide (0.5 mg tab, 1 mg tab)	1-Covered	QL (120 PER 30 DAYS)
repaglinide 2 mg tab	1-Covered	QL (240 PER 30 DAYS)
RYBELSUS	1-Covered	QL (30 PER 30 DAYS)
SOLIQUA	1-Covered	QL (18 PER 30 DAYS)
SYMLINPEN 120	1-Covered	QL (10.8 PER 30 DAYS), NDS (Non-Extended Day Supply)
SYMLINPEN 60	1-Covered	QL (6 PER 30 DAYS), NDS (Non-Extended Day Supply)
SYNJARDY (5-1000 MG TAB, 12.5-500 MG TAB, 12.5-1000 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
SYNJARDY 5-500 MG TAB	1-Covered	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1000 MG TAB ER, 10-1000 MG TAB ER, 12.5-1000 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	1-Covered	QL (30 PER 30 DAYS)
TRADJENTA	1-Covered	QL (30 PER 30 DAYS)
TRIJARDY XR (10-5-1000 MG TAB ER, 25-5-1000 MG TAB ER)	1-Covered	QL (30 PER 30 DAYS)
TRIJARDY XR (5-2.5-1000 MG TAB ER, 12.5-2.5-1000 MG TAB ER)	1-Covered	QL (60 PER 30 DAYS)
TRULICITY (0.75 MG/0.5ML SOLN, 1.5 MG/0.5ML SOLN)	1-Covered	QL (2 PER 28 DAYS)
TRULICITY (3 MG/0.5ML SOLN, 4.5 MG/0.5ML SOLN)	1-Covered	QL (2 PER 28 DAYS)
VICTOZA	1-Covered	QL (9 PER 30 DAYS)
XIGDUO XR (10-500 MG TAB ER, 10-1000 MG TAB ER)	1-Covered	QL (30 PER 30 DAYS)
XIGDUO XR (2.5-1000 MG TAB ER, 5-500 MG TAB ER, 5-1000 MG TAB ER)	1-Covered	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
GLYCEMIC AGENTS		
diazoxide	1-Covered	
GLUCAGEN HYPOKIT	1-Covered	
GLUCAGON EMERGENCY (1 MG KIT, 1 MG/ML RECON SOLN)	1-Covered	
glucagon emergency 1 mg kit (generic)	1-Covered	
GVOKE HYPOPEN 1-PACK	1-Covered	
GVOKE HYPOPEN 2-PACK	1-Covered	
GVOKE KIT	1-Covered	
GVOKE PFS	1-Covered	
INSULINS		
BASAGLAR KWIKPEN	1-Covered	
HUMALOG (100 UNIT/ML SOLUTION, 100 UNIT/ML SOLN CART)	1-Covered	
HUMALOG JUNIOR KWIKPEN	1-Covered	
HUMALOG KWIKPEN	1-Covered	
HUMALOG MIX 50/50	1-Covered	
HUMALOG MIX 50/50 KWIKPEN	1-Covered	
HUMALOG MIX 75/25	1-Covered	
HUMALOG MIX 75/25 KWIKPEN	1-Covered	
HUMULIN 70/30	1-Covered	
HUMULIN 70/30 KWIKPEN	1-Covered	
HUMULIN N	1-Covered	
HUMULIN N KWIKPEN	1-Covered	
HUMULIN R	1-Covered	
HUMULIN R U-500 (CONCENTRATED)	1-Covered	
HUMULIN R U-500 KWIKPEN	1-Covered	
INSULIN LISPRO	1-Covered	
INSULIN LISPRO (1 UNIT DIAL)	1-Covered	
INSULIN LISPRO JUNIOR KWIKPEN	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INSULIN LISPRO PROT & LISPRO	1-Covered	
LANTUS	1-Covered	
LANTUS SOLOSTAR	1-Covered	
LEVEMIR	1-Covered	
LEVEMIR FLEXPEN	1-Covered	
LEVEMIR FLEXTOUCH	1-Covered	
LYUMJEV	1-Covered	
LYUMJEV KWIKPEN	1-Covered	
TOUJEO MAX SOLOSTAR	1-Covered	
TOUJEO SOLOSTAR	1-Covered	
TRESIBA	1-Covered	
TRESIBA FLEXTOUCH	1-Covered	
BLOOD PRODUCTS AND MODIFIERS		
ANTICOAGULANTS		
ELIQUIS	1-Covered	
ELIQUIS DVT/PE STARTER PACK	1-Covered	
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)	1-Covered	
fondaparinux sodium (5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml)	1-Covered	NDS (Non-Extended Day Supply)
fondaparinux sodium 2.5 mg/0.5ml solution	1-Covered	
heparin sodium (porcine) ((porcine) 1000 unit/ml, (porcine) 5000 unit/ml, (porcine) 10000 unit/ml, (porcine) 20000 unit/ml)	1-Covered	
jantoven	1-Covered	
warfarin sodium	1-Covered	
XARELTO (1 MG/ML RECON SUSP, 2.5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB)	1-Covered	

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
XARELTO STARTER PACK	1-Covered	
ZONTIVITY	1-Covered	
BLOOD PRODUCTS AND MODIFIERS, OTHER		
anagrelide hcl	1-Covered	
LEUKINE	1-Covered	NDS (Non-Extended Day Supply)
NYVEPRIA	1-Covered	PA, NDS (Non-Extended Day Supply)
PROCRIT (2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML)	1-Covered	PA - TO CONFIRM PART D COVERAGE
PROCRIT (20000 UNIT/ML, 40000 UNIT/ML)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
PROMACTA 12.5 MG PACKET	1-Covered	PA, QL (360 PER 30 DAYS), NDS (Non-Extended Day Supply)
PROMACTA 25 MG PACKET	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
PROMACTA (12.5 MG TAB, 25 MG TAB)	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
PROMACTA (50 MG TAB, 75 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
RETACRIT	1-Covered	PA - TO CONFIRM PART D COVERAGE
ZARXIO	1-Covered	PA, NDS (Non-Extended Day Supply)
ZIEXTENZO	1-Covered	PA, NDS (Non-Extended Day Supply)
HEMOSTASIS AGENTS		
tranexamic acid 650 mg tab	1-Covered	
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole er	1-Covered	
BRILINTA	1-Covered	
cilostazol	1-Covered	
clopidogrel bisulfate	1-Covered	
dipyridamole	1-Covered	PA
prasugrel hcl	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine	1-Covered	QL (4 PER 28 DAYS)
clonidine hcl	1-Covered	
droxidopa (200 mg cap, 300 mg cap)	1-Covered	QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
droxidopa 100 mg cap	1-Covered	QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
guanfacine hcl	1-Covered	PA
midodrine hcl	1-Covered	
ALPHA-ADRENERGIC BLOCKING AGENTS		
doxazosin mesylate	1-Covered	
phenoxybenzamine hcl	1-Covered	NDS (Non-Extended Day Supply)
prazosin hcl	1-Covered	
terazosin hcl	1-Covered	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1-Covered	
irbesartan	1-Covered	
losartan potassium	1-Covered	
olmesartan medoxomil	1-Covered	
telmisartan	1-Covered	
valsartan (40 mg tab, 80 mg tab, 160 mg tab, 320 mg tab)	1-Covered	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl	1-Covered	
captopril	1-Covered	
enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
fosinopril sodium	1-Covered	
lisinopril	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
moexipril hcl	1-Covered	
perindopril erbumine	1-Covered	
quinapril hcl	1-Covered	
ramipril	1-Covered	
trandolapril	1-Covered	
ANTIARRHYTHMICS		
amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)	1-Covered	
disopyramide phosphate	1-Covered	PA
dofetilide	1-Covered	
flecainide acetate	1-Covered	
mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)	1-Covered	
MULTAQ	1-Covered	
pacerone	1-Covered	
propafenone hcl	1-Covered	
propafenone hcl er	1-Covered	
quinidine sulfate	1-Covered	
sorine	1-Covered	
sotalol hcl	1-Covered	
sotalol hcl (af)	1-Covered	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	1-Covered	
atenolol	1-Covered	
betaxolol hcl (10 mg tab, 20 mg tab)	1-Covered	
bisoprolol fumarate	1-Covered	
carvedilol	1-Covered	
labetalol hcl (100 mg tab, 200 mg tab, 300 mg tab)	1-Covered	
metoprolol succinate er	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
nadolol	1-Covered	
nebivolol hcl (2.5 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (30 PER 30 DAYS)
nebivolol hcl 20 mg tab	1-Covered	QL (60 PER 30 DAYS)
pindolol	1-Covered	
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)	1-Covered	
propranolol hcl er	1-Covered	
timolol maleate (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
amlodipine besylate	1-Covered	
felodipine er	1-Covered	
isradipine	1-Covered	
nicardipine hcl (20 mg cap, 30 mg cap)	1-Covered	
nifedipine er	1-Covered	
nifedipine er osmotic release	1-Covered	
nimodipine	1-Covered	
CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES		
cartia xt	1-Covered	
dilt-xr	1-Covered	
diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)	1-Covered	
diltiazem hcl er (er 60 mg cap er 12h, er 90 mg cap er 12h, er 120 mg cap er 24h, er 120 mg tab er 24h, er 120 mg cap er 12h, er 180 mg tab er 24h, er 180 mg cap er 24h, er 240 mg cap er 24h, er 240 mg tab er 24h, er 300 mg tab er 24h, er 360 mg tab er 24h, er 420 mg tab er 24h)	1-Covered	
diltiazem hcl er beads	1-Covered	
diltiazem hcl er coated beads	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
matzim la	1-Covered	
taztia xt	1-Covered	
tiadylt er	1-Covered	
verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)	1-Covered	
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)	1-Covered	
CARDIOVASCULAR AGENTS, OTHER		
acetazolamide	1-Covered	
aliskiren fumarate	1-Covered	QL (30 PER 30 DAYS)
amiloride-hydrochlorothiazide	1-Covered	
amlodipine besy-benazepril hcl	1-Covered	
amlodipine besylate-valsartan	1-Covered	
amlodipine-atorvastatin	1-Covered	
amlodipine-olmesartan	1-Covered	
amlodipine-valsartan-hctz	1-Covered	
atenolol-chlorthalidone	1-Covered	
benazepril-hydrochlorothiazide	1-Covered	
bisoprolol-hydrochlorothiazide	1-Covered	
candesartan cilexetil-hctz	1-Covered	
CORLANOR 5 MG/5ML SOLUTION	1-Covered	QL (450 PER 30 DAYS)
CORLANOR (5 MG TAB, 7.5 MG TAB)	1-Covered	QL (60 PER 30 DAYS)
digoxin 0.05 mg/ml solution	1-Covered	
digoxin (125 mcg tab, 250 mcg tab)	1-Covered	QL (30 PER 30 DAYS)
enalapril-hydrochlorothiazide	1-Covered	
ENTRESTO	1-Covered	QL (60 PER 30 DAYS)
fosinopril sodium-hctz	1-Covered	

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
irbesartan-hydrochlorothiazide	1-Covered	
lisinopril-hydrochlorothiazide	1-Covered	
losartan potassium-hctz	1-Covered	
metoprolol-hydrochlorothiazide	1-Covered	
metyrosine	1-Covered	NDS (Non-Extended Day Supply)
olmesartan medoxomil-hctz	1-Covered	
olmesartan-amlodipine-hctz	1-Covered	
pentoxifylline er	1-Covered	
quinapril-hydrochlorothiazide	1-Covered	
ranolazine er	1-Covered	
spironolactone-hctz	1-Covered	
telmisartan-amlodipine	1-Covered	
telmisartan-hctz	1-Covered	
trandolapril-verapamil hcl er	1-Covered	
triamterene-hctz (37.5-25 mg cap, 37.5-25 mg tab, 75-50 mg tab)	1-Covered	
valsartan-hydrochlorothiazide	1-Covered	
DIURETICS, LOOP		
bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	
furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)	1-Covered	
torsemide	1-Covered	
DIURETICS, POTASSIUM-SPARING		
amiloride hcl	1-Covered	
eplerenone	1-Covered	
spironolactone (25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
DIURETICS, THIAZIDE		
chlorthalidone	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydrochlorothiazide (12.5 mg tab, 12.5 mg cap, 25 mg tab, 50 mg tab)	1-Covered	
indapamide	1-Covered	
metolazone	1-Covered	
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)	1-Covered	
fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)	1-Covered	
fenofibric acid	1-Covered	
gemfibrozil	1-Covered	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium (10 mg tab, 40 mg tab)	1-Covered	QL (60 PER 30 DAYS)
atorvastatin calcium 20 mg tab	1-Covered	QL (90 PER 30 DAYS)
atorvastatin calcium 80 mg tab	1-Covered	QL (30 PER 30 DAYS)
LIVALO	1-Covered	ST, QL (30 PER 30 DAYS)
lovastatin (10 mg tab, 20 mg tab)	1-Covered	QL (30 PER 30 DAYS)
lovastatin 40 mg tab	1-Covered	QL (60 PER 30 DAYS)
pravastatin sodium	1-Covered	QL (30 PER 30 DAYS)
rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	QL (60 PER 30 DAYS)
rosuvastatin calcium 40 mg tab	1-Covered	QL (30 PER 30 DAYS)
simvastatin	1-Covered	QL (30 PER 30 DAYS)
DYSLIPIDEMICS, OTHER		
cholestyramine (4 gm packet, 4 gm/dose powder)	1-Covered	
cholestyramine light (4 gm packet, 4 gm/dose powder)	1-Covered	
colesevelam hcl (3.75 gm packet, 625 mg tab)	1-Covered	
colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ezetimibe	1-Covered	QL (30 PER 30 DAYS)
ezetimibe-simvastatin	1-Covered	QL (30 PER 30 DAYS)
niacin er (antihyperlipidemic)	1-Covered	
omega-3-acid ethyl esters	1-Covered	
prevalite (4 gm packet, 4 gm/dose powder)	1-Covered	
REPATHA	1-Covered	PA, QL (3 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM	1-Covered	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	1-Covered	PA, QL (3 PER 28 DAYS)
VASCEPA	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)	1-Covered	
minoxidil (2.5 mg tab, 10 mg tab)	1-Covered	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)	1-Covered	
isosorbide mononitrate	1-Covered	
isosorbide mononitrate er	1-Covered	
NITRO-BID	1-Covered	
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, 0.4 mg/spray solution, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)	1-Covered	
RECTIV	1-Covered	QL (30 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
amphetamine-dextroamphet er	1-Covered	QL (30 PER 30 DAYS)
amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)	1-Covered	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)	1-Covered	QL (120 PER 30 DAYS)
amphetamine-dextroamphetamine 30 mg tab	1-Covered	QL (60 PER 30 DAYS)
dextroamphetamine sulfate (5 mg tab, 10 mg tab)	1-Covered	QL (180 PER 30 DAYS)
dextroamphetamine sulfate er	1-Covered	QL (120 PER 30 DAYS)
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)	1-Covered	QL (60 PER 30 DAYS)
atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)	1-Covered	QL (30 PER 30 DAYS)
atomoxetine hcl 18 mg cap	1-Covered	QL (120 PER 30 DAYS)
dexmethylphenidate hcl	1-Covered	QL (60 PER 30 DAYS)
guanfacine hcl er	1-Covered	QL (30 PER 30 DAYS)
methylphenidate hcl (2.5 mg tab, 5 mg tab, 10 mg tab)	1-Covered	QL (180 PER 30 DAYS)
methylphenidate hcl 10 mg/5ml solution	1-Covered	QL (900 PER 30 DAYS)
methylphenidate hcl 5 mg/5ml solution	1-Covered	QL (1800 PER 30 DAYS)
methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)	1-Covered	QL (90 PER 30 DAYS)
methylphenidate hcl er (er 10 mg tab er, er 20 mg tab er)	1-Covered	QL (90 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO (9 MG TAB, 12 MG TAB)	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO 6 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR (6 MG TAB ER, 12 MG TAB ER)	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
AUSTEDO XR 24 MG TAB ER 24H	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
bac	1-Covered	PA, QL (180 PER 30 DAYS)
butalbital-apap-caffeine 50-325-40 mg tab	1-Covered	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)	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
INGREZZA 60 MG CAP	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
INGREZZA 40 & 80 MG CAP THPK	1-Covered	PA, QL (28 PER 28 DAYS), NDS (Non-Extended Day Supply)
NUEDEXTA	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
riluzole	1-Covered	
tetrabenazine 12.5 mg tab	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
tetrabenazine 25 mg tab	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
FIBROMYALGIA AGENTS		
DRIZALMA SPRINKLE	1-Covered	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
duloxetine hcl (20 mg dr, 30 mg dr, 60 mg dr)	1-Covered	QL (60 PER 30 DAYS)
pregabalin (225 mg cap, 300 mg cap)	1-Covered	QL (60 PER 30 DAYS)
pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)	1-Covered	QL (90 PER 30 DAYS)
pregabalin 20 mg/ml solution	1-Covered	QL (900 PER 30 DAYS)
pregabalin er (er 82.5 mg tab er, er 165 mg tab er)	1-Covered	PA, QL (90 PER 30 DAYS)
pregabalin er 330 mg tab er 24h	1-Covered	PA, QL (60 PER 30 DAYS)
SAVELLA	1-Covered	
SAVELLA TITRATION PACK	1-Covered	
MULTIPLE SCLEROSIS AGENTS		
AVONEX PEN	1-Covered	NDS (Non-Extended Day Supply)
AVONEX PREFILLED	1-Covered	NDS (Non-Extended Day Supply)
BAFIERTAM	1-Covered	NDS (Non-Extended Day Supply)
BETASERON	1-Covered	NDS (Non-Extended Day Supply)
COPAXONE 20 MG/ML SOLN PRSYR	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)

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
COPAXONE 40 MG/ML SOLN PRSYR	1-Covered	QL (12 PER 28 DAYS), NDS (Non-Extended Day Supply)
dalfampridine er	1-Covered	QL (60 PER 30 DAYS)
fingolimod hcl	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
GILENYA 0.5 MG CAP	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
KESIMPTA	1-Covered	PA, NDS (Non-Extended Day Supply)
PLEGRIDY (125 MCG/0.5ML SOLN PEN, 125 MCG/0.5ML SOLN PRSYR)	1-Covered	NDS (Non-Extended Day Supply)
PLEGRIDY STARTER PACK (63 94 MCG/0.5ML SOLN PRSYR, 63 94 MCG/0.5ML SOLN PEN)	1-Covered	NDS (Non-Extended Day Supply)
TECFIDERA (120 MG CAP DR, 240 MG CAP DR)	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
TECFIDERA 120 & 240 MG MISC	1-Covered	NDS (Non-Extended Day Supply)
VUMERITY	1-Covered	QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
DENTAL AND ORAL AGENTS		
cevimeline hcl	1-Covered	
chlorhexidine gluconate	1-Covered	
oralone	1-Covered	
paroex	1-Covered	
periogard	1-Covered	
pilocarpine hcl (5 mg tab, 7.5 mg tab)	1-Covered	
triamcinolone acetonide 0.1 % paste	1-Covered	
DERMATOLOGICAL AGENTS		
ACNE AND ROSACEA AGENTS		
accutane	1-Covered	
acitretin	1-Covered	PA - FOR NEW STARTS ONLY
amnesteem	1-Covered	
avita	1-Covered	PA, QL (45 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
benzoyl peroxide-erythromycin	1-Covered	QL (46.6 PER 30 DAYS)
claravis	1-Covered	
clindamycin phos-benzoyl perox 1-5 % gel	1-Covered	QL (50 PER 30 DAYS)
clindamycin phos-benzoyl perox 1.2-5 % gel	1-Covered	QL (45 PER 30 DAYS)
isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)	1-Covered	
myorisan	1-Covered	
tazarotene 0.1 % cream	1-Covered	QL (60 PER 30 DAYS)
TAZORAC 0.05 % CREAM	1-Covered	QL (60 PER 30 DAYS)
tretinoin (0.01 % gel, 0.025 % gel, 0.025 % cream, 0.05 % cream, 0.1 % cream)	1-Covered	PA, QL (45 PER 30 DAYS)
zenatane	1-Covered	
DERMATITIS AND PRURITUS AGENTS		
ala-cort	1-Covered	
alclometasone dipropionate (0.05 % cream, 0.05 % ointment)	1-Covered	
ammonium lactate (12 % lotion, 12 % cream)	1-Covered	
betamethasone dipropionate (0.05 % lotion, 0.05 % ointment, 0.05 % cream)	1-Covered	
betamethasone dipropionate aug (0.05 % cream, 0.05 % ointment, 0.05 % gel)	1-Covered	
betamethasone valerate (0.1 % cream, 0.1 % ointment, 0.1 % lotion)	1-Covered	
clobetasol prop emollient base	1-Covered	QL (120 PER 30 DAYS)
clobetasol propionate (0.05 % solution, 0.05 % foam)	1-Covered	QL (100 PER 30 DAYS)
clobetasol propionate 0.05 % liquid	1-Covered	QL (125 PER 30 DAYS)
clobetasol propionate (0.05 % lotion, 0.05 % shampoo)	1-Covered	QL (118 PER 30 DAYS)
clobetasol propionate (0.05 % ointment, 0.05 % gel, 0.05 % cream)	1-Covered	QL (120 PER 30 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clobetasol propionate e	1-Covered	QL (120 PER 30 DAYS)
clobetasol propionate emulsion	1-Covered	QL (100 PER 30 DAYS)
clodan	1-Covered	QL (118 PER 30 DAYS)
desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)	1-Covered	
desoximetasone (0.05 % ointment, 0.05 % cream, 0.05 % gel, 0.25 % cream, 0.25 % ointment)	1-Covered	
fluocinolone acetonide (0.01 % cream, 0.01 % solution, 0.025 % ointment, 0.025 % cream)	1-Covered	
fluocinolone acetonide body	1-Covered	
fluocinolone acetonide scalp	1-Covered	
fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)	1-Covered	QL (120 PER 30 DAYS)
fluocinonide 0.05 % solution	1-Covered	QL (60 PER 30 DAYS)
fluocinonide emulsified base	1-Covered	QL (120 PER 30 DAYS)
fluticasone propionate (0.005 % ointment, 0.05 % cream)	1-Covered	
halobetasol propionate (0.05 % ointment, 0.05 % cream)	1-Covered	QL (50 PER 30 DAYS)
hydrocortisone (1 % cream, 1 % ointment, 2.5 % lotion, 2.5 % ointment, 2.5 % cream)	1-Covered	
hydrocortisone (perianal)	1-Covered	
hydrocortisone butyrate (0.1 % ointment, 0.1 % solution)	1-Covered	
hydrocortisone valerate (0.2 % ointment, 0.2 % cream)	1-Covered	
mometasone furoate (0.1 % solution, 0.1 % ointment, 0.1 % cream)	1-Covered	
procto-med hc	1-Covered	
procto-pak	1-Covered	
proctosol hc	1-Covered	
proctozone-hc	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
selenium sulfide 2.5 % lotion	1-Covered	
tacrolimus (0.03 %, 0.1 %)	1-Covered	QL (100 PER 30 DAYS)
tovet	1-Covered	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)	1-Covered	
triderm	1-Covered	
DERMATOLOGICAL AGENTS, OTHER		
calcipotriene (0.005 % cream, 0.005 % ointment)	1-Covered	QL (120 PER 30 DAYS)
calcipotriene 0.005 % solution	1-Covered	QL (60 PER 30 DAYS)
calcitrene	1-Covered	QL (120 PER 30 DAYS)
clotrimazole-betamethasone 1-0.05 % cream	1-Covered	QL (45 PER 30 DAYS)
clotrimazole-betamethasone 1-0.05 % lotion	1-Covered	QL (60 PER 30 DAYS)
fluorouracil 0.5 % cream	1-Covered	QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
fluorouracil 5 % cream	1-Covered	QL (80 PER 30 DAYS)
fluorouracil (2 %, 5 %)	1-Covered	QL (20 PER 30 DAYS)
imiquimod 5 % cream	1-Covered	QL (24 PER 30 DAYS)
nystatin-triamcinolone (100000-0.1 unit/gm-% ointment, 100000-0.1 unit/gm-% cream)	1-Covered	QL (60 PER 30 DAYS)
PODOFILOX	1-Covered	
REGRANEX	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
SANTYL	1-Covered	QL (90 PER 30 DAYS)
silver sulfadiazine	1-Covered	
ssd	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PEDICULICIDES/SCABICIDES		
lindane	1-Covered	
malathion	1-Covered	
permethrin	1-Covered	
TOPICAL ANTI-INFECTIVES		
acyclovir 5 % ointment	1-Covered	QL (30 PER 30 DAYS)
ciclodan	1-Covered	QL (13.2 PER 30 DAYS)
ciclopirox 0.77 % gel	1-Covered	QL (100 PER 30 DAYS)
ciclopirox 1 % shampoo	1-Covered	QL (120 PER 30 DAYS)
ciclopirox 8 % solution	1-Covered	QL (13.2 PER 30 DAYS)
clindamycin phosphate 1 % gel	1-Covered	QL (75 PER 30 DAYS)
clindamycin phosphate (1 % lotion, 1 % solution)	1-Covered	QL (60 PER 30 DAYS)
ery	1-Covered	QL (60 PER 30 DAYS)
erythromycin 2 % gel	1-Covered	QL (60 PER 30 DAYS)
erythromycin 2 % solution	1-Covered	QL (120 PER 30 DAYS)
mupirocin 2 % ointment	1-Covered	QL (66 PER 30 DAYS)
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
carglumic acid	1-Covered	NDS (Non-Extended Day Supply)
CLINIMIX E/DEXTROSE (2.75/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/10)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/15)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/20)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/5)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15)	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20)	1-Covered	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clinisol sf	1-Covered	PA - TO CONFIRM PART D COVERAGE
CLINOLIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
dextrose (5 %, 10 %, 50 %, 70 %, 250 mg/ml)	1-Covered	
dextrose-nacl (2.5-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.9 %, 5-0.45 %, 10-0.45 %, 10-0.2 %)	1-Covered	
dextrose-sodium chloride (2.5-0.45 %, 5-0.45 %, 5-0.9 %)	1-Covered	
FREAMINE III	1-Covered	PA - TO CONFIRM PART D COVERAGE
INTRALIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
ISOLYTE-P IN D5W	1-Covered	
ISOLYTE-S	1-Covered	
ISOLYTE-S PH 7.4	1-Covered	
kcl in dextrose-nacl (10-5-0.45 meq/l-%-%, 20-5-0.225 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-%-%)	1-Covered	
KCL-LACTATED RINGERS-D5W	1-Covered	
klor-con (8 tab er, 20 packet)	1-Covered	
klor-con 10	1-Covered	
klor-con m10	1-Covered	
klor-con m15	1-Covered	
klor-con m20	1-Covered	
klor-con sprinkle	1-Covered	
levocarnitine (1 gm/10ml solution, 330 mg tab)	1-Covered	
levocarnitine sf	1-Covered	
magnesium sulfate 50 % solution	1-Covered	
NUTRILIPID	1-Covered	PA - TO CONFIRM PART D COVERAGE
PLASMA-LYTE 148	1-Covered	
PLASMA-LYTE A	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
plenamine	1-Covered	PA - TO CONFIRM PART D COVERAGE
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)	1-Covered	
potassium chloride crys er	1-Covered	
potassium chloride er (er 8 tab er, er 8 cap er, er 10 tab er, er 10 cap er, er 20 tab er)	1-Covered	
potassium chloride in dextrose 20-5 meq/l-% solution	1-Covered	
potassium chloride in nacl (20-0.45 meq/l-% solution, 40-0.9 meq/l-% solution)	1-Covered	
potassium citrate er	1-Covered	
PREMASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
PROSOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
sodium chloride (0.45 %, 0.9 %, 3 %, 5 %)	1-Covered	
sodium chloride (pf)	1-Covered	
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-Covered	
TPN ELECTROLYTES	1-Covered	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	1-Covered	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE	1-Covered	PA - TO CONFIRM PART D COVERAGE
ELECTROLYTE/MINERAL/METAL MODIFIERS		
CHEMET	1-Covered	
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)	1-Covered	PA, NDS (Non-Extended Day Supply)
deferasirox 90 mg tab	1-Covered	PA

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
deferasirox granules	1-Covered	PA, NDS (Non-Extended Day Supply)
deferiprone	1-Covered	NDS (Non-Extended Day Supply)
FERRIPROX 100 MG/ML SOLUTION	1-Covered	NDS (Non-Extended Day Supply)
FERRIPROX TWICE-A-DAY	1-Covered	NDS (Non-Extended Day Supply)
trientine hcl	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
PHOSPHATE BINDERS		
calcium acetate	1-Covered	
calcium acetate (phos binder) (binder) 667 mg tab, binder) 667 mg cap)	1-Covered	
sevelamer carbonate (0.8 gm packet, 2.4 gm packet, 800 mg tab)	1-Covered	
POTASSIUM BINDERS		
LOKELMA	1-Covered	
sodium polystyrene sulfonate	1-Covered	
sps	1-Covered	
VELTASSA	1-Covered	
VITAMINS		
prenatal vitamin oral tablet	1-Covered	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
constulose	1-Covered	
enulose	1-Covered	
generlac	1-Covered	
lactulose (10 gm/15ml, 20 gm/30ml)	1-Covered	
lactulose encephalopathy	1-Covered	
LINZESS	1-Covered	QL (30 PER 30 DAYS)
lubiprostone	1-Covered	QL (60 PER 30 DAYS)
MOVANTIK	1-Covered	QL (30 PER 30 DAYS)
RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION, 150 MG TAB)	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTI-DIARRHEAL AGENTS		
alosetron hcl	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)	1-Covered	
loperamide hcl 2 mg cap	1-Covered	
VIBERZI	1-Covered	QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
XERMELO	1-Covered	PA, QL (84 PER 28 DAYS), NDS (Non-Extended Day Supply)
ANTISPASMODICS, GASTROINTESTINAL		
dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)	1-Covered	
glycopyrrolate (1 mg tab, 2 mg tab)	1-Covered	
methscopolamine bromide	1-Covered	
GASTROINTESTINAL AGENTS, OTHER		
GATTEX	1-Covered	PA, NDS (Non-Extended Day Supply)
gavilyte-c	1-Covered	
gavilyte-g	1-Covered	
gavilyte-n with flavor pack	1-Covered	
MYALEPT	1-Covered	PA, NDS (Non-Extended Day Supply)
na sulfate-k sulfate-mg sulf	1-Covered	
OCALIVA	1-Covered	PA, NDS (Non-Extended Day Supply)
peg 3350-kcl-na bicarb-nacl	1-Covered	
peg-3350/electrolytes	1-Covered	
peg-3350/electrolytes/ascorbat	1-Covered	
peg-kcl-nacl-nasulf-na asc-c	1-Covered	
SUPREP BOWEL PREP KIT	1-Covered	
ursodiol (250 mg tab, 300 mg cap, 500 mg tab)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
cimetidine	1-Covered	
cimetidine hcl	1-Covered	
famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)	1-Covered	
nizatidine (150 mg cap, 300 mg cap)	1-Covered	
PROTECTANTS		
misoprostol	1-Covered	
sucralfate (1 gm/10ml suspension, 1 gm tab)	1-Covered	
PROTON PUMP INHIBITORS		
esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
lansoprazole (15 mg cap dr, 30 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)	1-Covered	QL (60 PER 30 DAYS)
pantoprazole sodium (20 mg tab dr, 40 mg tab dr)	1-Covered	QL (60 PER 30 DAYS)
rabeprazole sodium	1-Covered	QL (30 PER 30 DAYS)
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
ARALAST NP	1-Covered	PA, NDS (Non-Extended Day Supply)
betaine	1-Covered	NDS (Non-Extended Day Supply)
CREON	1-Covered	
cromolyn sodium 100 mg/5ml conc	1-Covered	
CYSTAGON	1-Covered	
CYSTARAN	1-Covered	PA, NDS (Non-Extended Day Supply)
ENDARI	1-Covered	PA, QL (180 PER 30 DAYS), NDS (Non-Extended Day Supply)
GLASSIA	1-Covered	PA, NDS (Non-Extended Day Supply)
javygtor (100 mg tab, 100 mg packet, 500 mg packet)	1-Covered	NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
miglustat	1-Covered	QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
nitisinone	1-Covered	NDS (Non-Extended Day Supply)
NITYR	1-Covered	NDS (Non-Extended Day Supply)
PANCREAZE	1-Covered	
PROLASTIN-C (1000 MG/20ML SOLUTION, 1000 MG RECON SOLN)	1-Covered	PA, NDS (Non-Extended Day Supply)
RAVICTI	1-Covered	PA, QL (525 PER 30 DAYS), NDS (Non-Extended Day Supply)
sapropterin dihydrochloride (100 mg packet, 100 mg tab, 500 mg packet)	1-Covered	NDS (Non-Extended Day Supply)
sodium phenylbutyrate 500 mg tab	1-Covered	NDS (Non-Extended Day Supply)
ZEMAIRA	1-Covered	PA, NDS (Non-Extended Day Supply)
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin hydrobromide er	1-Covered	QL (30 PER 30 DAYS)
fesoterodine fumarate er	1-Covered	QL (30 PER 30 DAYS)
flavoxate hcl	1-Covered	
GEMTESA	1-Covered	
MYRBETRIQ (8 MG/ML SRER, 25 MG TAB ER 24H, 50 MG TAB ER 24H)	1-Covered	
oxybutynin chloride (5 mg/5ml syrup, 5 mg tab)	1-Covered	
oxybutynin chloride er	1-Covered	QL (60 PER 30 DAYS)
solifenacin succinate	1-Covered	QL (30 PER 30 DAYS)
tolterodine tartrate	1-Covered	QL (60 PER 30 DAYS)
tolterodine tartrate er	1-Covered	QL (30 PER 30 DAYS)
trospium chloride	1-Covered	QL (60 PER 30 DAYS)
trospium chloride er	1-Covered	QL (30 PER 30 DAYS)
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er	1-Covered	QL (30 PER 30 DAYS)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
dutasteride	1-Covered	QL (30 PER 30 DAYS)
dutasteride-tamsulosin hcl	1-Covered	QL (30 PER 30 DAYS)
finasteride	1-Covered	QL (30 PER 30 DAYS)
silodosin	1-Covered	QL (30 PER 30 DAYS)
tamsulosin hcl	1-Covered	QL (60 PER 30 DAYS)
GENITOURINARY AGENTS, OTHER		
bethanechol chloride	1-Covered	
ELMIRON	1-Covered	
penicillamine 250 mg tab	1-Covered	NDS (Non-Extended Day Supply)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ACTHAR	1-Covered	PA, NDS (Non-Extended Day Supply)
betamethasone dipropionate aug 0.05 % lotion	1-Covered	
CORTROPHIN	1-Covered	PA, NDS (Non-Extended Day Supply)
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)	1-Covered	
dexamethasone sod phosphate pf 10 mg/ml solution	1-Covered	
dexamethasone sodium phosphate (4 mg/ml, 10 mg/ml, 20 mg/5ml, 100 mg/10ml, 120 mg/30ml)	1-Covered	
fludrocortisone acetate	1-Covered	
KORLYM	1-Covered	PA, NDS (Non-Extended Day Supply)
methylprednisolone (4 mg tab thpk, 4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)	1-Covered	
methylprednisolone acetate	1-Covered	
methylprednisolone sodium succ	1-Covered	
prednisolone 15 mg/5ml solution	1-Covered	
prednisolone sodium phosphate (6.7 (5 base) mg/5ml, 15 mg/5ml, 25 mg/5ml)	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
prednisone (1 mg tab, 2.5 mg tab, 5 mg/5ml solution, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 5 mg tab, 10 mg (48) tab thpk, 10 mg (21) tab thpk, 10 mg tab, 20 mg tab, 50 mg tab)	1-Covered	
PREDNISONE INTENSOL	1-Covered	
SOLU-MEDROL 2 GM RECON SOLN	1-Covered	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
desmopressin ace spray refrig	1-Covered	
desmopressin acetate (0.1 mg tab, 0.2 mg tab, 4 mcg/ml solution)	1-Covered	
desmopressin acetate pf	1-Covered	
desmopressin acetate spray	1-Covered	
INCRELEX	1-Covered	NDS (Non-Extended Day Supply)
NORDITROPIN FLEXPRO	1-Covered	PA, NDS (Non-Extended Day Supply)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
OXANDROLONE 10 MG TAB	1-Covered	PA, QL (60 PER 30 DAYS)
oxandrolone 2.5 mg tab	1-Covered	PA, QL (240 PER 30 DAYS)
ANDROGENS		
danazol	1-Covered	
testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)	1-Covered	PA, QL (300 PER 30 DAYS)
testosterone cypionate	1-Covered	PA - FOR NEW STARTS ONLY
testosterone enanthate	1-Covered	PA - FOR NEW STARTS ONLY
testosterone td gel pump 20.25 mg/act (1.62%)	1-Covered	PA, QL (150 PER 30 DAYS)
ESTROGENS		
afirmelle	1-Covered	
altavera	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
alyacen 1/35	1-Covered	
alyacen 7/7/7	1-Covered	
amabelz	1-Covered	
apri	1-Covered	
aranelle	1-Covered	
aubra eq	1-Covered	
aurovela 1.5/30	1-Covered	
aurovela 1/20	1-Covered	
aurovela fe 1.5/30	1-Covered	
aurovela fe 1/20	1-Covered	
aviane	1-Covered	
ayuna	1-Covered	
azurette	1-Covered	
balziva	1-Covered	
bekyree	1-Covered	
blisovi fe 1.5/30	1-Covered	
blisovi fe 1/20	1-Covered	
briellyn	1-Covered	
camrese lo	1-Covered	
chateal eq	1-Covered	
cryselle-28	1-Covered	
cyred eq	1-Covered	
dasetta 1/35	1-Covered	
dasetta 7/7/7	1-Covered	
delyla	1-Covered	
desogestrel-ethinyl estradiol	1-Covered	
dotti	1-Covered	
drospirenone-ethinyl estradiol	1-Covered	
elinest	1-Covered	
eluryng	1-Covered	

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
emoquette	1-Covered	
enpresse-28	1-Covered	
enskyce	1-Covered	
estarylla	1-Covered	
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)	1-Covered	
estradiol valerate	1-Covered	
estradiol-norethindrone acet	1-Covered	
ethynodiol diac-eth estradiol	1-Covered	
etonogestrel-ethinyl estradiol	1-Covered	
falmina	1-Covered	
femynor	1-Covered	
hailey 1.5/30	1-Covered	
hailey fe 1.5/30	1-Covered	
hailey fe 1/20	1-Covered	
haloette	1-Covered	
iclevia	1-Covered	
introvale	1-Covered	
isibloom	1-Covered	
jasmiel	1-Covered	
jolessa	1-Covered	
juleber	1-Covered	
junel 1.5/30	1-Covered	
junel 1/20	1-Covered	
junel fe 1.5/30	1-Covered	

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

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lyllana	1-Covered	
marlissa	1-Covered	
microgestin 1.5/30	1-Covered	
microgestin 1/20	1-Covered	
microgestin fe 1.5/30	1-Covered	
microgestin fe 1/20	1-Covered	
mili	1-Covered	
mimvey	1-Covered	
mono-linyah	1-Covered	
necon 0.5/35 (28)	1-Covered	
nikki	1-Covered	
norethin ace-eth estrad-fe (1-20 tab, 1.5-30 tab)	1-Covered	
norethin-eth estradiol-fe 0.4-35 mg-mcg chew tab	1-Covered	
norethindron-ethinyl estrad-fe	1-Covered	
norethindrone acet-ethinyl est	1-Covered	
norgestim-eth estrad triphasic	1-Covered	
norgestimate-eth estradiol	1-Covered	
nortrel 0.5/35 (28)	1-Covered	
nortrel 1/35 (21)	1-Covered	
nortrel 1/35 (28)	1-Covered	
nortrel 7/7/7	1-Covered	
nylia 1/35	1-Covered	
nylia 7/7/7	1-Covered	
nymyo	1-Covered	
ocella	1-Covered	
orsythia	1-Covered	
philith	1-Covered	
pimtrea	1-Covered	
pirmella 1/35	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pirmella 7/7/7	1-Covered	
portia-28	1-Covered	
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)	1-Covered	
PREMPHASE	1-Covered	
PREMPRO	1-Covered	
reclipsen	1-Covered	
setlakin	1-Covered	
simliya	1-Covered	
sprintec 28	1-Covered	
sronyx	1-Covered	
syeda	1-Covered	
tarina fe 1/20 eq	1-Covered	
tilia fe	1-Covered	
tri femynor	1-Covered	
tri-estarylla	1-Covered	
tri-legest fe	1-Covered	
tri-linyah	1-Covered	
tri-lo-estarylla	1-Covered	
tri-lo-marzia	1-Covered	
tri-lo-mili	1-Covered	
tri-lo-sprintec	1-Covered	
tri-mili	1-Covered	
tri-nymyo	1-Covered	
tri-previfem	1-Covered	
tri-sprintec	1-Covered	
tri-vylibra	1-Covered	
tri-vylibra lo	1-Covered	
trivora (28)	1-Covered	
velivet	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
vestura	1-Covered	
vienva	1-Covered	
viorele	1-Covered	
volnea	1-Covered	
vyfemla	1-Covered	
vylibra	1-Covered	
wera	1-Covered	
wymzya fe	1-Covered	
xulane	1-Covered	
yuvafem	1-Covered	
zafemy	1-Covered	
zarah	1-Covered	
zovia 1/35 (28)	1-Covered	
zumandimine	1-Covered	
PROGESTINS		
camila	1-Covered	
deblitane	1-Covered	
DEPO-SUBQ PROVERA 104	1-Covered	
errin	1-Covered	
heather	1-Covered	
incassia	1-Covered	
jencycla	1-Covered	
lyleq	1-Covered	
lyza	1-Covered	
medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml suspension, 150 mg/ml susp prsyr)	1-Covered	
megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension, 800 mg/20ml suspension)	1-Covered	
nora-be	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
norethindrone	1-Covered	
norethindrone acetate	1-Covered	
norlyda	1-Covered	
norlyroc	1-Covered	
progesterone (100 mg cap, 200 mg cap)	1-Covered	
sharobel	1-Covered	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
DUAVEE	1-Covered	
raloxifene hcl	1-Covered	QL (30 PER 30 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
euthyrox	1-Covered	
levo-t	1-Covered	
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-Covered	
levoxyl	1-Covered	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	1-Covered	
SYNTHROID	1-Covered	
unithroid	1-Covered	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN	1-Covered	NDS (Non-Extended Day Supply)
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
cabergoline	1-Covered	
ELIGARD	1-Covered	PA - TO CONFIRM PART D COVERAGE
FIRMAGON	1-Covered	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (240 MG DOSE)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
leuprolide acetate	1-Covered	PA - TO CONFIRM PART D COVERAGE
LEUPROLIDE ACETATE (3 MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (1-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (3-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (4-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT (6-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (1-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
LUPRON DEPOT-PED (3-MONTH)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
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)	1-Covered	
ORGOVYX	1-Covered	PA - FOR NEW STARTS ONLY, NDS (Non-Extended Day Supply)
SIGNIFOR	1-Covered	NDS (Non-Extended Day Supply)
SOMATULINE DEPOT	1-Covered	NDS (Non-Extended Day Supply)
SOMAVERT	1-Covered	NDS (Non-Extended Day Supply)
SYNAREL	1-Covered	NDS (Non-Extended Day Supply)
TRELSTAR MIXJECT	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole (5 mg tab, 10 mg tab)	1-Covered	
propylthiouracil	1-Covered	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
CINRYZE	1-Covered	PA, NDS (Non-Extended Day Supply)
icatibant acetate	1-Covered	PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply)
sajazir	1-Covered	PA, QL (27 PER 30 DAYS), NDS (Non-Extended Day Supply)
IMMUNOGLOBULINS		
ATGAM	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
BIVIGAM	1-Covered	PA, NDS (Non-Extended Day Supply)
FLEBOGAMMA DIF	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAGARD	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAGARD S/D LESS IGA	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAKED	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMMAPLEX	1-Covered	PA, NDS (Non-Extended Day Supply)
GAMUNEX-C	1-Covered	PA, NDS (Non-Extended Day Supply)
OCTAGAM	1-Covered	PA, NDS (Non-Extended Day Supply)
PANZYGA	1-Covered	PA, NDS (Non-Extended Day Supply)
PRIVIGEN	1-Covered	PA, NDS (Non-Extended Day Supply)
THYMOGLOBULIN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST	1-Covered	NDS (Non-Extended Day Supply)
BENLYSTA (120 MG SOLN, 400 MG SOLN)	1-Covered	PA, NDS (Non-Extended Day Supply)
BENLYSTA (200 MG/ML SOLN PRSYR, 200 MG/ML SOLN A-INJ)	1-Covered	PA, QL (8 PER 28 DAYS), NDS (Non-Extended Day Supply)
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)	1-Covered	PA, NDS (Non-Extended Day Supply)

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OTEZLA (10 20 30 MG TAB THPK, 30 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
RIDAURA	1-Covered	NDS (Non-Extended Day Supply)
SIMULECT 20 MG RECON SOLN	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
SKYRIZI (150 MG/ML SOLN PRSYR, 180 MG/1.2ML SOLN CART, 360 MG/2.4ML SOLN CART, 600 MG/10ML SOLUTION)	1-Covered	PA, NDS (Non-Extended Day Supply)
SKYRIZI PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
TALTZ (80 MG/ML SOLN A-INJ, 80 MG/ML SOLN PRSYR)	1-Covered	PA, NDS (Non-Extended Day Supply)
XELJANZ (1 MG/ML SOLUTION, 5 MG TAB, 10 MG TAB)	1-Covered	PA, NDS (Non-Extended Day Supply)
XELJANZ XR	1-Covered	PA, NDS (Non-Extended Day Supply)
XOLAIR (75 MG/0.5ML SOLN PRSYR, 150 MG/ML SOLN PRSYR, 150 MG RECON SOLN)	1-Covered	PA, NDS (Non-Extended Day Supply)
IMMUNOSTIMULANTS		
ACTIMMUNE	1-Covered	PA, NDS (Non-Extended Day Supply)
INTRON A (6000000 UNIT/ML SOLUTION, 10000000 UNIT/ML SOLUTION, 10000000 UNIT RECON SOLN, 18000000 UNIT RECON SOLN, 50000000 UNIT RECON SOLN)	1-Covered	NDS (Non-Extended Day Supply)
PEGASYS (180 MCG/0.5ML SOLN PRSYR, 180 MCG/ML SOLUTION)	1-Covered	NDS (Non-Extended Day Supply)
IMMUNOSUPPRESSANTS		
ASTAGRAF XL	1-Covered	PA - TO CONFIRM PART D COVERAGE
AVSOLA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
azathioprine 50 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE
AZATHIOPRINE SODIUM	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine (25 mg cap, 50 mg/ml solution, 100 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)	1-Covered	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
ENBREL (25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION, 25 MG RECON SOLN, 50 MG/ML SOLN PRSYR)	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL MINI	1-Covered	PA, NDS (Non-Extended Day Supply)
ENBREL SURECLICK	1-Covered	PA, NDS (Non-Extended Day Supply)
ENVARSUS XR	1-Covered	PA - TO CONFIRM PART D COVERAGE
everolimus (0.5 mg tab, 0.75 mg tab, 1 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
everolimus 0.25 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE
gengraf (25 mg cap, 100 mg/ml solution, 100 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
HUMIRA	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEDIATRIC CROHNS START	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN-CD/UC/HS STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN-PEDIATRIC UC START	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN-PS/UV/ADOL HS START	1-Covered	PA, NDS (Non-Extended Day Supply)
HUMIRA PEN-PSOR/UVEIT STARTER	1-Covered	PA, NDS (Non-Extended Day Supply)
INFLECTRA	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
leflunomide 10 mg tab	1-Covered	QL (30 PER 30 DAYS)
leflunomide 20 mg tab	1-Covered	QL (150 PER 30 DAYS)
methotrexate	1-Covered	
methotrexate sodium (1 gm recon soln, 2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution, 1000 mg/40ml solution)	1-Covered	
methotrexate sodium (pf)	1-Covered	
mycophenolate mofetil 200 mg/ml recon susp	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
mycophenolate mofetil (250 mg cap, 500 mg recon soln, 500 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate mofetil hcl	1-Covered	PA - TO CONFIRM PART D COVERAGE
mycophenolate sodium	1-Covered	PA - TO CONFIRM PART D COVERAGE

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NULOJIX	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
OTREXUP	1-Covered	
PROGRAF (0.2 MG, 1 MG)	1-Covered	PA - TO CONFIRM PART D COVERAGE
RASUVO	1-Covered	
RENFLEXIS	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
REZUROCK	1-Covered	PA, NDS (Non-Extended Day Supply)
RINVOQ	1-Covered	PA, NDS (Non-Extended Day Supply)
SANDIMMUNE 100 MG/ML SOLUTION	1-Covered	PA - TO CONFIRM PART D COVERAGE
sirolimus 1 mg/ml solution	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)	1-Covered	PA - TO CONFIRM PART D COVERAGE
tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)	1-Covered	PA - TO CONFIRM PART D COVERAGE
temsirolimus	1-Covered	NDS (Non-Extended Day Supply)
TREXALL	1-Covered	
XATMEP	1-Covered	
VACCINES		
ACTHIB	1-Covered	
ADACEL	1-Covered	
BCG VACCINE	1-Covered	
BEXSERO	1-Covered	
BOOSTRIX (5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR, 5-2.5-18.5 LF-MCG/0.5 SUSPENSION)	1-Covered	
DAPTACEL	1-Covered	
DIPHTHERIA-TETANUS TOXOIDS DT	1-Covered	
ENGERIX-B (10 MCG/0.5ML SUSP PRSYR, 20 MCG/ML SUSP PRSYR, 20 MCG/ML SUSPENSION)	1-Covered	PA - TO CONFIRM PART D COVERAGE
GARDASIL 9 (9SUSPPRSYR, 9SUSPENSION)	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HAVRIX	1-Covered	
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	1-Covered	PA - TO CONFIRM PART D COVERAGE
HIBERIX	1-Covered	
IMOVAX RABIES	1-Covered	
INFANRIX	1-Covered	
IPOL	1-Covered	
IXIARO	1-Covered	
JYNNEOS	1-Covered	PA - TO CONFIRM PART D COVERAGE
KINRIX	1-Covered	
M-M-R II	1-Covered	
MENACTRA	1-Covered	
MENQUADFI	1-Covered	
MENVEO (RECONSOLN, SOLUTION)	1-Covered	
PEDIARIX	1-Covered	
PEDVAX HIB	1-Covered	
PENTACEL	1-Covered	
PREHEVBRIO	1-Covered	PA - TO CONFIRM PART D COVERAGE
PRIORIX	1-Covered	
PROQUAD	1-Covered	
QUADRACEL (0.5MLSUSPPRSYR, SUSPENSION)	1-Covered	
RABAVERT	1-Covered	
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)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ROTARIX (RECONSUSP, SUSPENSION)	1-Covered	
ROTATEQ	1-Covered	
SHINGRIX	1-Covered	
TDVAX	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TENIVAC	1-Covered	
TICOVAC	1-Covered	
TRUMENBA	1-Covered	
TWINRIX	1-Covered	
TYPHIM VI (25 MCG/0.5ML SOLN PRSYR, 25 MCG/0.5ML SOLUTION)	1-Covered	
VAQTA	1-Covered	
VARIVAX	1-Covered	
YF-VAX	1-Covered	
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
balsalazide disodium	1-Covered	
mesalamine (1.2 gm tab dr, 4 gm enema, 400 mg cap dr, 800 mg tab dr)	1-Covered	
mesalamine er 0.375 gm cap er 24h	1-Covered	
mesalamine-cleanser	1-Covered	
sulfasalazine (500 mg tab dr, 500 mg tab)	1-Covered	
GLUCOCORTICOIDS		
budesonide 3 mg cp dr part	1-Covered	
budesonide er	1-Covered	NDS (Non-Extended Day Supply)
hydrocortisone (5 mg tab, 10 mg tab, 20 mg tab, 100 mg/60ml enema)	1-Covered	
METABOLIC BONE DISEASE AGENTS		
alendronate sodium 70 mg/75ml solution	1-Covered	
alendronate sodium (35 mg tab, 70 mg tab)	1-Covered	QL (4 PER 28 DAYS)
alendronate sodium 10 mg tab	1-Covered	QL (30 PER 30 DAYS)
calcitonin (salmon) 200 unit/act solution	1-Covered	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
calcitriol (0.25 mcg cap, 0.5 mcg cap, 1 mcg/ml solution)	1-Covered	
cinacalcet hcl 30 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
cinacalcet hcl 60 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
cinacalcet hcl 90 mg tab	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
doxercalciferol (0.5 mcg cap, 1 mcg cap, 2.5 mcg cap)	1-Covered	
FORTEO	1-Covered	PA, NDS (Non-Extended Day Supply)
ibandronate sodium 150 mg tab	1-Covered	QL (1 PER 30 DAYS)
NATPARA	1-Covered	PA, NDS (Non-Extended Day Supply)
paricalcitol (1 mcg cap, 2 mcg cap, 4 mcg cap)	1-Covered	
PROLIA	1-Covered	
RAYALDEE	1-Covered	NDS (Non-Extended Day Supply)
risedronate sodium (5 mg tab, 30 mg tab, 35 mg tab dr, 35 mg tab, 150 mg tab)	1-Covered	
TERIPARATIDE (RECOMBINANT)	1-Covered	PA, NDS (Non-Extended Day Supply)
XGEVA	1-Covered	PA, NDS (Non-Extended Day Supply)
zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)	1-Covered	PA - TO CONFIRM PART D COVERAGE
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL PADS	1-Covered	
GAUZE PADS & DRESSINGS - PADS 2 X 2	1-Covered	
INSULIN PEN NEEDLE (Novo/BD/Ultimed/Owen/Trividia)	1-Covered	
INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/Ultimed/Allison/Trividia/MHC)	1-Covered	
INSULIN SYRINGE (DISP) U-100 1 ML (BD/Ultimed/Allison/Trividia/MHC)	1-Covered	

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
INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/Ultimed/Allison/Trividia/MHC)	1-Covered	
NEEDLES, INSULIN DISP., SAFETY	1-Covered	
sterile water for irrigation	1-Covered	
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
ak-poly-bac	1-Covered	
ATROPINE SULFATE 1 % SOLUTION	1-Covered	
bacitra-neomycin-polymyxin-hc	1-Covered	
bacitracin-polymyxin b	1-Covered	
COMBIGAN	1-Covered	
cyclopentolate hcl	1-Covered	
dorzolamide hcl-timolol mal	1-Covered	
dorzolamide hcl-timolol mal pf	1-Covered	
ISOPTO ATROPINE	1-Covered	
neo-polycin	1-Covered	
neo-polycin hc	1-Covered	
neomycin-bacitracin zn-polymyx	1-Covered	
neomycin-polymyxin-dexameth (3.5-10000-0.1suspension, 3.5-10000-0.1ointment)	1-Covered	
neomycin-polymyxin-gramicidin	1-Covered	
neomycin-polymyxin-hc 3.5-10000-1 suspension	1-Covered	
OXERVATE	1-Covered	PA, NDS (Non-Extended Day Supply)
polycin	1-Covered	
proparacaine hcl	1-Covered	
RESTASIS	1-Covered	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	1-Covered	QL (5.5 PER 28 DAYS)
sulfacetamide-prednisolone	1-Covered	
TOBRADEX 0.3-0.1 % OINTMENT	1-Covered	

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
tobramycin-dexamethasone	1-Covered	
XIIDRA	1-Covered	QL (60 PER 30 DAYS)
ZYLET	1-Covered	
OPHTHALMIC ANTI-ALLERGY AGENTS		
ALOCRIL	1-Covered	
ALOMIDE	1-Covered	
azelastine hcl 0.05 % solution	1-Covered	
cromolyn sodium 4 % solution	1-Covered	
epinastine hcl	1-Covered	
olopatadine hcl (0.1 %, 0.2 %)	1-Covered	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE	1-Covered	
bacitracin 500 unit/gm ointment	1-Covered	
erythromycin 5 mg/gm ointment	1-Covered	
gatifloxacin	1-Covered	
gentak	1-Covered	
gentamicin sulfate 0.3 % solution	1-Covered	
levofloxacin 0.5 % solution	1-Covered	
moxifloxacin hcl 0.5 % solution	1-Covered	
moxifloxacin hcl (2x day)	1-Covered	
NATACYN	1-Covered	
ofloxacin 0.3 % solution	1-Covered	
polymyxin b-trimethoprim	1-Covered	
sulfacetamide sodium (10 % ointment, 10 % solution)	1-Covered	
tobramycin 0.3 % solution	1-Covered	
ZIRGAN	1-Covered	
OPHTHALMIC ANTI-INFLAMMATORIES		
bromfenac sodium (once-daily)	1-Covered	
dexamethasone sodium phosphate 0.1 % solution	1-Covered	

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
diclofenac sodium 0.1 % solution	1-Covered	
difluprednate	1-Covered	
FLAREX	1-Covered	
fluorometholone	1-Covered	
flurbiprofen sodium	1-Covered	
ILEVRO	1-Covered	
ketorolac tromethamine (0.4 %, 0.5 %)	1-Covered	
loteprednol etabonate (0.5 % gel, 0.5 % suspension)	1-Covered	
prednisolone acetate	1-Covered	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	1-Covered	
PROLENSA	1-Covered	
OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS		
betaxolol hcl 0.5 % solution	1-Covered	
carteolol hcl	1-Covered	
levobunolol hcl	1-Covered	
timolol maleate (0.25 % gel f soln, 0.25 % solution, 0.5 % solution, 0.5 % gel f soln, 0.5 % (daily) solution)	1-Covered	
OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER		
acetazolamide er	1-Covered	
ALPHAGAN P 0.1 % SOLUTION	1-Covered	
apraclonidine hcl	1-Covered	
AZOPT	1-Covered	
brimonidine tartrate (0.15 %, 0.2 %)	1-Covered	
dorzolamide hcl	1-Covered	
methazolamide	1-Covered	
pilocarpine hcl (1 %, 2 %, 4 %)	1-Covered	
RHOPRESSA	1-Covered	
SIMBRINZA	1-Covered	

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
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
bimatoprost 0.03% ophth solution	1-Covered	
latanoprost	1-Covered	
LUMIGAN	1-Covered	
travoprost (bak free)	1-Covered	
OTIC AGENTS		
CIPRODEX	1-Covered	
ciprofloxacin hcl 0.2 % solution	1-Covered	
flac	1-Covered	
fluocinolone acetonide 0.01 % oil	1-Covered	
hydrocortisone-acetic acid	1-Covered	
neomycin-polymyxin-hc (1 %, 3.5-10000-1)	1-Covered	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ARNUITY ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
budesonide (0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml)	1-Covered	PA - TO CONFIRM PART D COVERAGE
FLOVENT DISKUS	1-Covered	QL (80 PER 30 DAYS)
FLOVENT HFA (110 MCG/ACT, 220 MCG/ACT)	1-Covered	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG/ACT AEROSOL	1-Covered	QL (22 PER 30 DAYS)
flunisolide	1-Covered	QL (50 PER 30 DAYS)
fluticasone propionate 50 mcg/act suspension	1-Covered	QL (16 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA (110 MCG/ACT, 220 MCG/ACT)	1-Covered	QL (24 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA 44 MCG/ACT AEROSOL	1-Covered	QL (22 PER 30 DAYS)
mometasone furoate 50 mcg/act suspension	1-Covered	QL (34 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
PULMICORT FLEXHALER	1-Covered	QL (2 PER 30 DAYS)
ANTIHISTAMINES		
azelastine hcl (0.1 %, 0.15 %, 137 mcg/spray)	1-Covered	
cetirizine hcl 1 mg/ml solution	1-Covered	
cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)	1-Covered	
desloratadine 5 mg tab	1-Covered	
diphenhydramine hcl 50 mg/ml solution	1-Covered	
hydroxyzine hcl (10 mg/5ml syrup, 10 mg tab, 25 mg tab, 50 mg tab)	1-Covered	
levocetirizine dihydrochloride (2.5 mg/5ml solution, 5 mg tab)	1-Covered	
olopatadine hcl 0.6 % solution	1-Covered	
promethazine hcl (6.25 mg/5ml solution, 6.25 mg/5ml syrup)	1-Covered	PA
ANTILEUKOTRIENES		
montelukast sodium (4 mg chew tab, 4 mg packet, 5 mg chew tab, 10 mg tab)	1-Covered	QL (30 PER 30 DAYS)
zafirlukast 10 mg tab	1-Covered	QL (120 PER 30 DAYS)
zafirlukast 20 mg tab	1-Covered	QL (60 PER 30 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	1-Covered	QL (25.8 PER 30 DAYS)
INCRUSE ELLIPTA	1-Covered	QL (30 PER 30 DAYS)
ipratropium bromide (0.03 %, 0.06 %)	1-Covered	
ipratropium bromide 0.02 % solution	1-Covered	PA - TO CONFIRM PART D COVERAGE
SPIRIVA HANDIHALER	1-Covered	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
YUPELRI	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)

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
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)	1-Covered	PA - TO CONFIRM PART D COVERAGE
albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab)	1-Covered	
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)	1-Covered	QL (17 PER 30 DAYS)
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)	1-Covered	QL (13.4 PER 30 DAYS)
albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)	1-Covered	QL (36 PER 30 DAYS)
arformoterol tartrate	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
epinephrine (0.15 mg/0.15ml soln, 0.15 mg/0.3ml soln, 0.3 mg/0.3ml soln)	1-Covered	
formoterol fumarate	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
levalbuterol hcl (0.31 mg/3ml soln, 0.63 mg/3ml soln, 1.25 mg/3ml soln, 1.25 mg/0.5ml soln)	1-Covered	PA - TO CONFIRM PART D COVERAGE
levalbuterol tartrate	1-Covered	QL (30 PER 30 DAYS)
SEREVENT DISKUS	1-Covered	QL (60 PER 30 DAYS)
STRIVERDI RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
terbutaline sulfate (2.5 mg tab, 5 mg tab)	1-Covered	
CYSTIC FIBROSIS AGENTS		
CAYSTON	1-Covered	NDS (Non-Extended Day Supply)
KALYDECO (13.4 MG, 25 MG, 50 MG)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
KALYDECO (75 MG PACKET, 150 MG TAB)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ORKAMBI (75-94 MG, 100-125 MG, 150-188 MG)	1-Covered	PA, QL (56 PER 28 DAYS), NDS (Non-Extended Day Supply)
ORKAMBI 100-125 MG TAB	1-Covered	PA, QL (112 PER 28 DAYS), NDS (Non-Extended Day Supply)

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
ORKAMBI 200-125 MG TAB	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)
PULMOZYME	1-Covered	PA - TO CONFIRM PART D COVERAGE, NDS (Non-Extended Day Supply)
TOBI PODHALER	1-Covered	QL (240 PER 30 DAYS), NDS (Non-Extended Day Supply)
tobramycin 300 mg/5ml nebu soln	1-Covered	PA - TO CONFIRM PART D COVERAGE, QL (300 PER 30 DAYS), NDS (Non-Extended Day Supply)
MAST CELL STABILIZERS		
cromolyn sodium 20 mg/2ml nebu soln	1-Covered	PA - TO CONFIRM PART D COVERAGE
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
DALIRESP	1-Covered	
elixophyllin	1-Covered	
roflumilast	1-Covered	
theophylline (80 mg/15ml solution, 80 mg/15ml elixir)	1-Covered	
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)	1-Covered	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
alyq	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
ambrisentan	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
bosentan	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
OPSUMIT	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
sildenafil citrate 20 mg tab	1-Covered	PA, QL (90 PER 30 DAYS)
tadalafil (pah)	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
TRACLEER 32 MG TAB SOL	1-Covered	PA, QL (120 PER 30 DAYS), NDS (Non-Extended Day Supply)

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
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)	1-Covered	PA, NDS (Non-Extended Day Supply)
PULMONARY FIBROSIS AGENTS		
OFEV	1-Covered	PA, QL (60 PER 30 DAYS), NDS (Non-Extended Day Supply)
pirfenidone (267 mg tab, 267 mg cap)	1-Covered	PA, QL (270 PER 30 DAYS), NDS (Non-Extended Day Supply)
pirfenidone (534 mg tab, 801 mg tab)	1-Covered	PA, QL (90 PER 30 DAYS), NDS (Non-Extended Day Supply)
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine (10 %, 20 %)	1-Covered	PA - TO CONFIRM PART D COVERAGE
ADVAIR DISKUS	1-Covered	QL (60 PER 30 DAYS)
ADVAIR HFA	1-Covered	QL (12 PER 30 DAYS)
ANORO ELLIPTA	1-Covered	QL (60 PER 30 DAYS)
BEVESPI AEROSPHERE	1-Covered	QL (10.7 PER 30 DAYS)
BREO ELLIPTA 100-25 MCG/ACT AER POW BA	1-Covered	QL (60 PER 30 DAYS)
BREO ELLIPTA 200-25 MCG/ACT AER POW BA	1-Covered	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE	1-Covered	QL (10.7 PER 30 DAYS)
COMBIVENT RESPIMAT	1-Covered	QL (4 PER 30 DAYS)
FASENRA	1-Covered	PA, NDS (Non-Extended Day Supply)
FASENRA PEN	1-Covered	PA, NDS (Non-Extended Day Supply)
fluticasone furoate-vilanterol	1-Covered	QL (60 PER 30 DAYS)
ipratropium-albuterol	1-Covered	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)	1-Covered	PA, NDS (Non-Extended Day Supply)
SYMBICORT	1-Covered	QL (10.2 PER 30 DAYS)
TRELEGY ELLIPTA	1-Covered	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
SKELETAL MUSCLE RELAXANTS		
BOTOX	1-Covered	PA
carisoprodol 350 mg tab	1-Covered	PA, QL (120 PER 30 DAYS)
cyclobenzaprine hcl 10 mg tab	1-Covered	PA, QL (90 PER 30 DAYS)
cyclobenzaprine hcl 5 mg tab	1-Covered	PA, QL (180 PER 30 DAYS)
methocarbamol (500 mg tab, 750 mg tab)	1-Covered	PA
vanadom	1-Covered	PA, QL (120 PER 30 DAYS)
XEOMIN	1-Covered	PA
SLEEP DISORDER AGENTS		
SLEEP PROMOTING AGENTS		
doxepin hcl (3 mg tab, 6 mg tab)	1-Covered	QL (30 PER 30 DAYS)
eszopiclone	1-Covered	PA, QL (30 PER 30 DAYS)
HETLIOZ	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
HETLIOZ LQ	1-Covered	PA, QL (158 PER 30 DAYS), NDS (Non-Extended Day Supply)
ramelteon	1-Covered	QL (30 PER 30 DAYS)
tasimelteon	1-Covered	PA, QL (30 PER 30 DAYS), NDS (Non-Extended Day Supply)
temazepam (15 mg cap, 30 mg cap)	1-Covered	QL (30 PER 30 DAYS)
zaleplon	1-Covered	PA, QL (30 PER 30 DAYS)
zolpidem tartrate 10 mg tab	1-Covered	PA, QL (30 PER 30 DAYS)
zolpidem tartrate 5 mg tab	1-Covered	QL (30 PER 30 DAYS)
zolpidem tartrate er	1-Covered	PA, QL (30 PER 30 DAYS)
WAKEFULNESS PROMOTING AGENTS		
armodafinil	1-Covered	PA, QL (30 PER 30 DAYS)
modafinil 100 mg tab	1-Covered	PA, QL (30 PER 30 DAYS)
modafinil 200 mg tab	1-Covered	PA, QL (60 PER 30 DAYS)
XYREM	1-Covered	PA, QL (540 PER 30 DAYS), NDS (Non-Extended Day Supply)

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
XYWAV	1-Covered	PA, QL (540 PER 30 DAYS), NDS (Non-Extended Day Supply)

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

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This formulary was updated on 8/1/2023. For more recent information or other questions, please contact Health Partners Medicare at 1-866-901-8000 or, for TTY users, 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.

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