



2023 Formulary List of Covered Drugs

**Health Partners Medicare
Prime and Complete (HMO-POS)**

Health Partners 
Medicare

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

Health Partners Medicare Prime and Complete (HMO-POS) 2023 Formulary (List of Covered Drugs)

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

Formulary ID 00023466, Version 16

This formulary was updated on 9/1/2023. For more recent information or other questions, please contact Health Partners Medicare Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477) or visit www.HPPMedicare.com. From October 1 to March 31, we're available 8 a.m. to 8 p.m., 7 days a week. And from April 1 to September 30, we're available 8 a.m. to 8 p.m., Monday to Friday.

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

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

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

This document includes a list of the drugs (formulary) for our plan which is current as of 9/1/2023. 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 Prime and Complete 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 Prime and Complete Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled “How do I request an exception to the Health Partners Medicare Prime and Complete 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 9/1/2023. To get updated information about the drugs covered by Health Partners Medicare Prime and Complete, please contact us. Our contact information appears on the first and last pages.

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

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents.” If you know what your drug is used for, look for the category name in the list that begins on page 108. 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 115. 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 Prime and Complete cover both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Health Partners Medicare Prime and Complete require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, Health Partners Medicare Prime and Complete limit the amount of the drug that our plan will cover. For example, our plan provides 360 tablets per prescription for Endocet, 5-325 mg. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Health Partners Medicare Prime and Complete require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

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

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Health Partners Medicare Prime and Complete 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 Prime and Complete. 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 Prime and Complete 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 Prime or Complete prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Health Partners Medicare Prime or Complete, 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 Prime and Complete’s Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Health Partners Medicare Prime and Complete. If you have trouble finding your drug in the list, turn to the Index that begins on page 115.

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 Prime or Complete has any special requirements for coverage of your drug.

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

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

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

LEGEND

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>naproxen (250 mg tab, 375 mg tab, 500 mg tab)</i>	1-Preferred Generics	
<i>naproxen (375 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>naproxen dr</i>	2-Generic	
<i>naproxen sodium</i>	2-Generic	
<i>oxaprozin</i>	4-Non-Preferred Drug	
<i>piroxicam (10 mg cap, 20 mg cap)</i>	2-Generic	
<i>relafen</i>	2-Generic	
<i>sulindac</i>	2-Generic	
OPIOID ANALGESICS, LONG-ACTING		
<i>buprenorphine</i>	4-Non-Preferred Drug	QL (4 PER 28 DAYS)
<i>fentanyl</i>	4-Non-Preferred Drug	QL (10 PER 30 DAYS)
<i>methadone hcl 10 mg/5ml solution</i>	3-Preferred Brands	QL (1800 PER 30 DAYS)
<i>methadone hcl 5 mg/5ml solution</i>	3-Preferred Brands	QL (3600 PER 30 DAYS)
<i>methadone hcl 10 mg tab</i>	3-Preferred Brands	QL (240 PER 30 DAYS)
<i>methadone hcl 5 mg tab</i>	3-Preferred Brands	QL (480 PER 30 DAYS)
<i>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)</i>	3-Preferred Brands	QL (90 PER 30 DAYS)
<i>tramadol hcl er (er 100 mg tab er, er 200 mg tab er, er 300 mg tab er)</i>	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>tramadol hcl er (biphasic)</i>	3-Preferred Brands	QL (30 PER 30 DAYS)
XTAMPZA ER	3-Preferred Brands	QL (60 PER 30 DAYS)
OPIOID ANALGESICS, SHORT-ACTING		
<i>acetaminophen-codeine 120-12 mg/5ml solution</i>	2-Generic	QL (2700 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>acetaminophen-codeine 300-15 mg tab</i>	2-Generic	QL (390 PER 30 DAYS)
<i>acetaminophen-codeine 300-30 mg tab</i>	2-Generic	QL (360 PER 30 DAYS)
<i>acetaminophen-codeine 300-60 mg tab</i>	2-Generic	QL (180 PER 30 DAYS)
<i>butalbital-apap-caff-cod 50-325-40-30 mg cap</i>	4-Non-Preferred Drug	PA, QL (180 PER 30 DAYS)
<i>butorphanol tartrate 10 mg/ml solution</i>	4-Non-Preferred Drug	QL (5 PER 30 DAYS)
<i>endocet 10-325 mg tab</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>endocet 2.5-325 mg tab</i>	3-Preferred Brands	QL (360 PER 30 DAYS)
<i>endocet 5-325 mg tab</i>	3-Preferred Brands	QL (360 PER 30 DAYS)
<i>endocet 7.5-325 mg tab</i>	3-Preferred Brands	QL (240 PER 30 DAYS)
<i>fentanyl citrate (400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg)</i>	5-Specialty	PA, QL (120 PER 30 DAYS)
<i>fentanyl citrate 200 mcg loz handle</i>	4-Non-Preferred Drug	PA, QL (120 PER 30 DAYS)
<i>hydrocodone-acetaminophen (2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml)</i>	4-Non-Preferred Drug	QL (2700 PER 30 DAYS)
<i>hydrocodone-acetaminophen 10-325 mg tab</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>hydrocodone-acetaminophen 5-325 mg tab</i>	3-Preferred Brands	QL (360 PER 30 DAYS)
<i>hydrocodone-acetaminophen 7.5-325 mg tab</i>	3-Preferred Brands	QL (240 PER 30 DAYS)
<i>hydrocodone-ibuprofen (5-200 mg tab, 10-200 mg tab)</i>	3-Preferred Brands	QL (150 PER 30 DAYS)
<i>hydrocodone-ibuprofen 7.5-200 mg tab</i>	3-Preferred Brands	QL (150 PER 30 DAYS)
<i>hydromorphone hcl (2 mg tab, 4 mg tab, 8 mg tab)</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>morphine sulfate (10 mg/5ml, 20 mg/5ml)</i>	3-Preferred Brands	QL (900 PER 30 DAYS)
<i>morphine sulfate (15 mg tab, 30 mg tab)</i>	3-Preferred Brands	QL (180 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>morphine sulfate (concentrate)</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>oxycodone hcl 100 mg/5ml conc</i>	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
<i>oxycodone hcl 5 mg/5ml solution</i>	3-Preferred Brands	QL (900 PER 30 DAYS)
<i>oxycodone hcl (5 mg tab, 5 mg cap, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>oxycodone-acetaminophen (2.5-325 mg tab, 5-325 mg tab)</i>	3-Preferred Brands	QL (360 PER 30 DAYS)
<i>oxycodone-acetaminophen 10-325 mg tab</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>oxycodone-acetaminophen 7.5-325 mg tab</i>	3-Preferred Brands	QL (240 PER 30 DAYS)
<i>oxymorphone hcl</i>	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
<i>tramadol hcl 50 mg tab</i>	2-Generic	QL (240 PER 30 DAYS)
<i>tramadol-acetaminophen</i>	2-Generic	QL (240 PER 30 DAYS)

ANESTHETICS

LOCAL ANESTHETICS

<i>lidocaine 5 % patch</i>	2-Generic	PA, QL (90 PER 30 DAYS)
<i>lidocaine 5 % ointment</i>	4-Non-Preferred Drug	QL (50 PER 30 DAYS)
<i>lidocaine viscous hcl</i>	2-Generic	
<i>lidocaine-prilocaine</i>	2-Generic	QL (30 PER 30 DAYS)

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

ALCOHOL DETERRENTS/ANTI-CRAVING

<i>acamprosate calcium</i>	2-Generic	
<i>disulfiram</i>	2-Generic	
<i>naltrexone hcl 50 mg tab</i>	2-Generic	
VIVITROL	5-Specialty	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPIOID DEPENDENCE		
<i>buprenorphine hcl 2 mg sl tab</i>	2-Generic	QL (90 PER 30 DAYS)
<i>buprenorphine hcl 8 mg sl tab</i>	2-Generic	QL (60 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl (2-0.5 mg, 4-1 mg, 8-2 mg)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 12-3 mg film</i>	2-Generic	QL (60 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 2-0.5 mg sl tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>buprenorphine hcl-naloxone hcl 8-2 mg sl tab</i>	2-Generic	QL (90 PER 30 DAYS)
LUCEMYRA	4-Non-Preferred Drug	PA, QL (16 PER DAY)
OPIOID REVERSAL AGENTS		
<i>naloxone hcl (0.4 mg/ml soln cart, 0.4 mg/ml solution, 2 mg/2ml soln prsyr, 4 mg/10ml solution)</i>	1-Preferred Generics	
<i>naloxone hcl 4 mg/0.1ml nasal spray</i>	2-Generic	
SMOKING CESSATION AGENTS		
<i>bupropion hcl er (smoking det)</i>	2-Generic	QL (60 PER 30 DAYS)
NICOTROL	4-Non-Preferred Drug	
NICOTROL NS	4-Non-Preferred Drug	
<i>varenicline tartrate (0.5 mg x 11 & 1 mg x 42 tab thpk, 0.5 mg tab, 1 mg tab)</i>	3-Preferred Brands	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
<i>amikacin sulfate</i>	2-Generic	
<i>gentamicin in saline</i>	1-Preferred Generics	
<i>gentamicin sulfate (0.1 % ointment, 0.1 % cream)</i>	2-Generic	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>gentamicin sulfate (10 mg/ml, 40 mg/ml)</i>	1-Preferred Generics	
<i>neomycin sulfate</i>	2-Generic	
<i>paromomycin sulfate</i>	1-Preferred Generics	
<i>streptomycin sulfate</i>	1-Preferred Generics	
<i>tobramycin sulfate (1.2 gm recon soln, 1.2 gm/30ml solution, 2 gm/50ml solution, 10 mg/ml solution, 80 mg/2ml solution)</i>	4-Non-Preferred Drug	
ANTIBACTERIALS, OTHER		
<i>acetic acid 2 % solution</i>	2-Generic	
<i>aztreonam</i>	4-Non-Preferred Drug	
<i>clindamycin hcl</i>	2-Generic	
<i>clindamycin palmitate hcl</i>	2-Generic	
<i>clindamycin phosphate (9 gm/60ml, 300 mg/2ml, 600 mg/4ml, 900 mg/6ml, 9000 mg/60ml)</i>	1-Preferred Generics	
<i>clindamycin phosphate (1 % swab, 2 % cream)</i>	2-Generic	
<i>clindamycin phosphate in d5w</i>	1-Preferred Generics	
<i>colistimethate sodium (cba)</i>	1-Preferred Generics	
<i>daptomycin (350 mg recon soln)</i>	5-Specialty	
<i>fosfomycin tromethamine</i>	4-Non-Preferred Drug	
<i>linezolid 100 mg/5ml recon susp</i>	5-Specialty	QL (1800 PER 30 DAYS)
<i>linezolid 600 mg/300ml solution</i>	4-Non-Preferred Drug	
<i>linezolid 600 mg tab</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>linezolid in sodium chloride</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>methenamine hippurate</i>	2-Generic	
<i>metronidazole (0.75 % gel, 0.75 % cream, 0.75 % lotion, 1 % gel, 250 mg tab, 500 mg tab)</i>	2-Generic	
<i>metronidazole 500 mg/100ml solution</i>	4-Non-Preferred Drug	
<i>nitrofurantoin macrocrystal (50 mg cap, 100 mg cap)</i>	3-Preferred Brands	
<i>nitrofurantoin monohyd macro</i>	3-Preferred Brands	
<i>polymyxin b sulfate</i>	1-Preferred Generics	
TIGECYCLINE	5-Specialty	
TRIMETHOPRIM 100 MG TAB	1-Preferred Generics	
<i>vancomycin hcl 125 mg cap</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>vancomycin hcl 250 mg cap</i>	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
<i>vancomycin hcl (1 gm soln, 10 gm soln, 100 gm soln, 500 mg soln, 750 mg soln)</i>	4-Non-Preferred Drug	
XIFAXAN 200 MG TAB	4-Non-Preferred Drug	PA
XIFAXAN 550 MG TAB	5-Specialty	PA

BETA-LACTAM, CEPHALOSPORINS

<i>cefaclor (250 mg cap, 500 mg cap)</i>	2-Generic	
CEFACLOR ER	2-Generic	
<i>cefadroxil (250 mg/5ml recon susp, 500 mg/5ml recon susp, 500 mg cap)</i>	1-Preferred Generics	
<i>cefazolin sodium (1 gm soln, 10 gm soln, 100 gm soln, 300 gm soln, 500 mg soln)</i>	4-Non-Preferred Drug	
<i>cefdinir (125 mg/5ml recon susp, 250 mg/5ml recon susp, 300 mg cap)</i>	2-Generic	
<i>cefepime hcl (1 gm soln, 2 gm soln)</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>cefepime hcl for iv soln 2 gm</i>	4-Non-Preferred Drug	
<i>cefixime (100 mg/5ml recon susp, 200 mg/5ml recon susp, 400 mg cap)</i>	2-Generic	
<i>cefotetan disodium (1 gm soln, 2 gm soln)</i>	4-Non-Preferred Drug	
<i>cefoxitin sodium</i>	4-Non-Preferred Drug	
<i>cefpodoxime proxetil (50 mg/5ml recon susp, 100 mg/5ml recon susp, 100 mg tab, 200 mg tab)</i>	2-Generic	
<i>cefprozil (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg tab, 500 mg tab)</i>	2-Generic	
<i>ceftazidime</i>	4-Non-Preferred Drug	
<i>ceftriaxone sodium (1 gm soln, 2 gm soln, 10 gm soln, 100 gm soln, 250 mg soln, 500 mg soln)</i>	4-Non-Preferred Drug	
<i>ceftriaxone sodium in dextrose</i>	4-Non-Preferred Drug	
<i>cefuroxime axetil</i>	2-Generic	
<i>cefuroxime sodium</i>	4-Non-Preferred Drug	
<i>cephalexin (125 mg/5ml recon susp, 250 mg/5ml recon susp, 250 mg cap, 500 mg cap)</i>	2-Generic	
<i>tazicef</i>	4-Non-Preferred Drug	
TEFLARO	5-Specialty	

BETA-LACTAM, PENICILLINS

<i>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)</i>	1-Preferred Generics
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>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)</i>	2-Generic	
<i>amoxicillin-pot clavulanate er</i>	2-Generic	
<i>ampicillin</i>	2-Generic	
<i>ampicillin sodium</i>	1-Preferred Generics	
<i>ampicillin-sulbactam sodium</i>	2-Generic	
BICILLIN L-A	3-Preferred Brands	
<i>dicloxacillin sodium</i>	1-Preferred Generics	
<i>naficillin sodium</i>	2-Generic	
<i>oxacillin sodium</i>	1-Preferred Generics	
OXACILLIN SODIUM IN DEXTROSE	1-Preferred Generics	
PENICILLIN G POT IN DEXTROSE	4-Non-Preferred Drug	
<i>penicillin g potassium</i>	4-Non-Preferred Drug	
PENICILLIN G PROCAINE	4-Non-Preferred Drug	
<i>penicillin g sodium</i>	4-Non-Preferred Drug	
<i>penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, 250 mg tab, 500 mg tab)</i>	1-Preferred Generics	
<i>pfizerpen</i>	4-Non-Preferred Drug	
<i>piperacillin sod-tazobactam so</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CARBAPENEMS		
<i>ertapenem sodium</i>	4-Non-Preferred Drug	
<i>imipenem-cilastatin</i>	2-Generic	
<i>meropenem</i>	2-Generic	
MACROLIDES		
<i>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)</i>	1-Preferred Generics	
<i>clarithromycin (125 mg/5ml recon susp, 250 mg tab, 250 mg/5ml recon susp, 500 mg tab)</i>	2-Generic	
<i>clarithromycin er</i>	2-Generic	
DIFICID (40 MG/ML RECON SUSP, 200 MG TAB)	5-Specialty	
<i>e.e.s. 400</i>	2-Generic	
<i>ery-tab</i>	2-Generic	
ERYTHROCIN LACTOBIONATE	4-Non-Preferred Drug	
<i>erythromycin (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>erythromycin base (250 mg tab, 250 mg cp dr part, 500 mg tab)</i>	4-Non-Preferred Drug	
<i>erythromycin base (250 mg tab dr, 333 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>erythromycin ethylsuccinate 400 mg tab</i>	2-Generic	
QUINOLONES		
BESIVANCE	3-Preferred Brands	
CILOXAN	4-Non-Preferred Drug	
<i>ciprofloxacin hcl 0.3 % solution</i>	2-Generic	
<i>ciprofloxacin hcl (100 mg tab, 250 mg tab, 500 mg tab, 750 mg tab)</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ciprofloxacin in d5w</i>	2-Generic	
<i>levofloxacin (250 mg tab, 500 mg tab, 750 mg tab)</i>	2-Generic	
<i>levofloxacin 25 mg/ml oral solution</i>	2-Generic	
<i>levofloxacin in d5w</i>	2-Generic	
<i>levofloxacin iv soln 25 mg/ml</i>	2-Generic	
<i>moxifloxacin hcl 400 mg tab</i>	2-Generic	
<i>moxifloxacin hcl in nacl</i>	2-Generic	
<i>ofloxacin (300 mg tab, 400 mg tab)</i>	2-Generic	
SULFONAMIDES		
<i>sulfacetamide sodium (acne)</i>	2-Generic	QL (118 PER 30 DAYS)
<i>sulfadiazine</i>	4-Non-Preferred Drug	
<i>sulfamethoxazole-trimethoprim (200-40 mg/5ml suspension, 400-80 mg tab, 800-160 mg tab)</i>	1-Preferred Generics	
TETRACYCLINES		
<i>demeclocycline hcl</i>	1-Preferred Generics	
<i>doxy 100</i>	4-Non-Preferred Drug	
<i>doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg tab, 100 mg cap)</i>	2-Generic	
<i>doxycycline hyclate 100 mg recon soln</i>	4-Non-Preferred Drug	
<i>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)</i>	2-Generic	
<i>minocycline hcl (50 mg cap, 75 mg cap, 100 mg cap)</i>	2-Generic	
<i>mondoxylene nl</i>	2-Generic	
<i>tetracycline hcl (250 mg cap, 500 mg cap)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT 10 MG/ML SOLUTION	5-Specialty	QL (600 PER 30 DAYS)
BRIVIACT 50 MG/5ML SOLUTION	5-Specialty	
BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
DIACOMIT (250 MG CAP, 250 MG PACKET)	5-Specialty	QL (360 PER 30 DAYS)
DIACOMIT (500 MG PACKET, 500 MG CAP)	5-Specialty	QL (180 PER 30 DAYS)
<i>divalproex sodium (125 mg cap dr, 125 mg tab dr, 250 mg tab dr, 500 mg tab dr)</i>	2-Generic	
<i>divalproex sodium er</i>	2-Generic	
EPIDIOLEX	5-Specialty	PA - FOR NEW STARTS ONLY, QL (600 PER 30 DAYS)
EPRONTIA	4-Non-Preferred Drug	
<i>felbamate (400 mg tab, 600 mg tab, 600 mg/5ml suspension)</i>	4-Non-Preferred Drug	
FINTEPLA	5-Specialty	PA - FOR NEW STARTS ONLY, QL (360 PER 30 DAYS)
FYCOMPA 0.5 MG/ML SUSPENSION	5-Specialty	QL (720 PER 30 DAYS)
FYCOMPA (4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
FYCOMPA 2 MG TAB	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>levetiracetam (100 mg/ml solution, 250 mg tab, 500 mg tab, 500 mg/5ml solution, 750 mg tab, 1000 mg tab)</i>	2-Generic	
<i>levetiracetam er</i>	2-Generic	
<i>levetiracetam in nacl</i>	4-Non-Preferred Drug	
<i>roweepra</i>	2-Generic	
<i>roweepra xr</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SPRITAM 1000 MG TAB	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
SPRITAM 250 MG TAB	4-Non-Preferred Drug	QL (360 PER 30 DAYS)
SPRITAM 500 MG TAB	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
SPRITAM 750 MG TAB	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>topiramate (15 mg cap sprink, 25 mg cap sprink, 25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)</i>	2-Generic	
<i>valproate sodium 100 mg/ml solution</i>	2-Generic	
<i>valproic acid (250 mg cap, 250 mg/5ml solution)</i>	2-Generic	
XCOPRI (150 MG TAB, 200 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
XCOPRI (50 MG TAB, 100 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
XCOPRI (14 50 MG 14 100 MG TAB, 14 150 MG 14 200 MG TAB)	5-Specialty	QL (28 PER 28 DAYS)
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	4-Non-Preferred Drug	QL (28 PER 28 DAYS)
XCOPRI (250 MG DAILY DOSE)	5-Specialty	QL (56 PER 28 DAYS)
XCOPRI (350 MG DAILY DOSE)	5-Specialty	QL (56 PER 28 DAYS)
ZTALMY	5-Specialty	PA - FOR NEW STARTS ONLY, QL (1100 PER 30 DAYS)

CALCIUM CHANNEL MODIFYING AGENTS

CELONTIN	3-Preferred Brands	
<i>ethosuximide (250 mg/5ml solution, 250 mg cap)</i>	2-Generic	
<i>methsuximide</i>	3-Preferred Brands	

GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS

<i>clobazam 2.5 mg/ml suspension</i>	4-Non-Preferred Drug	QL (480 PER 30 DAYS)
<i>clobazam (10 mg tab, 20 mg tab)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>diazepam (2.5 mg gel, 10 mg gel, 20 mg gel)</i>	4-Non-Preferred Drug	
<i>gabapentin (100 mg cap, 250 mg/5ml solution, 300 mg cap, 300 mg/6ml solution, 400 mg cap, 600 mg tab, 800 mg tab)</i>	2-Generic	
NAYZILAM	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
<i>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)</i>	2-Generic	
<i>primidone (50 mg tab, 125 mg tab, 250 mg tab)</i>	2-Generic	
SYMPAZAN (10 MG, 20 MG)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
SYMPAZAN 5 MG FILM	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>tiagabine hcl</i>	4-Non-Preferred Drug	
VALTOCO 10 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 15 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 20 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
VALTOCO 5 MG DOSE	5-Specialty	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
<i>vigabatrin (500 mg tab, 500 mg packet)</i>	5-Specialty	QL (180 PER 30 DAYS)
<i>vigadrone (500 mg packet, 500 mg tab)</i>	5-Specialty	QL (180 PER 30 DAYS)
SODIUM CHANNEL AGENTS		
APTIOM (200 MG TAB, 400 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
APTIOM (600 MG TAB, 800 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
<i>carbamazepine (100 mg chew tab, 100 mg/5ml suspension, 200 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>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)</i>	2-Generic	
DILANTIN 30 MG CAP	3-Preferred Brands	
<i>epitol</i>	2-Generic	
<i>fosphenytoin sodium</i>	4-Non-Preferred Drug	
<i>lacosamide 10 mg/ml solution</i>	4-Non-Preferred Drug	QL (1200 PER 30 DAYS)
<i>lacosamide 200 mg/20ml solution</i>	4-Non-Preferred Drug	
<i>lacosamide (100 mg tab, 150 mg tab, 200 mg tab)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>lacosamide 50 mg tab</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>oxcarbazepine (150 mg tab, 300 mg/5ml suspension, 300 mg tab, 600 mg tab)</i>	2-Generic	
<i>phenytoin (50 mg chew tab, 100 mg/4ml suspension, 125 mg/5ml suspension)</i>	1-Preferred Generics	
<i>phenytoin infatabs</i>	1-Preferred Generics	
<i>phenytoin sodium 50 mg/ml solution</i>	1-Preferred Generics	
<i>phenytoin sodium extended</i>	1-Preferred Generics	
<i>rufinamide 40 mg/ml suspension</i>	5-Specialty	QL (2760 PER 30 DAYS)
<i>rufinamide 200 mg tab</i>	4-Non-Preferred Drug	QL (480 PER 30 DAYS)
<i>rufinamide 400 mg tab</i>	5-Specialty	QL (240 PER 30 DAYS)
ZONISADE	4-Non-Preferred Drug	
<i>zonisamide (25 mg cap, 50 mg cap, 100 mg cap)</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
<i>ergoloid mesylates</i>	2-Generic	PA
NAMZARIC (7 & 14 & 21 & 28 -10 MG CP24 THPK, 7-10 MG CAP ER 24H, 14-10 MG CAP ER 24H, 21-10 MG CAP ER 24H, 28-10 MG CAP ER 24H)	4-Non-Preferred Drug	
CHOLINESTERASE INHIBITORS		
<i>donepezil hcl (5 mg tab, 10 mg tab)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>donepezil hcl 23 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>donepezil hcl (5 mg tab disp, 10 mg tab disp)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>galantamine hydrobromide 4 mg/ml solution</i>	2-Generic	QL (360 PER 30 DAYS)
<i>galantamine hydrobromide (4 mg tab, 8 mg tab, 12 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>galantamine hydrobromide er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>rivastigmine</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>rivastigmine tartrate</i>	2-Generic	QL (60 PER 30 DAYS)
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
<i>memantine hcl (2 mg/ml solution, 28 5 mg & 21 10 mg tab)</i>	2-Generic	
<i>memantine hcl (5 mg tab, 10 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>memantine hcl er</i>	2-Generic	QL (30 PER 30 DAYS)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
AUVELITY	5-Specialty	QL (60 PER 30 DAYS)
<i>bupropion hcl</i>	2-Generic	QL (120 PER 30 DAYS)
<i>bupropion hcl er (sr)</i>	2-Generic	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>bupropion hcl er (xl) 150 mg tab er 24h</i>	2-Generic	QL (90 PER 30 DAYS)
<i>bupropion hcl er (xl) 300 mg tab er 24h</i>	2-Generic	QL (30 PER 30 DAYS)
<i>chlordiazepoxide-amitriptyline</i>	4-Non-Preferred Drug	
LYBALVI	5-Specialty	QL (30 PER 30 DAYS)
<i>mirtazapine (15 mg tab, 15 mg tab disp)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>mirtazapine (30 mg tab disp, 30 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>mirtazapine (7.5 mg tab, 45 mg tab disp, 45 mg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>olanzapine-fluoxetine hcl</i>	4-Non-Preferred Drug	
<i>perphenazine-amitriptyline</i>	4-Non-Preferred Drug	

MONOAMINE OXIDASE INHIBITORS

EMSAM	5-Specialty	QL (30 PER 30 DAYS)
MARPLAN	3-Preferred Brands	
<i>phenelzine sulfate</i>	1-Preferred Generics	
<i>tranylcypromine sulfate</i>	2-Generic	

SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)

<i>citalopram hydrobromide 10 mg/5ml solution</i>	2-Generic	QL (600 PER 30 DAYS)
<i>citalopram hydrobromide (20 mg tab, 40 mg tab)</i>	1-Preferred Generics	QL (45 PER 30 DAYS)
<i>citalopram hydrobromide 10 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>desvenlafaxine succinate er</i>	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>escitalopram oxalate 5 mg/5ml solution</i>	2-Generic	QL (600 PER 30 DAYS)
<i>escitalopram oxalate 10 mg tab</i>	1-Preferred Generics	QL (45 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>escitalopram oxalate 20 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>escitalopram oxalate 5 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
FETZIMA	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
FETZIMA TITRATION	4-Non-Preferred Drug	
<i>fluoxetine hcl 10 mg cap</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>fluoxetine hcl 20 mg cap</i>	1-Preferred Generics	QL (120 PER 30 DAYS)
<i>fluoxetine hcl 40 mg cap</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>fluoxetine hcl 90 mg cap dr</i>	4-Non-Preferred Drug	QL (4 PER 28 DAYS)
<i>fluoxetine hcl 20 mg/5ml solution</i>	2-Generic	
<i>fluoxetine hcl 10 mg tab</i>	2-Generic	QL (90 PER 30 DAYS)
<i>fluoxetine hcl 20 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>fluvoxamine maleate</i>	2-Generic	QL (90 PER 30 DAYS)
<i>fluvoxamine maleate er</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nefazodone hcl (50 mg tab, 100 mg tab, 250 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nefazodone hcl 150 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>nefazodone hcl 200 mg tab</i>	2-Generic	QL (90 PER 30 DAYS)
<i>paroxetine hcl 10 mg/5ml suspension</i>	4-Non-Preferred Drug	
<i>paroxetine hcl (10 mg tab, 20 mg tab, 30 mg tab, 40 mg tab)</i>	2-Generic	
<i>paroxetine hcl er</i>	4-Non-Preferred Drug	
<i>sertraline hcl 20 mg/ml conc</i>	2-Generic	QL (300 PER 30 DAYS)
<i>sertraline hcl (25 mg tab, 50 mg tab)</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>sertraline hcl 100 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>trazodone hcl</i>	1-Preferred Generics	
TRINTELLIX	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
VENLAFAXINE BESYLATE ER	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>venlafaxine hcl</i>	2-Generic	
<i>venlafaxine hcl er (er 37.5 mg cap er, er 75 mg cap er)</i>	2-Generic	QL (90 PER 30 DAYS)
<i>venlafaxine hcl er 150 mg cap er 24h</i>	2-Generic	QL (60 PER 30 DAYS)
VIIBRYD STARTER PACK	4-Non-Preferred Drug	
<i>vilazodone hcl</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

TRICYCLICS

<i>amitriptyline hcl</i>	2-Generic	
<i>amoxapine</i>	3-Preferred Brands	
<i>clomipramine hcl</i>	4-Non-Preferred Drug	
<i>desipramine hcl</i>	3-Preferred Brands	
<i>doxepin hcl (10 mg/ml conc, 10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap)</i>	2-Generic	
<i>imipramine hcl</i>	2-Generic	
<i>imipramine pamoate</i>	4-Non-Preferred Drug	
<i>nortriptyline hcl (10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap)</i>	2-Generic	
<i>nortriptyline hcl 10 mg/5ml solution</i>	4-Non-Preferred Drug	
<i>protriptyline hcl</i>	4-Non-Preferred Drug	
<i>trimipramine maleate</i>	4-Non-Preferred Drug	

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIEMETICS		
ANTIEMETICS, OTHER		
<i>compro</i>	2-Generic	
<i>meclizine hcl (12.5 mg tab, 25 mg tab)</i>	2-Generic	
<i>metoclopramide hcl (5 mg/5ml solution, 5 mg tab, 10 mg/10ml solution, 10 mg tab)</i>	1-Preferred Generics	
<i>perphenazine</i>	2-Generic	
<i>phenadoz</i>	2-Generic	
<i>prochlorperazine</i>	2-Generic	
<i>prochlorperazine edisylate</i>	4-Non-Preferred Drug	
<i>prochlorperazine maleate</i>	2-Generic	
<i>promethazine hcl (12.5 mg, 25 mg)</i>	2-Generic	
<i>promethazine hcl (12.5 mg tab, 25 mg tab, 50 mg tab)</i>	1-Preferred Generics	PA
<i>promethegan</i>	2-Generic	
<i>scopolamine</i>	4-Non-Preferred Drug	QL (10 PER 30 DAYS)
EMETOGENIC THERAPY ADJUNCTS		
<i>aprepitant (40 mg cap, 80 & 125 mg misc, 80 & 125 mg cap, 80 mg cap, 125 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>dronabinol</i>	4-Non-Preferred Drug	PA, QL (60 PER 30 DAYS)
EMEND 125 MG/5ML RECON SUSP	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>granisetron hcl 1 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (60 PER 30 DAYS)
<i>ondansetron 4 mg tab disp</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
<i>ondansetron 8 mg tab disp</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
<i>ondansetron hcl (4 mg/2ml soln prsyr, 40 mg/20ml solution)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ondansetron hcl 4 mg/5ml solution</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>ondansetron hcl 4 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (180 PER 30 DAYS)
<i>ondansetron hcl 8 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE, QL (90 PER 30 DAYS)
<i>ondansetron hcl inj 4 mg/2ml</i>	2-Generic	
SANCUSO	5-Specialty	ST, QL (4 PER 28 DAYS)

ANTIFUNGALS

ABELCET	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
AMBISOME	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>amphotericin b</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>amphotericin b liposome</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>caspofungin acetate</i>	4-Non-Preferred Drug	
<i>ciclopirox olamine 0.77 % cream</i>	2-Generic	QL (90 PER 30 DAYS)
<i>ciclopirox olamine 0.77 % suspension</i>	2-Generic	QL (60 PER 30 DAYS)
<i>clotrimazole 1 % cream</i>	2-Generic	QL (90 PER 30 DAYS)
<i>clotrimazole 1 % solution</i>	2-Generic	QL (30 PER 30 DAYS)
<i>clotrimazole 10 mg troche</i>	2-Generic	
<i>econazole nitrate</i>	4-Non-Preferred Drug	QL (85 PER 30 DAYS)
<i>fluconazole (10 mg/ml recon susp, 40 mg/ml recon susp, 50 mg tab, 100 mg tab, 150 mg tab, 200 mg tab)</i>	2-Generic	
<i>fluconazole in sodium chloride (200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%)</i>	2-Generic	
<i>flucytosine</i>	5-Specialty	
<i>griseofulvin microsize (125 mg/5ml suspension, 500 mg tab)</i>	2-Generic	
<i>griseofulvin ultramicrosize</i>	2-Generic	
<i>itraconazole (10 mg/ml solution, 100 mg cap)</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ketoconazole 2 % cream</i>	2-Generic	QL (60 PER 30 DAYS)
<i>ketoconazole 2 % shampoo</i>	2-Generic	QL (120 PER 30 DAYS)
<i>ketoconazole 200 mg tab</i>	2-Generic	
<i>micafungin sodium</i>	5-Specialty	
<i>naftifine hcl 1 % cream</i>	2-Generic	QL (90 PER 30 DAYS)
<i>naftifine hcl 2 % cream</i>	2-Generic	QL (60 PER 30 DAYS)
NOXAFIL 300 MG PACKET	5-Specialty	PA, QL (60 PER 30 DAYS)
NOXAFIL 40 MG/ML SUSPENSION	5-Specialty	PA, QL (630 PER 30 DAYS)
<i>nyamyc</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nystatin (100000 unit/gm ointment, 100000 unit/gm cream, 100000 unit/gm powder)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nystatin (100000 unit/ml suspension, 500000 unit tab)</i>	2-Generic	
<i>nystop</i>	2-Generic	QL (60 PER 30 DAYS)
<i>posaconazole 40 mg/ml suspension</i>	5-Specialty	PA, QL (630 PER 30 DAYS)
<i>posaconazole 100 mg tab dr</i>	5-Specialty	PA, QL (93 PER 30 DAYS)
<i>terbinafine hcl 250 mg tab</i>	2-Generic	
<i>terconazole (0.4 %, 0.8 %)</i>	2-Generic	
<i>terconazole 80 mg suppos</i>	1-Preferred Generics	
<i>voriconazole 200 mg recon soln</i>	5-Specialty	PA
<i>voriconazole 40 mg/ml recon susp</i>	5-Specialty	
<i>voriconazole (50 mg tab, 200 mg tab)</i>	4-Non-Preferred Drug	

ANTIGOUT AGENTS

<i>allopurinol (100 mg tab, 300 mg tab)</i>	1-Preferred Generics	
<i>colchicine 0.6 mg tab</i>	3-Preferred Brands	
<i>colchicine-probenecid</i>	2-Generic	
<i>febuxostat</i>	2-Generic	ST

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MITIGARE	3-Preferred Brands	
<i>probenecid</i>	2-Generic	

ANTIMIGRAINE AGENTS

ANTIMIGRAINE AGENTS, OTHER

AIMOVIG	4-Non-Preferred Drug	PA, QL (1 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN A-INJ	4-Non-Preferred Drug	PA, QL (1.5 PER 28 DAYS)
AJOVY 225 MG/1.5ML SOLN PRSYR	4-Non-Preferred Drug	PA, QL (1.5 PER 28 DAYS)
EMGALITY (120 MG/ML SOLN A-INJ, 120 MG/ML SOLN PRSYR)	4-Non-Preferred Drug	PA, QL (2 PER 28 DAYS)
EMGALITY (300 MG DOSE)	4-Non-Preferred Drug	PA, QL (3 PER 28 DAYS)
NURTEC	5-Specialty	ST, QL (16 PER 30 DAYS)

ERGOT ALKALOIDS

<i>dihydroergotamine mesylate 4 mg/ml solution</i>	5-Specialty	PA, QL (8 PER 30 DAYS)
<i>ergotamine-caffeine</i>	2-Generic	

SEROTONIN (5-HT) RECEPTOR AGONIST

<i>naratriptan hcl</i>	2-Generic	QL (9 PER 30 DAYS)
<i>rizatriptan benzoate (5 mg tab, 5 mg tab disp, 10 mg tab disp, 10 mg tab)</i>	2-Generic	QL (12 PER 30 DAYS)
<i>sumatriptan (5 mg/act, 20 mg/act)</i>	4-Non-Preferred Drug	QL (12 PER 28 DAYS)
<i>sumatriptan succinate (4 mg/0.5ml soln a-inj, 6 mg/0.5ml soln a-inj, 6 mg/0.5ml solution)</i>	4-Non-Preferred Drug	QL (6 PER 30 DAYS)
<i>sumatriptan succinate (25 mg tab, 50 mg tab, 100 mg tab)</i>	2-Generic	QL (9 PER 30 DAYS)
<i>sumatriptan succinate refill</i>	4-Non-Preferred Drug	QL (6 PER 30 DAYS)
<i>zolmitriptan (2.5 mg tab, 2.5 mg tab disp, 5 mg tab, 5 mg tab disp)</i>	2-Generic	QL (9 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
<i>pyridostigmine bromide 60 mg tab</i>	3-Preferred Brands	
<i>pyridostigmine bromide er</i>	4-Non-Preferred Drug	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
<i>dapsone (25 mg tab, 100 mg tab)</i>	2-Generic	
<i>rifabutin</i>	1-Preferred Generics	
ANTITUBERCULARS		
<i>ethambutol hcl</i>	2-Generic	
<i>isoniazid (50 mg/5ml syrup, 100 mg tab, 300 mg tab)</i>	1-Preferred Generics	
PRETOMANID	3-Preferred Brands	QL (30 PER 30 DAYS)
PRIFTIN	3-Preferred Brands	
<i>pyrazinamide</i>	2-Generic	
<i>rifampin (150 mg cap, 300 mg cap, 600 mg recon soln)</i>	2-Generic	
SIRTURO	5-Specialty	
TRECTOR	4-Non-Preferred Drug	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
<i>bendamustine hcl (25 mg soln, 100 mg soln)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>busulfan</i>	5-Specialty	
<i>cyclophosphamide (25 mg cap, 25 mg tab, 50 mg cap, 50 mg tab)</i>	2-Generic	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.

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GLEOSTINE (10 MG CAP, 40 MG CAP)	4-Non-Preferred Drug	
GLEOSTINE 100 MG CAP	5-Specialty	
<i>ifosfamide (1 gm recon soln, 1 gm/20ml solution, 3 gm/60ml solution)</i>	4-Non-Preferred Drug	
LEUKERAN	3-Preferred Brands	
MATULANE	5-Specialty	
MELPHALAN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>melphalan hcl</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TREANDA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VALCHLOR	5-Specialty	QL (60 PER 30 DAYS)
YONDELIS	5-Specialty	

ANTIANDROGENS

<i>abiraterone acetate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
<i>bicalutamide</i>	2-Generic	
ERLEADA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>flutamide</i>	2-Generic	
<i>nilutamide</i>	5-Specialty	
NUBEQA	5-Specialty	PA - FOR NEW STARTS ONLY
ORSERDU 345 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ORSERDU 86 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
XTANDI (40 MG TAB, 40 MG CAP, 80 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
YONSA	5-Specialty	PA - FOR NEW STARTS ONLY

ANTIANGIOGENIC AGENTS

<i>lenalidomide</i>	5-Specialty	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)
POMALYST	5-Specialty	PA - FOR NEW STARTS ONLY
REVLIMID	5-Specialty	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
THALOMID (150 MG CAP, 200 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
THALOMID (50 MG CAP, 100 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ANTIESTROGENS/MODIFIERS		
EMCYT	5-Specialty	
<i>fulvestrant</i>	5-Specialty	
SOLTAMOX	5-Specialty	
<i>tamoxifen citrate</i>	2-Generic	
<i>toremifene citrate</i>	5-Specialty	
ANTIMETABOLITES		
<i>adrucil</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>cladribine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>clofarabine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>cytarabine</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>cytarabine (pf)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
DROXIA	3-Preferred Brands	
<i>fluorouracil (1 gm/20ml, 2.5 gm/50ml, 5 gm/100ml, 500 mg/10ml)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
FOLOTYN 40 MG/2ML SOLUTION	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>gemcitabine hcl 1 gm recon soln</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>hydroxyurea</i>	2-Generic	
INQOVI	5-Specialty	PA - FOR NEW STARTS ONLY
<i>mercaptopurine</i>	2-Generic	
NIPENT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>pemetrexed disodium (100 mg soln, 500 mg soln, 750 mg soln, 1000 mg soln)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PURIXAN	5-Specialty	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TABLOID	3-Preferred Brands	
ANTINEOPLASTICS, OTHER		
<i>adriamycin 2 mg/ml solution</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>arsenic trioxide 10 mg/10ml solution</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
AYVAKIT	5-Specialty	PA - FOR NEW STARTS ONLY
<i>azacitidine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BESREMI	5-Specialty	
<i>bleomycin sulfate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>bortezomib 3.5 mg recon soln</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BRUKINSA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>carboplatin</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>cisplatin (50 mg/50ml solution)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>dacarbazine 200 mg recon soln</i>	4-Non-Preferred Drug	
<i>dactinomycin</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 20 MG/4ML SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
DAUNORUBICIN HCL 50 MG/10ML SOLUTION	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>decitabine</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>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)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>doxorubicin hcl 2 mg/ml solution</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>doxorubicin hcl liposomal</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>epirubicin hcl</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EXKIVITY	5-Specialty	PA - FOR NEW STARTS ONLY
<i>fludarabine phosphate 50 mg recon soln</i>	4-Non-Preferred Drug	
FOTIVDA	5-Specialty	PA - FOR NEW STARTS ONLY
HALAVEN	5-Specialty	
<i>idarubicin hcl</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IDHIFA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>irinotecan hcl</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
KISQALI FEMARA (400 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI FEMARA (600 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI FEMARA(200 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KRAZATI	5-Specialty	PA - FOR NEW STARTS ONLY
LONSURF	5-Specialty	PA - FOR NEW STARTS ONLY
LUMAKRAS	5-Specialty	PA - FOR NEW STARTS ONLY
<i>mitomycin (5 mg soln, 20 mg soln, 40 mg soln)</i>	4-Non-Preferred Drug	
<i>mitoxantrone hcl</i>	4-Non-Preferred Drug	
<i>mutamycin</i>	4-Non-Preferred Drug	
NINLARO	5-Specialty	PA - FOR NEW STARTS ONLY
ONUREG	5-Specialty	PA - FOR NEW STARTS ONLY
<i>oxaliplatin (50 mg/10ml solution, 50 mg recon soln, 100 mg/20ml solution, 100 mg recon soln)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>paclitaxel</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>paclitaxel protein-bound part</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>paraplatin</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
QINLOCK	5-Specialty	PA - FOR NEW STARTS ONLY
RETEVMO	5-Specialty	PA - FOR NEW STARTS ONLY

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>romidepsin 10 mg recon soln</i>	5-Specialty	
SYNRIBO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TABRECTA	5-Specialty	PA - FOR NEW STARTS ONLY
TAZVERIK	5-Specialty	PA - FOR NEW STARTS ONLY
<i>vinblastine sulfate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>vincasar pfs</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>vincristine sulfate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>vinorelbine tartrate 50 mg/5ml solution</i>	4-Non-Preferred Drug	
VYXEOS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
WELIREG	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (60 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK	5-Specialty	PA - FOR NEW STARTS ONLY
XPOVIO (80 MG TWICE WEEKLY)	5-Specialty	PA - FOR NEW STARTS ONLY
ZALTRAP 100 MG/4ML SOLUTION	5-Specialty	
ZANOSAR	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ZOLINZA	5-Specialty	PA - FOR NEW STARTS ONLY
AROMATASE INHIBITORS, 3RD GENERATION		
<i>anastrozole</i>	2-Generic	
<i>exemestane</i>	2-Generic	
<i>letrozole</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ENZYME INHIBITORS		
<i>etoposide</i>	2-Generic	
JAYPIRCA 100 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
JAYPIRCA 50 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
<i>toposar</i>	2-Generic	
<i>topotecan hcl 4 mg recon soln</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MOLECULAR TARGET INHIBITORS		
ALECENSA	5-Specialty	PA - FOR NEW STARTS ONLY
ALIQOPA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ALUNBRIG (30 MG TAB, 90 MG TAB, 90 & 180 MG TAB THPK, 180 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
BALVERSA	5-Specialty	PA - FOR NEW STARTS ONLY
BOSULIF	5-Specialty	PA - FOR NEW STARTS ONLY
BRAFTOVI	5-Specialty	PA - FOR NEW STARTS ONLY
CABOMETYX	5-Specialty	PA - FOR NEW STARTS ONLY
CALQUENCE (100 MG CAP, 100 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
CAPRELSA	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (100 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (140 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COMETRIQ (60 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
COPIKTRA	5-Specialty	PA - FOR NEW STARTS ONLY
COTELLIC	5-Specialty	PA - FOR NEW STARTS ONLY
CYRAMZA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DAURISMO	5-Specialty	PA - FOR NEW STARTS ONLY
ERIVEDGE	5-Specialty	PA - FOR NEW STARTS ONLY
<i>erlotinib hcl</i>	5-Specialty	PA - FOR NEW STARTS ONLY
<i>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)</i>	5-Specialty	PA - FOR NEW STARTS ONLY

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GAVRETO	5-Specialty	PA - FOR NEW STARTS ONLY
<i>gefitinib</i>	5-Specialty	PA - FOR NEW STARTS ONLY
GILOTRIF	5-Specialty	PA - FOR NEW STARTS ONLY
IBRANCE (75 MG TAB, 75 MG CAP, 100 MG CAP, 100 MG TAB, 125 MG TAB, 125 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
ICLUSIG	5-Specialty	PA - FOR NEW STARTS ONLY
<i>imatinib mesylate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
IMBRUVICA (70 MG/ML SUSPENSION, 70 MG CAP, 140 MG TAB, 140 MG CAP, 280 MG TAB, 420 MG TAB, 560 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
INLYTA	5-Specialty	PA - FOR NEW STARTS ONLY
INREBIC	5-Specialty	PA - FOR NEW STARTS ONLY
IRESSA	5-Specialty	PA - FOR NEW STARTS ONLY
JAKAFI	5-Specialty	PA - FOR NEW STARTS ONLY
JEVTANA	5-Specialty	
KISQALI (200 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI (400 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KISQALI (600 MG DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
KOSELUGO	5-Specialty	PA - FOR NEW STARTS ONLY
KYPROLIS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>lapatinib ditosylate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (10 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (12 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (14 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (18 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (20 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (24 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (4 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LENVIMA (8 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LORBRENA	5-Specialty	PA - FOR NEW STARTS ONLY

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LYNPARZA	5-Specialty	PA - FOR NEW STARTS ONLY
LYTGOBI (12 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LYTGOBI (16 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
LYTGOBI (20 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
MEKINIST (0.05 MG/ML RECON SOLN, 0.5 MG TAB, 2 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
MEKTOVI	5-Specialty	PA - FOR NEW STARTS ONLY
NERLYNX	5-Specialty	PA - FOR NEW STARTS ONLY
ODOMZO	5-Specialty	PA - FOR NEW STARTS ONLY
PEMAZYRE	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (200 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (250 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
PIQRAY (300 MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
REZLIDHIA	5-Specialty	PA - FOR NEW STARTS ONLY
ROZLYTREK	5-Specialty	PA - FOR NEW STARTS ONLY
RUBRACA	5-Specialty	PA - FOR NEW STARTS ONLY
RYDAPT	5-Specialty	PA - FOR NEW STARTS ONLY
SCEMBLIX	5-Specialty	PA - FOR NEW STARTS ONLY
<i>sorafenib tosylate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
SPRYCEL	5-Specialty	PA - FOR NEW STARTS ONLY
STIVARGA	5-Specialty	PA - FOR NEW STARTS ONLY
<i>sunitinib malate</i>	5-Specialty	PA - FOR NEW STARTS ONLY
TAFINLAR (10 MG TAB SOL, 50 MG CAP, 75 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
TAGRISSO	5-Specialty	PA - FOR NEW STARTS ONLY
TALZENNA	5-Specialty	PA - FOR NEW STARTS ONLY
TASIGNA	5-Specialty	PA - FOR NEW STARTS ONLY
TEPMETKO	5-Specialty	PA - FOR NEW STARTS ONLY
TIBSOVO	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (100MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (125MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TRUSELTIQ (50MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TRUSELTIQ (75MG DAILY DOSE)	5-Specialty	PA - FOR NEW STARTS ONLY
TUKYSA	5-Specialty	PA - FOR NEW STARTS ONLY
TURALIO	5-Specialty	PA - FOR NEW STARTS ONLY
VENCLEXTA (50 MG TAB, 100 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
VENCLEXTA 10 MG TAB	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY
VENCLEXTA STARTING PACK	5-Specialty	PA - FOR NEW STARTS ONLY
VERZENIO	5-Specialty	PA - FOR NEW STARTS ONLY
VITRAKVI (20 MG/ML SOLUTION, 25 MG CAP, 100 MG CAP)	5-Specialty	PA - FOR NEW STARTS ONLY
VIZIMPRO	5-Specialty	PA - FOR NEW STARTS ONLY
VONJO	5-Specialty	PA - FOR NEW STARTS ONLY
VOTRIENT	5-Specialty	PA - FOR NEW STARTS ONLY
XALKORI	5-Specialty	PA - FOR NEW STARTS ONLY
XOSPATA	5-Specialty	PA - FOR NEW STARTS ONLY
ZEJULA (100 MG CAP, 100 MG TAB, 200 MG TAB, 300 MG TAB)	5-Specialty	PA - FOR NEW STARTS ONLY
ZELBORAF	5-Specialty	PA - FOR NEW STARTS ONLY
ZYDELIG	5-Specialty	PA - FOR NEW STARTS ONLY
ZYKADIA 150 MG TAB	5-Specialty	PA - FOR NEW STARTS ONLY

MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE

ALYMSYS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
AVASTIN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BAVENCIO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
DARZALEX	5-Specialty	PA - TO CONFIRM PART D COVERAGE
EMPLICITI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ERBITUX 100 MG/50ML SOLUTION	5-Specialty	
HERCEPTIN HYLECTA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
HERZUMA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
IMFINZI	5-Specialty	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
KADCYLA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KANJINTI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
KEYTRUDA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MVASI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
MYLOTARG	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OGIVRI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
ONTRUZANT	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OPDIVO	5-Specialty	PA - TO CONFIRM PART D COVERAGE
PERJETA	5-Specialty	
RIABNI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RITUXAN HYCELA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RUXIENCE	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TECENTRIQ	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TRAZIMERA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TRUXIMA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
VECTIBIX 100 MG/5ML SOLUTION	5-Specialty	PA - TO CONFIRM PART D COVERAGE
YERVOY 50 MG/10ML SOLUTION	5-Specialty	
ZIRABEV	5-Specialty	PA - TO CONFIRM PART D COVERAGE
RETINOIDS		
<i>bexarotene 75 mg cap</i>	5-Specialty	PA - FOR NEW STARTS ONLY
<i>bexarotene 1 % gel</i>	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
PANRETIN	5-Specialty	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>tretinoin 10 mg cap</i>	5-Specialty	
TREATMENT ADJUNCTS		
<i>leucovorin calcium (50 mg soln, 100 mg soln, 200 mg soln, 350 mg soln, 500 mg soln)</i>	4-Non-Preferred Drug	
<i>leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>levoleucovorin calcium</i>	5-Specialty	
<i>levoleucovorin calcium pf</i>	5-Specialty	
<i>mesna</i>	4-Non-Preferred Drug	
MESNEX 400 MG TAB	5-Specialty	

ANTIPARASITICS

ANTHELMINTHICS

<i>albendazole</i>	5-Specialty	
<i>ivermectin 3 mg tab</i>	3-Preferred Brands	
<i>praziquantel</i>	2-Generic	

ANTIPROTOZOALS

<i>atovaquone</i>	4-Non-Preferred Drug	
<i>atovaquone-proguanil hcl</i>	2-Generic	
BENZNIDAZOLE	4-Non-Preferred Drug	
<i>chloroquine phosphate</i>	2-Generic	
COARTEM	3-Preferred Brands	
<i>hydroxychloroquine sulfate 200 mg tab</i>	2-Generic	
<i>mefloquine hcl</i>	2-Generic	
<i>nitazoxanide</i>	5-Specialty	
<i>pentamidine isethionate</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>pentamidine isethionate 300 mg inject soln</i>	2-Generic	
<i>pentamidine isethionate for nebulization soln 300 mg</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>primaquine phosphate</i>	2-Generic	
<i>pyrimethamine</i>	5-Specialty	
<i>quinine sulfate</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
<i>benztropine mesylate (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	1-Preferred Generics	
<i>trihexyphenidyl hcl (0.4 mg/ml solution, 2 mg tab, 5 mg tab)</i>	1-Preferred Generics	
ANTIPARKINSON AGENTS, OTHER		
<i>amantadine hcl (50 mg/5ml solution, 100 mg tab, 100 mg cap)</i>	2-Generic	
<i>carbidopa-levodopa-entacapone</i>	2-Generic	
<i>entacapone</i>	4-Non-Preferred Drug	
<i>tolcapone</i>	5-Specialty	
DOPAMINE AGONISTS		
APOKYN	5-Specialty	
<i>bromocriptine mesylate (2.5 mg tab, 5 mg cap)</i>	2-Generic	
KYNMOBI	5-Specialty	
NEUPRO	4-Non-Preferred Drug	
<i>pramipexole dihydrochloride</i>	1-Preferred Generics	
<i>pramipexole dihydrochloride er</i>	2-Generic	
<i>ropinirole hcl</i>	2-Generic	
<i>ropinirole hcl er</i>	4-Non-Preferred Drug	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
<i>carbidopa</i>	4-Non-Preferred Drug	
<i>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)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>carbidopa-levodopa er</i>	2-Generic	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
<i>rasagiline mesylate</i>	4-Non-Preferred Drug	
<i>selegiline hcl (5 mg cap, 5 mg tab)</i>	2-Generic	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
<i>chlorpromazine hcl (25 mg/ml, 50 mg/2ml)</i>	4-Non-Preferred Drug	
<i>chlorpromazine hcl (10 mg tab, 25 mg tab, 30 mg/ml conc, 50 mg tab, 100 mg tab, 100 mg/ml conc, 200 mg tab)</i>	2-Generic	
<i>fluphenazine decanoate</i>	4-Non-Preferred Drug	
<i>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)</i>	2-Generic	
<i>haloperidol (0.5 mg tab, 1 mg tab, 2 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	2-Generic	
<i>haloperidol decanoate</i>	2-Generic	
<i>haloperidol lactate (2 mg/ml conc, 5 mg/ml solution)</i>	2-Generic	
<i>loxapine succinate</i>	2-Generic	
<i>molindone hcl</i>	2-Generic	
<i>pimozide</i>	2-Generic	
<i>thioridazine hcl</i>	2-Generic	
<i>thiothixene</i>	2-Generic	
<i>trifluoperazine hcl</i>	2-Generic	
2ND GENERATION/ATYPICAL		
ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	5-Specialty	QL (2.4 PER 56 DAYS)
ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	5-Specialty	QL (3.2 PER 56 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG SRER, 400 MG PRSYR)	5-Specialty	QL (1 PER 28 DAYS)
<i>aripiprazole (1 mg/ml solution, 2 mg tab, 5 mg tab, 10 mg tab, 15 mg tab, 20 mg tab, 30 mg tab)</i>	2-Generic	
<i>aripiprazole (10 mg tab disp, 15 mg tab disp)</i>	4-Non-Preferred Drug	
ARISTADA 1064 MG/3.9ML PRSYR	5-Specialty	QL (3.9 PER 56 DAYS)
ARISTADA 441 MG/1.6ML PRSYR	5-Specialty	QL (1.6 PER 28 DAYS)
ARISTADA 662 MG/2.4ML PRSYR	5-Specialty	QL (2.4 PER 28 DAYS)
ARISTADA 882 MG/3.2ML PRSYR	5-Specialty	QL (3.2 PER 28 DAYS)
ARISTADA INITIO	5-Specialty	
<i>asenapine maleate</i>	4-Non-Preferred Drug	
CAPLYTA	5-Specialty	QL (30 PER 30 DAYS)
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
FANAPT (6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
FANAPT TITRATION PACK	4-Non-Preferred Drug	
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	5-Specialty	QL (3.5 PER 180 DAYS)
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	5-Specialty	QL (5 PER 180 DAYS)
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	5-Specialty	QL (0.75 PER 28 DAYS)
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	5-Specialty	QL (1 PER 28 DAYS)
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	5-Specialty	QL (1.5 PER 28 DAYS)
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	4-Non-Preferred Drug	QL (0.25 PER 28 DAYS)
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	5-Specialty	QL (0.5 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RISPERDAL CONSTA (12.5 MG, 25 MG)	4-Non-Preferred Drug	QL (2 PER 28 DAYS)
RISPERDAL CONSTA (37.5 MG, 50 MG)	5-Specialty	QL (2 PER 28 DAYS)
<i>risperidone 1 mg/ml solution</i>	2-Generic	
<i>risperidone (0.25 mg tab, 0.5 mg tab, 1 mg tab, 2 mg tab, 3 mg tab, 4 mg tab)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>risperidone (0.25 mg tab disp, 2 mg tab disp, 4 mg tab disp)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>risperidone 0.5 mg tab disp</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>risperidone 1 mg tab disp</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>risperidone 3 mg tab disp</i>	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
SECUADO	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
UZEDY 100 MG/0.28ML SUSP PRSYR	5-Specialty	QL (0.28 PER 28 DAYS)
UZEDY 125 MG/0.35ML SUSP PRSYR	5-Specialty	QL (0.35 PER 28 DAYS)
UZEDY 150 MG/0.42ML SUSP PRSYR	5-Specialty	QL (0.42 PER 28 DAYS)
UZEDY 200 MG/0.56ML SUSP PRSYR	5-Specialty	QL (0.56 PER 56 DAYS)
UZEDY 250 MG/0.7ML SUSP PRSYR	5-Specialty	QL (0.7 PER 56 DAYS)
UZEDY 50 MG/0.14ML SUSP PRSYR	5-Specialty	QL (0.14 PER 28 DAYS)
UZEDY 75 MG/0.21ML SUSP PRSYR	5-Specialty	QL (0.21 PER 28 DAYS)
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	5-Specialty	QL (30 PER 30 DAYS)
VRAYLAR 1.5 & 3 MG CAP THPK	4-Non-Preferred Drug	
<i>ziprasidone hcl</i>	2-Generic	QL (60 PER 30 DAYS)
<i>ziprasidone mesylate</i>	2-Generic	
ZYPREXA RELPREVV	4-Non-Preferred Drug	
TREATMENT-RESISTANT		
<i>clozapine (25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clozapine (12.5 mg tab disp, 25 mg tab disp, 100 mg tab disp, 150 mg tab disp, 200 mg tab disp)</i>	4-Non-Preferred Drug	
VERSACLOZ	5-Specialty	
ANTISPASTICITY AGENTS		
<i>baclofen (5 mg tab, 10 mg tab, 20 mg tab)</i>	2-Generic	
<i>dantrolene sodium</i>	4-Non-Preferred Drug	
<i>tizanidine hcl (2 mg tab, 4 mg tab)</i>	2-Generic	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
PREVYMIS (240 MG TAB, 480 MG TAB)	5-Specialty	QL (28 PER 28 DAYS)
<i>valganciclovir hcl 50 mg/ml recon soln</i>	5-Specialty	
<i>valganciclovir hcl 450 mg tab</i>	2-Generic	
ANTI-HEPATITIS B (HBV) AGENTS		
<i>adefovir dipivoxil</i>	5-Specialty	
BARACLUDE 0.05 MG/ML SOLUTION	5-Specialty	
<i>entecavir</i>	4-Non-Preferred Drug	
EPIVIR HBV 5 MG/ML SOLUTION	3-Preferred Brands	
<i>lamivudine 100 mg tab</i>	2-Generic	
VEMLIDY	5-Specialty	
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA (150-37.5 MG PACKET, 400-100 MG TAB)	5-Specialty	PA, QL (28 PER 28 DAYS)
EPCLUSA (200-50 MG TAB, 200-50 MG PACKET)	5-Specialty	PA, QL (56 PER 28 DAYS)
HARVONI (33.75-150 MG PACKET, 90-400 MG TAB)	5-Specialty	PA, QL (28 PER 28 DAYS)
HARVONI (45-200 MG PACKET, 45-200 MG TAB)	5-Specialty	PA, QL (56 PER 28 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MAVYRET 50-20 MG PACKET	5-Specialty	PA, QL (140 PER 28 DAYS)
MAVYRET 100-40 MG TAB	5-Specialty	PA, QL (84 PER 28 DAYS)
<i>ribavirin (200 mg cap, 200 mg tab)</i>	2-Generic	
SOFOSBUVIR-VELPATASVIR	5-Specialty	PA, QL (28 PER 28 DAYS)

ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)

BIKTARVY 30-120-15 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
BIKTARVY 50-200-25 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
DOVATO	5-Specialty	QL (30 PER 30 DAYS)
GENVOYA	5-Specialty	QL (30 PER 30 DAYS)
ISENTRESS (25 MG CHEW TAB, 100 MG CHEW TAB, 100 MG PACKET)	3-Preferred Brands	QL (180 PER 30 DAYS)
ISENTRESS 400 MG TAB	5-Specialty	QL (60 PER 30 DAYS)
ISENTRESS HD	5-Specialty	QL (60 PER 30 DAYS)
JULUCA	5-Specialty	QL (30 PER 30 DAYS)
STRIBILD	5-Specialty	QL (30 PER 30 DAYS)
TIVICAY (25 MG TAB, 50 MG TAB)	5-Specialty	QL (60 PER 30 DAYS)
TIVICAY 10 MG TAB	3-Preferred Brands	QL (60 PER 30 DAYS)
TIVICAY PD	5-Specialty	QL (180 PER 30 DAYS)

ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)

COMPLERA	5-Specialty	QL (30 PER 30 DAYS)
DELSTRIGO	5-Specialty	QL (30 PER 30 DAYS)
EDURANT	5-Specialty	QL (30 PER 30 DAYS)
EFAVIRENZ 200 MG CAP	4-Non-Preferred Drug	QL (90 PER 30 DAYS)
EFAVIRENZ 50 MG CAP	4-Non-Preferred Drug	QL (240 PER 30 DAYS)
<i>efavirenz 600 mg tab</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>efavirenz-emtricitab-tenofo df</i>	5-Specialty	QL (30 PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir</i>	5-Specialty	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>etravirine</i>	5-Specialty	
INTELENCE 25 MG TAB	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>nevirapine 50 mg/5ml suspension</i>	4-Non-Preferred Drug	
<i>nevirapine 200 mg tab</i>	2-Generic	QL (60 PER 30 DAYS)
<i>nevirapine er 100 mg tab er 24h</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>nevirapine er 400 mg tab er 24h</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
ODEFSEY	5-Specialty	QL (30 PER 30 DAYS)
PIFELTRO	5-Specialty	QL (60 PER 30 DAYS)

ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)

<i>abacavir sulfate 20 mg/ml solution</i>	3-Preferred Brands	
<i>abacavir sulfate 300 mg tab</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>abacavir sulfate-lamivudine</i>	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>abacavir-lamivudine-zidovudine</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
CIMDUO	5-Specialty	QL (30 PER 30 DAYS)
DESCOVY 120-15 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
DESCOVY 200-25 MG TAB	5-Specialty	QL (30 PER 30 DAYS)
<i>emtricitabine</i>	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>emtricitabine-tenofovir df</i>	5-Specialty	QL (30 PER 30 DAYS)
EMTRIVA 10 MG/ML SOLUTION	4-Non-Preferred Drug	
<i>lamivudine 10 mg/ml solution</i>	3-Preferred Brands	
<i>lamivudine 150 mg tab</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>lamivudine 300 mg tab</i>	3-Preferred Brands	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lamivudine-zidovudine</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
TEMIXYS	5-Specialty	QL (30 PER 30 DAYS)
<i>tenofovir disoproxil fumarate</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
TRIUMEQ	5-Specialty	QL (30 PER 30 DAYS)
TRIUMEQ PD	5-Specialty	QL (180 PER 30 DAYS)
TRIZIVIR	5-Specialty	QL (60 PER 30 DAYS)
VIREAD 40 MG/GM POWDER	5-Specialty	
VIREAD (150 MG TAB, 200 MG TAB, 250 MG TAB)	5-Specialty	QL (30 PER 30 DAYS)
<i>zidovudine 100 mg cap</i>	3-Preferred Brands	QL (180 PER 30 DAYS)
<i>zidovudine 50 mg/5ml syrup</i>	3-Preferred Brands	
<i>zidovudine 300 mg tab</i>	3-Preferred Brands	QL (60 PER 30 DAYS)

ANTI-HIV AGENTS, OTHER

APRETUDE	5-Specialty	
CABENUVA	5-Specialty	
FUZEON	5-Specialty	QL (60 PER 30 DAYS)
<i>maraviroc</i>	5-Specialty	
RUKOBIA	5-Specialty	QL (60 PER 30 DAYS)
SELZENTRY (20 MG/ML SOLUTION, 75 MG TAB)	5-Specialty	
SELZENTRY 25 MG TAB	3-Preferred Brands	
SUNLENCA (4 X 300 MG TAB THPK, 5 X 300 MG TAB THPK, 463.5 MG/1.5ML SOLUTION)	5-Specialty	
TROGARZO	5-Specialty	
TYBOST	3-Preferred Brands	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lorazepam (2 mg tab, 2 mg/ml conc)</i>	2-Generic	QL (150 PER 30 DAYS)
<i>lorazepam 0.5 mg tab</i>	2-Generic	QL (600 PER 30 DAYS)
<i>lorazepam 1 mg tab</i>	2-Generic	QL (300 PER 30 DAYS)
<i>lorazepam intensol</i>	2-Generic	QL (150 PER 30 DAYS)
<i>oxazepam</i>	2-Generic	QL (120 PER 30 DAYS)

BIPOLAR AGENTS

MOOD STABILIZERS

<i>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)</i>	1-Preferred Generics	
<i>lamotrigine er</i>	4-Non-Preferred Drug	
<i>lithium carbonate (150 mg cap, 300 mg cap, 600 mg cap)</i>	1-Preferred Generics	
<i>lithium carbonate 300 mg tab</i>	2-Generic	
<i>lithium carbonate er</i>	2-Generic	
<i>subvenite</i>	1-Preferred Generics	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

<i>acarbose</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>alogliptin benzoate</i>	2-Generic	QL (30 PER 30 DAYS)
<i>alogliptin-metformin hcl</i>	2-Generic	QL (60 PER 30 DAYS)
<i>alogliptin-pioglitazone (12.5-45 mg tab, 12.5-30 mg tab, 25-45 mg tab, 25-15 mg tab, 25-30 mg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
BYDUREON BCISE	3-Preferred Brands	QL (3.4 PER 28 DAYS)
BYETTA 10 MCG PEN	3-Preferred Brands	QL (2.4 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TOUJEO MAX SOLOSTAR	3-Preferred Brands	SI (Select Insulin)
TOUJEO SOLOSTAR	3-Preferred Brands	SI (Select Insulin)
TRESIBA	3-Preferred Brands	SI (Select Insulin)
TRESIBA FLEXTOUCH	3-Preferred Brands	SI (Select Insulin)

BLOOD PRODUCTS AND MODIFIERS

ANTICOAGULANTS

ELIQUIS	3-Preferred Brands	
ELIQUIS DVT/PE STARTER PACK	3-Preferred Brands	
<i>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)</i>	2-Generic	
<i>fondaparinux sodium (5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml)</i>	5-Specialty	
<i>fondaparinux sodium 2.5 mg/0.5ml solution</i>	4-Non-Preferred Drug	
<i>heparin sodium (porcine) ((porcine) 1000 unit/ml, (porcine) 5000 unit/ml, (porcine) 10000 unit/ml, (porcine) 20000 unit/ml)</i>	1-Preferred Generics	
<i>jantoven</i>	1-Preferred Generics	
<i>warfarin sodium</i>	1-Preferred Generics	
XARELTO (1 MG/ML RECON SUSP, 2.5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB)	3-Preferred Brands	
XARELTO STARTER PACK	3-Preferred Brands	
ZONTIVITY	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>captopril</i>	1-Preferred Generics	
<i>enalapril maleate (2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Preferred Generics	
<i>fosinopril sodium</i>	1-Preferred Generics	
<i>lisinopril</i>	1-Preferred Generics	
<i>moexipril hcl</i>	1-Preferred Generics	
<i>perindopril erbumine</i>	1-Preferred Generics	
<i>quinapril hcl</i>	1-Preferred Generics	
<i>ramipril</i>	1-Preferred Generics	
<i>trandolapril</i>	1-Preferred Generics	

ANTIARRHYTHMICS

<i>amiodarone hcl (100 mg tab, 200 mg tab, 400 mg tab)</i>	2-Generic	
<i>disopyramide phosphate</i>	1-Preferred Generics	PA
<i>dofetilide</i>	2-Generic	
<i>flecainide acetate</i>	2-Generic	
<i>mexiletine hcl (150 mg cap, 200 mg cap, 250 mg cap)</i>	1-Preferred Generics	
MULTAQ	3-Preferred Brands	
<i>pacerone</i>	2-Generic	
<i>propafenone hcl</i>	2-Generic	
<i>propafenone hcl er</i>	4-Non-Preferred Drug	
<i>quinidine sulfate</i>	2-Generic	
<i>sorine</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>felodipine er</i>	2-Generic	
<i>isradipine</i>	2-Generic	
<i>nicardipine hcl (20 mg cap, 30 mg cap)</i>	2-Generic	
<i>nifedipine er</i>	2-Generic	
<i>nifedipine er osmotic release</i>	2-Generic	
<i>nimodipine</i>	2-Generic	

CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES

<i>cartia xt</i>	2-Generic	
<i>dilt-xr</i>	2-Generic	
<i>diltiazem hcl (30 mg tab, 60 mg tab, 90 mg tab, 120 mg tab)</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>diltiazem hcl er beads</i>	2-Generic	
<i>diltiazem hcl er coated beads</i>	2-Generic	
<i>matzim la</i>	2-Generic	
<i>taztia xt</i>	2-Generic	
<i>tiadylt er</i>	2-Generic	
<i>verapamil hcl (40 mg tab, 80 mg tab, 120 mg tab)</i>	1-Preferred Generics	
<i>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)</i>	2-Generic	

CARDIOVASCULAR AGENTS, OTHER

<i>acetazolamide</i>	2-Generic	
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>aliskiren fumarate</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>amiloride-hydrochlorothiazide</i>	2-Generic	
<i>amlodipine besy-benazepril hcl</i>	1-Preferred Generics	
<i>amlodipine besylate-valsartan</i>	1-Preferred Generics	
<i>amlodipine-atorvastatin</i>	1-Preferred Generics	
<i>amlodipine-olmesartan</i>	1-Preferred Generics	
<i>amlodipine-valsartan-hctz</i>	1-Preferred Generics	
<i>atenolol-chlorthalidone</i>	1-Preferred Generics	
<i>benazepril-hydrochlorothiazide</i>	1-Preferred Generics	
<i>bisoprolol-hydrochlorothiazide</i>	1-Preferred Generics	
<i>candesartan cilexetil-hctz</i>	1-Preferred Generics	
CORLANOR 5 MG/5ML SOLUTION	4-Non-Preferred Drug	QL (450 PER 30 DAYS)
CORLANOR (5 MG TAB, 7.5 MG TAB)	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>digoxin 0.05 mg/ml solution</i>	2-Generic	
<i>digoxin (125 mcg tab, 250 mcg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>enalapril-hydrochlorothiazide</i>	1-Preferred Generics	
ENTRESTO	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>fosinopril sodium-hctz</i>	1-Preferred Generics	
<i>irbesartan-hydrochlorothiazide</i>	1-Preferred Generics	
<i>lisinopril-hydrochlorothiazide</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>losartan potassium-hctz</i>	1-Preferred Generics	
<i>metoprolol-hydrochlorothiazide</i>	1-Preferred Generics	
<i>metirosine</i>	5-Specialty	
<i>olmesartan medoxomil-hctz</i>	1-Preferred Generics	
<i>olmesartan-amlodipine-hctz</i>	1-Preferred Generics	
<i>pentoxifylline er</i>	2-Generic	
<i>quinapril-hydrochlorothiazide</i>	1-Preferred Generics	
<i>ranolazine er</i>	2-Generic	
<i>spironolactone-hctz</i>	2-Generic	
<i>telmisartan-amlodipine</i>	1-Preferred Generics	
<i>telmisartan-hctz</i>	1-Preferred Generics	
<i>trandolapril-verapamil hcl er</i>	1-Preferred Generics	
<i>triamterene-hctz (37.5-25 mg cap, 37.5-25 mg tab, 75-50 mg tab)</i>	1-Preferred Generics	
<i>valsartan-hydrochlorothiazide</i>	1-Preferred Generics	
DIURETICS, LOOP		
<i>bumetanide (0.25 mg/ml solution, 0.5 mg tab, 1 mg tab, 2 mg tab)</i>	2-Generic	
<i>furosemide (8 mg/ml solution, 10 mg/ml solution, 20 mg tab, 40 mg tab, 80 mg tab)</i>	1-Preferred Generics	
<i>toremide</i>	1-Preferred Generics	
DIURETICS, POTASSIUM-SPARING		
<i>amiloride hcl</i>	2-Generic	
<i>eplerenone</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>spironolactone (25 mg tab, 50 mg tab, 100 mg tab)</i>	1-Preferred Generics	
DIURETICS, THIAZIDE		
<i>chlorthalidone</i>	2-Generic	
<i>hydrochlorothiazide (12.5 mg tab, 12.5 mg cap, 25 mg tab, 50 mg tab)</i>	1-Preferred Generics	
<i>indapamide</i>	1-Preferred Generics	
<i>metolazone</i>	2-Generic	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
<i>fenofibrate (48 mg tab, 54 mg tab, 67 mg cap, 134 mg cap, 145 mg tab, 160 mg tab, 200 mg cap)</i>	2-Generic	
<i>fenofibrate micronized (67 mg cap, 134 mg cap, 200 mg cap)</i>	2-Generic	
<i>fenofibric acid</i>	2-Generic	
<i>gemfibrozil</i>	1-Preferred Generics	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium (10 mg tab, 40 mg tab)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>atorvastatin calcium 20 mg tab</i>	1-Preferred Generics	QL (90 PER 30 DAYS)
<i>atorvastatin calcium 80 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
LIVALO	3-Preferred Brands	ST, QL (30 PER 30 DAYS)
<i>lovastatin (10 mg tab, 20 mg tab)</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>lovastatin 40 mg tab</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>pravastatin sodium</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>rosuvastatin calcium 40 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>simvastatin</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
DYSLIPIDEMICS, OTHER		
<i>cholestyramine (4 gm packet, 4 gm/dose powder)</i>	2-Generic	
<i>cholestyramine light (4 gm packet, 4 gm/dose powder)</i>	2-Generic	
<i>colesevelam hcl 3.75 gm packet</i>	4-Non-Preferred Drug	
<i>colesevelam hcl 625 mg tab</i>	2-Generic	
<i>colestipol hcl (1 gm tab, 5 gm granules, 5 gm packet)</i>	2-Generic	
<i>ezetimibe</i>	2-Generic	QL (30 PER 30 DAYS)
<i>ezetimibe-simvastatin</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>niacin er (antihyperlipidemic)</i>	4-Non-Preferred Drug	
<i>omega-3-acid ethyl esters</i>	3-Preferred Brands	
<i>prevalite (4 gm packet, 4 gm/dose powder)</i>	2-Generic	
REPATHA	3-Preferred Brands	PA, QL (3 PER 28 DAYS)
REPATHA PUSHTRONEX SYSTEM	3-Preferred Brands	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	3-Preferred Brands	PA, QL (3 PER 28 DAYS)
VASCEPA	3-Preferred Brands	
VASODILATORS, DIRECT-ACTING ARTERIAL		
<i>hydralazine hcl (10 mg tab, 25 mg tab, 50 mg tab, 100 mg tab)</i>	2-Generic	
<i>minoxidil (2.5 mg tab, 10 mg tab)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
<i>isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)</i>	2-Generic	
<i>isosorbide mononitrate</i>	1-Preferred Generics	
<i>isosorbide mononitrate er</i>	2-Generic	
NITRO-BID	3-Preferred Brands	
<i>nitroglycerin (0.1 mg/hr patch 24hr, 0.2 mg/hr patch 24hr, 0.3 mg sl tab, 0.4 mg/hr patch 24hr, 0.4 mg sl tab, 0.6 mg sl tab, 0.6 mg/hr patch 24hr)</i>	2-Generic	
<i>nitroglycerin 0.4 mg/spray solution</i>	4-Non-Preferred Drug	
RECTIV	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

CENTRAL NERVOUS SYSTEM AGENTS

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES

<i>amphetamine-dextroamphet er</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>amphetamine-dextroamphetamine (10 mg tab, 12.5 mg tab, 15 mg tab, 20 mg tab)</i>	3-Preferred Brands	QL (90 PER 30 DAYS)
<i>amphetamine-dextroamphetamine (5 mg tab, 7.5 mg tab)</i>	3-Preferred Brands	QL (120 PER 30 DAYS)
<i>amphetamine-dextroamphetamine 30 mg tab</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>dextroamphetamine sulfate (5 mg tab, 10 mg tab)</i>	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
<i>dextroamphetamine sulfate er</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES

<i>atomoxetine hcl (10 mg cap, 25 mg cap, 40 mg cap)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>atomoxetine hcl (60 mg cap, 80 mg cap, 100 mg cap)</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>atomoxetine hcl 18 mg cap</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>dexmethylphenidate hcl</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>guanfacine hcl er</i>	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>methylphenidate hcl (2.5 mg tab, 5 mg tab, 10 mg tab)</i>	4-Non-Preferred Drug	QL (180 PER 30 DAYS)
<i>methylphenidate hcl 10 mg/5ml solution</i>	4-Non-Preferred Drug	QL (900 PER 30 DAYS)
<i>methylphenidate hcl 5 mg/5ml solution</i>	4-Non-Preferred Drug	QL (1800 PER 30 DAYS)
<i>methylphenidate hcl (5 mg tab, 10 mg tab, 20 mg tab)</i>	3-Preferred Brands	QL (90 PER 30 DAYS)
<i>methylphenidate hcl er (er 10 mg tab er, er 20 mg tab er)</i>	4-Non-Preferred Drug	QL (90 PER 30 DAYS)

CENTRAL NERVOUS SYSTEM, OTHER

AUSTEDO (9 MG TAB, 12 MG TAB)	5-Specialty	PA, QL (120 PER 30 DAYS)
AUSTEDO 6 MG TAB	5-Specialty	PA, QL (60 PER 30 DAYS)
AUSTEDO XR (6 MG TAB ER, 12 MG TAB ER)	5-Specialty	PA, QL (30 PER 30 DAYS)
AUSTEDO XR 24 MG TAB ER 24H	5-Specialty	PA, QL (60 PER 30 DAYS)
AUSTEDO XR PATIENT TITRATION	5-Specialty	PA, QL (42 PER 28 DAYS)
<i>bac</i>	2-Generic	PA, QL (180 PER 30 DAYS)
<i>butalbital-apap-caffeine 50-325-40 mg tab</i>	2-Generic	PA, QL (180 PER 30 DAYS)
INGREZZA (40 MG CAP, 80 MG CAP)	5-Specialty	PA, QL (30 PER 30 DAYS)
INGREZZA 60 MG CAP	5-Specialty	PA, QL (30 PER 30 DAYS)
INGREZZA 40 & 80 MG CAP THPK	5-Specialty	PA, QL (28 PER 28 DAYS)
NUEDEXTA	5-Specialty	PA, QL (60 PER 30 DAYS)
<i>riluzole</i>	2-Generic	
<i>tetrabenazine 12.5 mg tab</i>	5-Specialty	PA, QL (90 PER 30 DAYS)
<i>tetrabenazine 25 mg tab</i>	5-Specialty	PA, QL (120 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FIBROMYALGIA AGENTS		
DRIZALMA SPRINKLE	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
<i>duloxetine hcl (20 mg dr, 30 mg dr, 60 mg dr)</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>pregabalin (225 mg cap, 300 mg cap)</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>pregabalin (25 mg cap, 50 mg cap, 75 mg cap, 100 mg cap, 150 mg cap, 200 mg cap)</i>	3-Preferred Brands	QL (90 PER 30 DAYS)
<i>pregabalin 20 mg/ml solution</i>	4-Non-Preferred Drug	QL (900 PER 30 DAYS)
<i>pregabalin er (er 82.5 mg tab er, er 165 mg tab er)</i>	3-Preferred Brands	PA, QL (90 PER 30 DAYS)
<i>pregabalin er 330 mg tab er 24h</i>	3-Preferred Brands	PA, QL (60 PER 30 DAYS)
SAVELLA	4-Non-Preferred Drug	
SAVELLA TITRATION PACK	4-Non-Preferred Drug	
MULTIPLE SCLEROSIS AGENTS		
AVONEX PEN	5-Specialty	
AVONEX PREFILLED	5-Specialty	
BAFIERTAM	5-Specialty	
BETASERON	5-Specialty	
COPAXONE 20 MG/ML SOLN PRSYR	5-Specialty	QL (30 PER 30 DAYS)
COPAXONE 40 MG/ML SOLN PRSYR	5-Specialty	QL (12 PER 28 DAYS)
<i>dalfampridine er</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>fingolimod hcl</i>	5-Specialty	QL (30 PER 30 DAYS)
GILENYA 0.5 MG CAP	5-Specialty	QL (30 PER 30 DAYS)
KESIMPTA	5-Specialty	PA
PLEGRIDY (125 MCG/0.5ML SOLN PEN, 125 MCG/0.5ML SOLN PRSYR)	5-Specialty	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PLEGRIDY STARTER PACK (63 94 MCG/0.5ML SOLN PRSYR, 63 94 MCG/0.5ML SOLN PEN)	5-Specialty	
TECFIDERA (120 MG CAP DR, 240 MG CAP DR)	5-Specialty	QL (60 PER 30 DAYS)
TECFIDERA 120 & 240 MG MISC	5-Specialty	
VUMERITY	5-Specialty	QL (120 PER 30 DAYS)

DENTAL AND ORAL AGENTS

<i>cevimeline hcl</i>	2-Generic	
<i>chlorhexidine gluconate</i>	1-Preferred Generics	
<i>oralone</i>	2-Generic	
<i>paroex</i>	1-Preferred Generics	
<i>periogard</i>	1-Preferred Generics	
<i>pilocarpine hcl (5 mg tab, 7.5 mg tab)</i>	2-Generic	
<i>triamcinolone acetonide 0.1 % paste</i>	2-Generic	

DERMATOLOGICAL AGENTS

ACNE AND ROSACEA AGENTS

<i>accutane</i>	4-Non-Preferred Drug	
<i>acitretin</i>	4-Non-Preferred Drug	PA - FOR NEW STARTS ONLY
<i>amneesteem</i>	4-Non-Preferred Drug	
<i>avita (0.025 % cream, 0.025 % gel)</i>	4-Non-Preferred Drug	PA, QL (45 PER 30 DAYS)
<i>benzoyl peroxide-erythromycin</i>	4-Non-Preferred Drug	QL (46.6 PER 30 DAYS)
<i>claravis</i>	4-Non-Preferred Drug	
<i>clindamycin phos-benzoyl perox 1-5 % gel</i>	2-Generic	QL (50 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clindamycin phos-benzoyl perox 1.2-5 % gel</i>	2-Generic	QL (45 PER 30 DAYS)
<i>isotretinoin (10 mg cap, 20 mg cap, 30 mg cap, 40 mg cap)</i>	4-Non-Preferred Drug	
<i>myorisan</i>	4-Non-Preferred Drug	
<i>tazarotene 0.1 % cream</i>	2-Generic	QL (60 PER 30 DAYS)
TAZORAC 0.05 % CREAM	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>tretinoin (0.01 % gel, 0.025 % gel, 0.025 % cream, 0.05 % cream, 0.1 % cream)</i>	4-Non-Preferred Drug	PA, QL (45 PER 30 DAYS)
<i>zenatane</i>	4-Non-Preferred Drug	

DERMATITIS AND PRURITUS AGENTS

<i>ala-cort</i>	1-Preferred Generics	
<i>alclometasone dipropionate (0.05 % cream, 0.05 % ointment)</i>	2-Generic	
<i>ammonium lactate (12 % lotion, 12 % cream)</i>	2-Generic	
<i>betamethasone dipropionate (0.05 % lotion, 0.05 % ointment, 0.05 % cream)</i>	2-Generic	
<i>betamethasone dipropionate aug (0.05 % cream, 0.05 % ointment, 0.05 % gel)</i>	2-Generic	
<i>betamethasone valerate (0.1 % cream, 0.1 % ointment, 0.1 % lotion)</i>	2-Generic	
<i>clobetasol prop emollient base</i>	2-Generic	QL (120 PER 30 DAYS)
<i>clobetasol propionate 0.05 % foam</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>clobetasol propionate 0.05 % liquid</i>	4-Non-Preferred Drug	QL (125 PER 30 DAYS)
<i>clobetasol propionate (0.05 % lotion, 0.05 % shampoo)</i>	4-Non-Preferred Drug	QL (118 PER 30 DAYS)
<i>clobetasol propionate (0.05 % ointment, 0.05 % gel, 0.05 % cream)</i>	2-Generic	QL (120 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clobetasol propionate 0.05 % solution</i>	2-Generic	QL (100 PER 30 DAYS)
<i>clobetasol propionate e</i>	2-Generic	QL (120 PER 30 DAYS)
<i>clobetasol propionate emulsion</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>clodan</i>	4-Non-Preferred Drug	QL (118 PER 30 DAYS)
<i>desonide (0.05 % cream, 0.05 % lotion, 0.05 % ointment)</i>	2-Generic	
<i>desoximetasone (0.05 % ointment, 0.05 % cream, 0.05 % gel, 0.25 % cream, 0.25 % ointment)</i>	2-Generic	
<i>fluocinolone acetonide (0.01 % cream, 0.01 % solution, 0.025 % ointment, 0.025 % cream)</i>	2-Generic	
<i>fluocinolone acetonide body</i>	2-Generic	
<i>fluocinolone acetonide scalp</i>	2-Generic	
<i>fluocinonide (0.05 % cream, 0.05 % gel, 0.05 % ointment)</i>	2-Generic	QL (120 PER 30 DAYS)
<i>fluocinonide 0.05 % solution</i>	2-Generic	QL (60 PER 30 DAYS)
<i>fluocinonide emulsified base</i>	2-Generic	QL (120 PER 30 DAYS)
<i>fluticasone propionate (0.005 % ointment, 0.05 % cream)</i>	2-Generic	
<i>halobetasol propionate (0.05 % ointment, 0.05 % cream)</i>	4-Non-Preferred Drug	QL (50 PER 30 DAYS)
<i>hydrocortisone (1 % cream, 1 % ointment, 2.5 % ointment, 2.5 % cream)</i>	1-Preferred Generics	
<i>hydrocortisone 2.5 % lotion</i>	2-Generic	
<i>hydrocortisone (perianal)</i>	2-Generic	
<i>hydrocortisone butyrate (0.1 % ointment, 0.1 % solution)</i>	2-Generic	
<i>hydrocortisone valerate (0.2 % ointment, 0.2 % cream)</i>	2-Generic	
<i>mometasone furoate (0.1 % solution, 0.1 % ointment, 0.1 % cream)</i>	2-Generic	
<i>procto-med hc</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>procto-pak</i>	2-Generic	
<i>proctosol hc</i>	2-Generic	
<i>proctozone-hc</i>	2-Generic	
<i>selenium sulfide 2.5 % lotion</i>	2-Generic	
<i>tacrolimus (0.03 %, 0.1 %)</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>tovet</i>	4-Non-Preferred Drug	QL (100 PER 30 DAYS)
<i>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)</i>	2-Generic	
<i>triderm</i>	2-Generic	
DERMATOLOGICAL AGENTS, OTHER		
<i>calcipotriene (0.005 % cream, 0.005 % ointment)</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>calcipotriene 0.005 % solution</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>calcitrene</i>	4-Non-Preferred Drug	QL (120 PER 30 DAYS)
<i>clotrimazole-betamethasone 1-0.05 % cream</i>	2-Generic	QL (45 PER 30 DAYS)
<i>clotrimazole-betamethasone 1-0.05 % lotion</i>	2-Generic	QL (60 PER 30 DAYS)
<i>fluorouracil 0.5 % cream</i>	5-Specialty	QL (30 PER 30 DAYS)
<i>fluorouracil 5 % cream</i>	2-Generic	QL (80 PER 30 DAYS)
<i>fluorouracil (2 %, 5 %)</i>	2-Generic	QL (20 PER 30 DAYS)
<i>imiquimod 5 % cream</i>	2-Generic	QL (24 PER 30 DAYS)
<i>nystatin-triamcinolone (100000-0.1 unit/gm-% ointment, 100000-0.1 unit/gm-% cream)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
PODOFILOX	2-Generic	
REGRANEX	5-Specialty	PA, QL (30 PER 30 DAYS)
SANTYL	4-Non-Preferred Drug	QL (90 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>silver sulfadiazine</i>	2-Generic	
<i>ssd</i>	2-Generic	
PEDICULICIDES/SCABICIDES		
<i>lindane</i>	2-Generic	
<i>malathion</i>	4-Non-Preferred Drug	
<i>permethrin</i>	2-Generic	
TOPICAL ANTI-INFECTIVES		
<i>acyclovir 5 % ointment</i>	2-Generic	QL (30 PER 30 DAYS)
<i>ciclodan</i>	2-Generic	QL (13.2 PER 30 DAYS)
<i>ciclopirox 0.77 % gel</i>	2-Generic	QL (100 PER 30 DAYS)
<i>ciclopirox 1 % shampoo</i>	2-Generic	QL (120 PER 30 DAYS)
<i>ciclopirox 8 % solution</i>	2-Generic	QL (13.2 PER 30 DAYS)
<i>clindamycin phosphate 1 % gel</i>	2-Generic	QL (75 PER 30 DAYS)
<i>clindamycin phosphate (1 % lotion, 1 % solution)</i>	2-Generic	QL (60 PER 30 DAYS)
<i>ery</i>	2-Generic	QL (60 PER 30 DAYS)
<i>erythromycin 2 % gel</i>	2-Generic	QL (60 PER 30 DAYS)
<i>erythromycin 2 % solution</i>	2-Generic	QL (120 PER 30 DAYS)
<i>mupirocin 2 % ointment</i>	2-Generic	QL (66 PER 30 DAYS)
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
<i>carglumic acid</i>	5-Specialty	
CLINIMIX E/DEXTROSE (2.75/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/10)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (4.25/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX E/DEXTROSE (5/15)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CLINIMIX E/DEXTROSE (5/20)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/10)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (4.25/5)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/15)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINIMIX/DEXTROSE (5/20)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>clinisol sf</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
CLINOLIPID	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>dextrose (5 %, 10 %, 50 %, 70 %, 250 mg/ml)</i>	2-Generic	
<i>dextrose-nacl (2.5-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.9 %, 5-0.45 %, 10-0.45 %, 10-0.2 %)</i>	2-Generic	
<i>dextrose-sodium chloride (2.5-0.45 %, 5-0.45 %, 5-0.9 %)</i>	2-Generic	
FREAMINE III	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
INTRALIPID	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
ISOLYTE-P IN D5W	4-Non-Preferred Drug	
ISOLYTE-S	4-Non-Preferred Drug	
ISOLYTE-S PH 7.4	4-Non-Preferred Drug	
<i>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-%)</i>	2-Generic	
KCL-LACTATED RINGERS-D5W	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>klor-con (8 tab er, 20 packet)</i>	2-Generic	
<i>klor-con 10</i>	2-Generic	
<i>klor-con m10</i>	2-Generic	
<i>klor-con m15</i>	2-Generic	
<i>klor-con m20</i>	2-Generic	
<i>klor-con sprinkle</i>	2-Generic	
<i>levocarnitine (1 gm/10ml solution, 330 mg tab)</i>	2-Generic	
<i>levocarnitine sf</i>	2-Generic	
<i>magnesium sulfate 50 % solution</i>	1-Preferred Generics	
NUTRILIPID	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
PLASMA-LYTE 148	4-Non-Preferred Drug	
PLASMA-LYTE A	4-Non-Preferred Drug	
<i>plenamine</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>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)</i>	2-Generic	
<i>potassium chloride crys er</i>	2-Generic	
<i>potassium chloride er (er 8 tab er, er 8 cap er, er 10 tab er, er 10 cap er, er 20 tab er)</i>	2-Generic	
<i>potassium chloride in dextrose 20-5 meq/l-% solution</i>	2-Generic	
<i>potassium chloride in nacl (20-0.45 meq/l-% solution, 40-0.9 meq/l-% solution)</i>	4-Non-Preferred Drug	
<i>potassium citrate er</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PREMASOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
PROSOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>sodium chloride (0.45 %, 0.9 %, 3 %, 5 %)</i>	2-Generic	
<i>sodium chloride (pf)</i>	2-Generic	
<i>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)</i>	1-Preferred Generics	
TPN ELECTROLYTES	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
TRAVASOL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
TROPHAMINE	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

ELECTROLYTE/MINERAL/METAL MODIFIERS

CHEMET	3-Preferred Brands	
<i>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)</i>	5-Specialty	PA
<i>deferasirox 90 mg tab</i>	4-Non-Preferred Drug	PA
<i>deferasirox granules</i>	5-Specialty	PA
<i>deferiprone</i>	5-Specialty	
FERRIPROX 100 MG/ML SOLUTION	5-Specialty	
FERRIPROX TWICE-A-DAY	5-Specialty	
<i>trientine hcl</i>	5-Specialty	QL (240 PER 30 DAYS)

PHOSPHATE BINDERS

<i>calcium acetate</i>	2-Generic	
<i>calcium acetate (phos binder) (binder) 667 mg tab, binder) 667 mg cap)</i>	2-Generic	
<i>sevelamer carbonate (0.8 gm, 2.4 gm)</i>	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>sevelamer carbonate 800 mg tab</i>	2-Generic	
POTASSIUM BINDERS		
LOKELMA	3-Preferred Brands	
<i>sodium polystyrene sulfonate</i>	3-Preferred Brands	
<i>sps</i>	3-Preferred Brands	
VELTASSA	3-Preferred Brands	
VITAMINS		
<i>prenatal vitamin oral tablet</i>	3-Preferred Brands	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
<i>constulose</i>	2-Generic	
<i>enulose</i>	2-Generic	
<i>generlac</i>	2-Generic	
<i>lactulose (10 gm/15ml, 20 gm/30ml)</i>	2-Generic	
<i>lactulose encephalopathy</i>	2-Generic	
LINZESS	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>lubiprostone</i>	2-Generic	QL (60 PER 30 DAYS)
MOVANTIK	3-Preferred Brands	QL (30 PER 30 DAYS)
RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION, 150 MG TAB)	5-Specialty	
ANTI-DIARRHEAL AGENTS		
<i>alosetron hcl</i>	5-Specialty	QL (60 PER 30 DAYS)
<i>diphenoxylate-atropine (2.5-0.025 mg tab, 2.5-0.025 mg/5ml liquid)</i>	2-Generic	
<i>loperamide hcl 2 mg cap</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VIBERZI	5-Specialty	QL (60 PER 30 DAYS)
XERMELO	5-Specialty	PA, QL (84 PER 28 DAYS)
ANTISPASMODICS, GASTROINTESTINAL		
<i>dicyclomine hcl (10 mg cap, 10 mg/5ml solution, 20 mg tab)</i>	2-Generic	
<i>glycopyrrolate (1 mg tab, 2 mg tab)</i>	2-Generic	
<i>methscopolamine bromide</i>	2-Generic	
GASTROINTESTINAL AGENTS, OTHER		
GATTEX	5-Specialty	PA
<i>gavilyte-c</i>	1-Preferred Generics	
<i>gavilyte-g</i>	1-Preferred Generics	
<i>gavilyte-n with flavor pack</i>	1-Preferred Generics	
MYALEPT	5-Specialty	PA
<i>na sulfate-k sulfate-mg sulf</i>	4-Non-Preferred Drug	
OICALIVA	5-Specialty	PA
<i>peg 3350-kcl-na bicarb-nacl</i>	1-Preferred Generics	
<i>peg-3350/electrolytes</i>	1-Preferred Generics	
<i>peg-3350/electrolytes/ascorbat</i>	2-Generic	
<i>peg-kcl-nacl-nasulf-na asc-c</i>	2-Generic	
SUPREP BOWEL PREP KIT	4-Non-Preferred Drug	
<i>ursodiol (250 mg tab, 300 mg cap, 500 mg tab)</i>	2-Generic	
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
<i>cimetidine</i>	2-Generic	
<i>cimetidine hcl</i>	2-Generic	
<i>famotidine (20 mg tab, 40 mg tab, 40 mg/5ml recon susp)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>nizatidine (150 mg cap, 300 mg cap)</i>	3-Preferred Brands	
PROTECTANTS		
<i>misoprostol</i>	2-Generic	
<i>sucalfate 1 gm/10ml suspension</i>	4-Non-Preferred Drug	
<i>sucalfate 1 gm tab</i>	2-Generic	
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium (20 mg cap dr, 40 mg cap dr)</i>	4-Non-Preferred Drug	QL (60 PER 30 DAYS)
<i>lansoprazole (15 mg cap dr, 30 mg cap dr)</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>omeprazole (10 mg cap dr, 20 mg cap dr, 40 mg cap dr)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>pantoprazole sodium (20 mg tab dr, 40 mg tab dr)</i>	1-Preferred Generics	QL (60 PER 30 DAYS)
<i>rabeprazole sodium</i>	2-Generic	QL (30 PER 30 DAYS)
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
ARALAST NP	5-Specialty	PA
<i>betaine</i>	5-Specialty	
CREON	3-Preferred Brands	
<i>cromolyn sodium 100 mg/5ml conc</i>	1-Preferred Generics	
CYSTAGON	3-Preferred Brands	
CYSTARAN	5-Specialty	PA
ENDARI	5-Specialty	PA, QL (180 PER 30 DAYS)
GLASSIA	5-Specialty	PA
<i>javygtor (100 mg tab, 100 mg packet, 500 mg packet)</i>	5-Specialty	
<i>miglustat</i>	5-Specialty	QL (90 PER 30 DAYS)
<i>nitisinone</i>	5-Specialty	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NITYR	5-Specialty	
PANCREAZE	3-Preferred Brands	
PROLASTIN-C (1000 MG/20ML SOLUTION, 1000 MG RECON SOLN)	5-Specialty	PA
RAVICTI	5-Specialty	PA, QL (525 PER 30 DAYS)
<i>sapropterin dihydrochloride (100 mg packet, 100 mg tab, 500 mg packet)</i>	5-Specialty	
<i>sodium phenylbutyrate 500 mg tab</i>	5-Specialty	
ZEMAIRA	5-Specialty	PA

GENITOURINARY AGENTS

ANTISPASMODICS, URINARY

<i>darifenacin hydrobromide er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>fesoterodine fumarate er</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>flavoxate hcl</i>	2-Generic	
GEMTESA	3-Preferred Brands	
MYRBETRIQ (8 MG/ML SRER, 25 MG TAB ER 24H, 50 MG TAB ER 24H)	3-Preferred Brands	
<i>oxybutynin chloride (5 mg/5ml syrup, 5 mg tab)</i>	2-Generic	
<i>oxybutynin chloride er</i>	2-Generic	QL (60 PER 30 DAYS)
<i>solifenacin succinate</i>	2-Generic	QL (30 PER 30 DAYS)
<i>tolterodine tartrate</i>	2-Generic	QL (60 PER 30 DAYS)
<i>tolterodine tartrate er</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>tropium chloride</i>	2-Generic	QL (60 PER 30 DAYS)
<i>tropium chloride er</i>	2-Generic	QL (30 PER 30 DAYS)

BENIGN PROSTATIC HYPERTROPHY AGENTS

<i>alfuzosin hcl er</i>	2-Generic	QL (30 PER 30 DAYS)
<i>dutasteride 0.5 mg cap</i>	2-Generic	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dutasteride-tamsulosin hcl</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>finasteride</i>	1-Preferred Generics	QL (30 PER 30 DAYS)
<i>silodosin</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)
<i>tamsulosin hcl</i>	2-Generic	QL (60 PER 30 DAYS)

GENITOURINARY AGENTS, OTHER

<i>bethanechol chloride</i>	2-Generic	
ELMIRON	3-Preferred Brands	
<i>penicillamine 250 mg tab</i>	5-Specialty	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)

ACTHAR	5-Specialty	PA
<i>betamethasone dipropionate aug 0.05 % lotion</i>	2-Generic	
CORTROPHIN	5-Specialty	PA
<i>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)</i>	2-Generic	
<i>dexamethasone sod phosphate pf 10 mg/ml solution</i>	4-Non-Preferred Drug	
<i>dexamethasone sodium phosphate (4 mg/ml, 10 mg/ml, 20 mg/5ml, 100 mg/10ml, 120 mg/30ml)</i>	4-Non-Preferred Drug	
<i>fludrocortisone acetate</i>	2-Generic	
KORLYM	5-Specialty	PA
<i>methylprednisolone (4 mg tab thpk, 4 mg tab, 8 mg tab, 16 mg tab, 32 mg tab)</i>	2-Generic	
<i>methylprednisolone acetate</i>	2-Generic	
<i>methylprednisolone sodium succ</i>	4-Non-Preferred Drug	
<i>prednisolone 15 mg/5ml solution</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>prednisolone sodium phosphate (6.7 (5 base) mg/5ml, 15 mg/5ml, 25 mg/5ml)</i>	2-Generic	
<i>prednisone (1 mg tab, 2.5 mg tab, 5 mg tab, 10 mg tab, 20 mg tab, 50 mg tab)</i>	1-Preferred Generics	
<i>prednisone (5 mg/5ml solution, 5 mg (21) tab thpk, 5 mg (48) tab thpk, 10 mg (48) tab thpk, 10 mg (21) tab thpk)</i>	2-Generic	
PREDNISONE INTENSOL	4-Non-Preferred Drug	
SOLU-MEDROL 2 GM RECON SOLN	4-Non-Preferred Drug	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)

<i>desmopressin ace spray refrig</i>	4-Non-Preferred Drug	
<i>desmopressin acetate 4 mcg/ml solution</i>	4-Non-Preferred Drug	
<i>desmopressin acetate (0.1 mg tab, 0.2 mg tab)</i>	2-Generic	
<i>desmopressin acetate pf</i>	4-Non-Preferred Drug	
<i>desmopressin acetate spray</i>	4-Non-Preferred Drug	
INCRELEX	5-Specialty	
NORDITROPIN FLEXPLO	5-Specialty	PA

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)

ANABOLIC STEROIDS

<i>oxandrolone 10 mg tab</i>	2-Generic	PA, QL (60 PER 30 DAYS)
<i>oxandrolone 2.5 mg tab</i>	2-Generic	PA, QL (240 PER 30 DAYS)

ANDROGENS

<i>danazol</i>	4-Non-Preferred Drug	
<i>testosterone (12.5 mg/act (1%) gel, 25 mg/2.5gm (1%) gel, 50 mg/5gm (1%) gel)</i>	4-Non-Preferred Drug	PA, QL (300 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>testosterone cypionate</i>	2-Generic	PA - FOR NEW STARTS ONLY
<i>testosterone enanthate</i>	2-Generic	PA - FOR NEW STARTS ONLY
<i>testosterone td gel pump 20.25 mg/act (1.62%)</i>	4-Non-Preferred Drug	PA, QL (150 PER 30 DAYS)
ESTROGENS		
<i>afirmelle</i>	2-Generic	
<i>altavera</i>	2-Generic	
<i>alyacen 1/35</i>	2-Generic	
<i>alyacen 7/7/7</i>	2-Generic	
<i>amabelz</i>	2-Generic	
<i>apri</i>	2-Generic	
<i>aranelle</i>	2-Generic	
<i>aubra eq</i>	2-Generic	
<i>aurovela 1.5/30</i>	2-Generic	
<i>aurovela 1/20</i>	2-Generic	
<i>aurovela fe 1.5/30</i>	2-Generic	
<i>aurovela fe 1/20</i>	2-Generic	
<i>aviane</i>	2-Generic	
<i>ayuna</i>	2-Generic	
<i>azurette</i>	2-Generic	
<i>balziva</i>	2-Generic	
<i>bekyree</i>	2-Generic	
<i>blisovi fe 1.5/30</i>	2-Generic	
<i>blisovi fe 1/20</i>	2-Generic	
<i>briellyn</i>	2-Generic	
<i>camrese lo</i>	2-Generic	
<i>chateal eq</i>	2-Generic	
<i>cryselle-28</i>	2-Generic	
<i>cyred eq</i>	2-Generic	
<i>dasetta 1/35</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>dasetta 7/7/7</i>	2-Generic	
<i>delyla</i>	2-Generic	
<i>desogestrel-ethinyl estradiol</i>	2-Generic	
<i>dotti</i>	2-Generic	
<i>drospirenone-ethinyl estradiol</i>	2-Generic	
<i>elinest</i>	2-Generic	
<i>eluryng</i>	2-Generic	
<i>emoquette</i>	2-Generic	
<i>enpresse-28</i>	2-Generic	
<i>enskyce</i>	2-Generic	
<i>estarylla</i>	2-Generic	
<i>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)</i>	2-Generic	
<i>estradiol valerate</i>	2-Generic	
<i>estradiol-norethindrone acet</i>	2-Generic	
<i>ethynodiol diac-eth estradiol</i>	2-Generic	
<i>etonogestrel-ethinyl estradiol</i>	2-Generic	
<i>falmina</i>	2-Generic	
<i>femynor</i>	2-Generic	
<i>hailey 1.5/30</i>	2-Generic	
<i>hailey fe 1.5/30</i>	2-Generic	
<i>hailey fe 1/20</i>	2-Generic	
<i>haloette</i>	2-Generic	
<i>iclevia</i>	2-Generic	
<i>introvale</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>incassia</i>	2-Generic	
<i>jencycla</i>	2-Generic	
<i>lyleq</i>	2-Generic	
<i>lyza</i>	2-Generic	
<i>medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml suspension, 150 mg/ml susp prsyr)</i>	2-Generic	
<i>megestrol acetate (20 mg tab, 40 mg tab, 40 mg/ml suspension, 400 mg/10ml suspension, 625 mg/5ml suspension, 800 mg/20ml suspension)</i>	2-Generic	
<i>nora-be</i>	2-Generic	
<i>norethindrone</i>	2-Generic	
<i>norethindrone acetate</i>	2-Generic	
<i>norlyda</i>	2-Generic	
<i>norlyroc</i>	2-Generic	
<i>progesterone (100 mg cap, 200 mg cap)</i>	2-Generic	
<i>sharobel</i>	2-Generic	

SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS

DUAVEE	3-Preferred Brands	
<i>raloxifene hcl</i>	2-Generic	QL (30 PER 30 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)

<i>euthyrox</i>	1-Preferred Generics	
<i>levo-t</i>	1-Preferred Generics	
<i>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)</i>	1-Preferred Generics	
<i>levoxyl</i>	1-Preferred Generics	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)</i>	2-Generic	
SYNTHROID	3-Preferred Brands	
<i>unithroid</i>	1-Preferred Generics	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN	5-Specialty	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
<i>cabergoline</i>	2-Generic	
ELIGARD	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FIRMAGON	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FIRMAGON (240 MG DOSE)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>leuprolide acetate</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
LEUPROLIDE ACETATE (3 MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (1-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (3-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (4-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT (6-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (1-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (3-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
LUPRON DEPOT-PED (6-MONTH)	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>octreotide acetate (50 mcg/ml solution, 50 mcg/ml soln prsy, 100 mcg/ml soln prsy, 100 mcg/ml solution, 200 mcg/ml solution, 500 mcg/ml solution, 500 mcg/ml soln prsy, 1000 mcg/ml solution)</i>	4-Non-Preferred Drug	
ORGOVYX	5-Specialty	PA - FOR NEW STARTS ONLY
SIGNIFOR	5-Specialty	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SOMATULINE DEPOT	5-Specialty	
SOMAVERT	5-Specialty	
SYNAREL	5-Specialty	
TRELSTAR MIXJECT	5-Specialty	PA - TO CONFIRM PART D COVERAGE

HORMONAL AGENTS, SUPPRESSANT (THYROID)

ANTITHYROID AGENTS

<i>methimazole (5 mg tab, 10 mg tab)</i>	1-Preferred Generics	
<i>propylthiouracil</i>	2-Generic	

IMMUNOLOGICAL AGENTS

ANGIOEDEMA AGENTS

CINRYZE	5-Specialty	PA
<i>icatibant acetate</i>	5-Specialty	PA, QL (27 PER 30 DAYS)
<i>sajazir</i>	5-Specialty	PA, QL (27 PER 30 DAYS)

IMMUNOGLOBULINS

ATGAM	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BIVIGAM	5-Specialty	PA
FLEBOGAMMA DIF	5-Specialty	PA
GAMMAGARD	5-Specialty	PA
GAMMAGARD S/D LESS IGA	5-Specialty	PA
GAMMAKED	5-Specialty	PA
GAMMAPLEX	5-Specialty	PA
GAMUNEX-C	5-Specialty	PA
OCTAGAM	5-Specialty	PA
PANZYGA	5-Specialty	PA
PRIVIGEN	5-Specialty	PA
THYMOGLOBULIN	5-Specialty	PA - TO CONFIRM PART D COVERAGE

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST	5-Specialty	
BENLYSTA (120 MG SOLN, 400 MG SOLN)	5-Specialty	PA
BENLYSTA (200 MG/ML SOLN PRSYR, 200 MG/ML SOLN A-INJ)	5-Specialty	PA, QL (8 PER 28 DAYS)
DUPIXENT (100 MG/0.67ML SOLN PRSYR, 200 MG/1.14ML SOLN PEN, 200 MG/1.14ML SOLN PRSYR, 300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	5-Specialty	PA
OTEZLA (10 20 30 MG TAB THPK, 30 MG TAB)	5-Specialty	PA
RIDAURA	5-Specialty	
SIMULECT 20 MG RECON SOLN	5-Specialty	PA - TO CONFIRM PART D COVERAGE
SKYRIZI (150 MG/ML SOLN PRSYR, 180 MG/1.2ML SOLN CART, 360 MG/2.4ML SOLN CART, 600 MG/10ML SOLUTION)	5-Specialty	PA
SKYRIZI PEN	5-Specialty	PA
TALTZ (80 MG/ML SOLN A-INJ, 80 MG/ML SOLN PRSYR)	5-Specialty	PA
XELJANZ (1 MG/ML SOLUTION, 5 MG TAB, 10 MG TAB)	5-Specialty	PA
XELJANZ XR	5-Specialty	PA
XOLAIR (75 MG/0.5ML SOLN PRSYR, 150 MG/ML SOLN PRSYR, 150 MG RECON SOLN)	5-Specialty	PA
IMMUNOSTIMULANTS		
ACTIMMUNE	5-Specialty	PA
INTRON A (6000000 UNIT/ML SOLUTION, 10000000 UNIT/ML SOLUTION, 10000000 UNIT RECON SOLN, 18000000 UNIT RECON SOLN, 50000000 UNIT RECON SOLN)	5-Specialty	
PEGASYS (180 MCG/0.5ML SOLN PRSYR, 180 MCG/ML SOLUTION)	5-Specialty	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMMUNOSUPPRESSANTS		
ASTAGRAF XL	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
AVSOLA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>azathioprine 50 mg tab</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
AZATHIOPRINE SODIUM	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine (25 mg cap, 50 mg/ml solution, 100 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>cyclosporine modified (25 mg cap, 50 mg cap, 100 mg cap, 100 mg/ml solution)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
ENBREL (25 MG/0.5ML SOLN PRSYR, 25 MG/0.5ML SOLUTION, 25 MG RECON SOLN, 50 MG/ML SOLN PRSYR)	5-Specialty	PA
ENBREL MINI	5-Specialty	PA
ENBREL SURECLICK	5-Specialty	PA
ENVARSUS XR	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>everolimus (0.5 mg tab, 0.75 mg tab, 1 mg tab)</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>everolimus 0.25 mg tab</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>engraf (25 mg cap, 100 mg/ml solution, 100 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
HUMIRA	5-Specialty	PA
HUMIRA PEDIATRIC CROHNS START	5-Specialty	PA
HUMIRA PEN	5-Specialty	PA
HUMIRA PEN-CD/UC/HS STARTER	5-Specialty	PA
HUMIRA PEN-PEDIATRIC UC START	5-Specialty	PA
HUMIRA PEN-PS/UV/ADOL HS START	5-Specialty	PA
HUMIRA PEN-PSOR/UEIT STARTER	5-Specialty	PA
INFLECTRA	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>leflunomide 10 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>leflunomide 20 mg tab</i>	2-Generic	QL (150 PER 30 DAYS)
<i>methotrexate</i>	2-Generic	
<i>methotrexate sodium 1 gm recon soln</i>	4-Non-Preferred Drug	
<i>methotrexate sodium (2.5 mg tab, 50 mg/2ml solution, 250 mg/10ml solution, 1000 mg/40ml solution)</i>	2-Generic	
<i>methotrexate sodium (pf)</i>	2-Generic	
<i>mycophenolate mofetil 200 mg/ml recon susp</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate mofetil (250 mg cap, 500 mg recon soln, 500 mg tab)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate mofetil hcl</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>mycophenolate sodium</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
NULOJIX	5-Specialty	PA - TO CONFIRM PART D COVERAGE
OTREXUP	4-Non-Preferred Drug	
PROGRAF (0.2 MG, 1 MG)	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
RASUVO	4-Non-Preferred Drug	
RENFLEXIS	5-Specialty	PA - TO CONFIRM PART D COVERAGE
REZUROCK	5-Specialty	PA
RINVOQ	5-Specialty	PA
SANDIMMUNE 100 MG/ML SOLUTION	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
<i>sirolimus 1 mg/ml solution</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>sirolimus (0.5 mg tab, 1 mg tab, 2 mg tab)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>tacrolimus (0.5 mg cap, 1 mg cap, 5 mg cap)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>temsirolimus</i>	5-Specialty	
TREXALL	4-Non-Preferred Drug	
XATMEP	4-Non-Preferred Drug	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VACCINES		
ABRYSCO	1-Preferred Generics	
ACTHIB	3-Preferred Brands	
ADACEL	1-Preferred Generics	
AREXVY	1-Preferred Generics	
BCG VACCINE	3-Preferred Brands	
BEXSERO	3-Preferred Brands	
BOOSTRIX (5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR, 5-2.5-18.5 LF-MCG/0.5 SUSPENSION)	1-Preferred Generics	
DAPTACEL	1-Preferred Generics	
DIPHTHERIA-TETANUS TOXOIDS DT	1-Preferred Generics	
ENGERIX-B (10 MCG/0.5ML SUSP PRSYR, 20 MCG/ML SUSP PRSYR, 20 MCG/ML SUSPENSION)	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
GARDASIL 9 (9SUSPPRSYR, 9SUSPENSION)	1-Preferred Generics	
HAVRIX	1-Preferred Generics	
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	3-Preferred Brands	PA - TO CONFIRM PART D COVERAGE
HIBERIX	3-Preferred Brands	
IMOVAX RABIES	3-Preferred Brands	
INFANRIX	1-Preferred Generics	
IPOL	3-Preferred Brands	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SHINGRIX	1-Preferred Generics	
TDVAX	1-Preferred Generics	
TENIVAC	1-Preferred Generics	
TICOVAC	3-Preferred Brands	
TRUMENBA	3-Preferred Brands	
TWINRIX	1-Preferred Generics	
TYPHIM VI (25 MCG/0.5ML SOLN PRSYR, 25 MCG/0.5ML SOLUTION)	3-Preferred Brands	
VAQTA	1-Preferred Generics	
VARIVAX	3-Preferred Brands	
YF-VAX	3-Preferred Brands	

INFLAMMATORY BOWEL DISEASE AGENTS

AMINOSALICYLATES

<i>balsalazide disodium</i>	2-Generic
<i>mesalamine (4 gm enema, 1000 mg suppos)</i>	4-Non-Preferred Drug
<i>mesalamine (1.2 gm tab dr, 400 mg cap dr, 800 mg tab dr)</i>	2-Generic
<i>mesalamine er 0.375 gm cap er 24h</i>	2-Generic
<i>mesalamine-cleanser</i>	4-Non-Preferred Drug
<i>sulfasalazine (500 mg tab dr, 500 mg tab)</i>	2-Generic

GLUCOCORTICOIDS

<i>budesonide 3 mg cp dr part</i>	4-Non-Preferred Drug
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You can find information on what the symbols and abbreviations on this table mean by going to page 1.

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>zoledronic acid (4 mg/5ml conc, 5 mg/100ml solution)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE

MISCELLANEOUS THERAPEUTIC AGENTS

BD ALCOHOL PADS	2-Generic	
GAUZE PADS & DRESSINGS - PADS 2 X 2	2-Generic	
INSULIN PEN NEEDLE (Novo/BD/Ultimed/Owen/Trividia)	2-Generic	
INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
INSULIN SYRINGE (DISP) U-100 1 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/Ultimed/Allison/Trividia/MHC)	2-Generic	
NEEDLES, INSULIN DISP., SAFETY	2-Generic	
<i>sterile water for irrigation</i>	4-Non-Preferred Drug	

OPHTHALMIC AGENTS

OPHTHALMIC AGENTS, OTHER

<i>ak-poly-bac</i>	2-Generic	
ATROPINE SULFATE 1 % SOLUTION	2-Generic	
<i>bacitra-neomycin-polymyxin-hc</i>	2-Generic	
<i>bacitracin-polymyxin b</i>	2-Generic	
COMBIGAN	3-Preferred Brands	
<i>cyclopentolate hcl</i>	2-Generic	
<i>dorzolamide hcl-timolol mal</i>	2-Generic	
<i>dorzolamide hcl-timolol mal pf</i>	2-Generic	
ISOPTO ATROPINE	2-Generic	
<i>neo-polycin</i>	2-Generic	
<i>neo-polycin hc</i>	2-Generic	
<i>neomycin-bacitracin zn-polymyx</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>neomycin-polymyxin-dexameth (3.5-10000-0.1suspension, 3.5-10000-0.1ointment)</i>	2-Generic	
<i>neomycin-polymyxin-gramicidin</i>	2-Generic	
<i>neomycin-polymyxin-hc 3.5-10000-1 suspension</i>	2-Generic	
OXERVATE	5-Specialty	PA
<i>polycin</i>	2-Generic	
<i>proparacaine hcl</i>	2-Generic	
RESTASIS	3-Preferred Brands	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE	3-Preferred Brands	QL (5.5 PER 28 DAYS)
<i>sulfacetamide-prednisolone</i>	2-Generic	
TOBRADEX 0.3-0.1 % OINTMENT	3-Preferred Brands	
<i>tobramycin-dexamethasone</i>	4-Non-Preferred Drug	
XIIDRA	3-Preferred Brands	QL (60 PER 30 DAYS)
ZYLET	4-Non-Preferred Drug	

OPHTHALMIC ANTI-ALLERGY AGENTS

ALOCRIIL	3-Preferred Brands	
ALOMIDE	3-Preferred Brands	
<i>azelastine hcl 0.05 % solution</i>	2-Generic	
<i>bepotastine besilate</i>	4-Non-Preferred Drug	
<i>cromolyn sodium 4 % solution</i>	1-Preferred Generics	
<i>epinastine hcl</i>	2-Generic	
<i>olopatadine hcl (0.1 %, 0.2 %)</i>	2-Generic	

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

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

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>fluorometholone</i>	2-Generic	
<i>flurbiprofen sodium</i>	2-Generic	
ILEVRO	3-Preferred Brands	
<i>ketorolac tromethamine (0.4 %, 0.5 %)</i>	2-Generic	
LOTEMAX 0.5 % OINTMENT	4-Non-Preferred Drug	
<i>loteprednol etabonate (0.5 % gel, 0.5 % suspension)</i>	4-Non-Preferred Drug	
<i>prednisolone acetate</i>	2-Generic	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	2-Generic	
PROLENSA	4-Non-Preferred Drug	

OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS

<i>betaxolol hcl 0.5 % solution</i>	2-Generic	
<i>carteolol hcl</i>	2-Generic	
<i>levobunolol hcl</i>	2-Generic	
<i>timolol maleate (0.25 % gel f soln, 0.5 % gel f soln, 0.5 % (daily) solution)</i>	2-Generic	
<i>timolol maleate (0.25 %, 0.5 %)</i>	1-Preferred Generics	

OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER

<i>acetazolamide er</i>	2-Generic	
ALPHAGAN P 0.1 % SOLUTION	3-Preferred Brands	
<i>apraclonidine hcl</i>	2-Generic	
AZOPT	3-Preferred Brands	
<i>brimonidine tartrate (0.15 %, 0.2 %)</i>	2-Generic	
<i>dorzolamide hcl</i>	2-Generic	
<i>methazolamide</i>	4-Non-Preferred Drug	

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pilocarpine hcl (1 %, 2 %, 4 %)</i>	2-Generic	
RHOPRESSA	3-Preferred Brands	
SIMBRINZA	3-Preferred Brands	

OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS

<i>bimatoprost 0.03% ophth solution</i>	2-Generic	
<i>latanoprost 0.005 % solution</i>	1-Preferred Generics	
LUMIGAN	3-Preferred Brands	
<i>travoprost (bak free)</i>	2-Generic	

OTIC AGENTS

CIPRODEX	3-Preferred Brands	
<i>ciprofloxacin hcl 0.2 % solution</i>	2-Generic	
<i>flac</i>	2-Generic	
<i>fluocinolone acetonide 0.01 % oil</i>	2-Generic	
<i>hydrocortisone-acetic acid</i>	2-Generic	
<i>neomycin-polymyxin-hc (1 %, 3.5-10000-1)</i>	2-Generic	

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

ARNUITY ELLIPTA	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>budesonide (0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
FLOVENT DISKUS	3-Preferred Brands	QL (80 PER 30 DAYS)
FLOVENT HFA (110 MCG/ACT, 220 MCG/ACT)	3-Preferred Brands	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG/ACT AEROSOL	3-Preferred Brands	QL (22 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>flunisolide</i>	2-Generic	QL (50 PER 30 DAYS)
<i>fluticasone propionate 50 mcg/act suspension</i>	1-Preferred Generics	QL (16 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA (110 MCG/ACT, 220 MCG/ACT)	3-Preferred Brands	QL (24 PER 30 DAYS)
FLUTICASONE PROPIONATE HFA 44 MCG/ACT AEROSOL	3-Preferred Brands	QL (22 PER 30 DAYS)
<i>mometasone furoate 50 mcg/act suspension</i>	4-Non-Preferred Drug	QL (34 PER 30 DAYS)
PULMICORT FLEXHALER	3-Preferred Brands	QL (2 PER 30 DAYS)

ANTIHISTAMINES

<i>azelastine hcl (0.1 %, 0.15 %, 137 mcg/spray)</i>	2-Generic	
<i>cetirizine hcl 1 mg/ml solution</i>	2-Generic	
<i>cyproheptadine hcl (2 mg/5ml syrup, 4 mg tab)</i>	2-Generic	
<i>desloratadine 5 mg tab</i>	2-Generic	
<i>diphenhydramine hcl 50 mg/ml solution</i>	2-Generic	
<i>hydroxyzine hcl 10 mg/5ml syrup</i>	3-Preferred Brands	
<i>hydroxyzine hcl (10 mg tab, 25 mg tab, 50 mg tab)</i>	2-Generic	
<i>levocetirizine dihydrochloride 2.5 mg/5ml solution</i>	4-Non-Preferred Drug	
<i>levocetirizine dihydrochloride 5 mg tab</i>	1-Preferred Generics	
<i>olopatadine hcl 0.6 % solution</i>	2-Generic	
<i>promethazine hcl (6.25 mg/5ml solution, 6.25 mg/5ml syrup)</i>	1-Preferred Generics	PA

ANTILEUKOTRIENES

<i>montelukast sodium (4 mg chew tab, 4 mg packet, 5 mg chew tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>montelukast sodium 10 mg tab</i>	1-Preferred Generics	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>zafirlukast 10 mg tab</i>	2-Generic	QL (120 PER 30 DAYS)
<i>zafirlukast 20 mg tab</i>	2-Generic	QL (60 PER 30 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	4-Non-Preferred Drug	QL (25.8 PER 30 DAYS)
INCRUSE ELLIPTA	3-Preferred Brands	QL (30 PER 30 DAYS)
<i>ipratropium bromide (0.03 %, 0.06 %)</i>	2-Generic	
<i>ipratropium bromide 0.02 % solution</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
SPIRIVA HANDIHALER	3-Preferred Brands	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
YUPELRI	5-Specialty	PA - TO CONFIRM PART D COVERAGE
BRONCHODILATORS, SYMPATHOMIMETIC		
<i>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)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
<i>albuterol sulfate (2 mg tab, 2 mg/5ml syrup, 4 mg tab)</i>	2-Generic	
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proair)</i>	1-Preferred Generics	QL (17 PER 30 DAYS)
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic proventil)</i>	1-Preferred Generics	QL (13.4 PER 30 DAYS)
<i>albuterol sulfate hfa 108 (90 base) mcg/act aero soln (generic ventolin)</i>	1-Preferred Generics	QL (36 PER 30 DAYS)
<i>arformoterol tartrate</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>epinephrine (0.15 mg/0.15ml soln, 0.15 mg/0.3ml soln, 0.3 mg/0.3ml soln)</i>	2-Generic	
<i>formoterol fumarate</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE
<i>levalbuterol hcl (0.31 mg/3ml soln, 0.63 mg/3ml soln, 1.25 mg/3ml soln, 1.25 mg/0.5ml soln)</i>	4-Non-Preferred Drug	PA - TO CONFIRM PART D COVERAGE
<i>levalbuterol tartrate</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SEREVENT DISKUS	3-Preferred Brands	QL (60 PER 30 DAYS)
STRIVERDI RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
<i>terbutaline sulfate (2.5 mg tab, 5 mg tab)</i>	2-Generic	

CYSTIC FIBROSIS AGENTS

CAYSTON	5-Specialty	
KALYDECO (13.4 MG, 25 MG, 50 MG)	5-Specialty	PA, QL (56 PER 28 DAYS)
KALYDECO (75 MG PACKET, 150 MG TAB)	5-Specialty	PA, QL (60 PER 30 DAYS)
ORKAMBI (75-94 MG, 100-125 MG, 150-188 MG)	5-Specialty	PA, QL (56 PER 28 DAYS)
ORKAMBI 100-125 MG TAB	5-Specialty	PA, QL (112 PER 28 DAYS)
ORKAMBI 200-125 MG TAB	5-Specialty	PA, QL (120 PER 30 DAYS)
PULMOZYME	5-Specialty	PA - TO CONFIRM PART D COVERAGE
TOBI PODHALER	5-Specialty	QL (240 PER 30 DAYS)
<i>tobramycin 300 mg/5ml nebu soln</i>	5-Specialty	PA - TO CONFIRM PART D COVERAGE, QL (300 PER 30 DAYS)

MAST CELL STABILIZERS

<i>cromolyn sodium 20 mg/2ml nebu soln</i>	1-Preferred Generics	PA - TO CONFIRM PART D COVERAGE
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PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE

DALIRESP	4-Non-Preferred Drug	
<i>elixophyllin</i>	2-Generic	
<i>roflumilast</i>	4-Non-Preferred Drug	
THEO-24	4-Non-Preferred Drug	
<i>theophylline (80 mg/15ml solution, 80 mg/15ml elixir)</i>	2-Generic	
<i>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)</i>	2-Generic	

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	5-Specialty	PA, QL (90 PER 30 DAYS)
<i>alyq</i>	5-Specialty	PA, QL (60 PER 30 DAYS)
<i>ambrisentan</i>	5-Specialty	PA, QL (30 PER 30 DAYS)
<i>bosentan</i>	5-Specialty	PA, QL (60 PER 30 DAYS)
OPSUMIT	5-Specialty	PA, QL (30 PER 30 DAYS)
<i>sildenafil citrate 20 mg tab</i>	2-Generic	PA, QL (90 PER 30 DAYS)
<i>tadalafil (pah)</i>	5-Specialty	PA, QL (60 PER 30 DAYS)
TRACLEER 32 MG TAB SOL	5-Specialty	PA, QL (120 PER 30 DAYS)
UPTRAVI (200 & 800 MCG TAB THPK, 200 MCG TAB, 400 MCG TAB, 600 MCG TAB, 800 MCG TAB, 1000 MCG TAB, 1200 MCG TAB, 1400 MCG TAB, 1600 MCG TAB)	5-Specialty	PA
PULMONARY FIBROSIS AGENTS		
OFEV	5-Specialty	PA, QL (60 PER 30 DAYS)
<i>pirfenidone (267 mg tab, 267 mg cap)</i>	5-Specialty	PA, QL (270 PER 30 DAYS)
<i>pirfenidone (534 mg tab, 801 mg tab)</i>	5-Specialty	PA, QL (90 PER 30 DAYS)
RESPIRATORY TRACT AGENTS, OTHER		
<i>acetylcysteine (10 %, 20 %)</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
ADVAIR DISKUS	2-Generic	QL (60 PER 30 DAYS)
ADVAIR HFA	3-Preferred Brands	QL (12 PER 30 DAYS)
ANORO ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)
BEVESPI AEROSPHERE	3-Preferred Brands	QL (10.7 PER 30 DAYS)
BREO ELLIPTA 100-25 MCG/ACT AER POW BA	3-Preferred Brands	QL (60 PER 30 DAYS)
BREO ELLIPTA 200-25 MCG/ACT AER POW BA	3-Preferred Brands	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE	3-Preferred Brands	QL (10.7 PER 30 DAYS)

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Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
COMBIVENT RESPIMAT	3-Preferred Brands	QL (4 PER 30 DAYS)
FASENRA	5-Specialty	PA
FASENRA PEN	5-Specialty	PA
<i>fluticasone furoate-vilanterol</i>	3-Preferred Brands	QL (60 PER 30 DAYS)
<i>ipratropium-albuterol</i>	2-Generic	PA - TO CONFIRM PART D COVERAGE
NUCALA (40 MG/0.4ML SOLN PRSYR, 100 MG RECON SOLN, 100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR)	5-Specialty	PA
SYMBICORT	3-Preferred Brands	QL (10.2 PER 30 DAYS)
TRELEGY ELLIPTA	3-Preferred Brands	QL (60 PER 30 DAYS)

SKELETAL MUSCLE RELAXANTS

BOTOX	4-Non-Preferred Drug	PA
<i>carisoprodol 350 mg tab</i>	2-Generic	PA, QL (120 PER 30 DAYS)
<i>cyclobenzaprine hcl 10 mg tab</i>	2-Generic	PA, QL (90 PER 30 DAYS)
<i>cyclobenzaprine hcl 5 mg tab</i>	2-Generic	PA, QL (180 PER 30 DAYS)
<i>methocarbamol (500 mg tab, 750 mg tab)</i>	2-Generic	PA
<i>vanadom</i>	2-Generic	PA, QL (120 PER 30 DAYS)
XEOMIN	4-Non-Preferred Drug	PA

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

<i>doxepin hcl (3 mg tab, 6 mg tab)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>eszopiclone</i>	2-Generic	PA, QL (30 PER 30 DAYS)
HETLIOZ	5-Specialty	PA, QL (30 PER 30 DAYS)
HETLIOZ LQ	5-Specialty	PA, QL (158 PER 30 DAYS)
<i>ramelteon</i>	4-Non-Preferred Drug	QL (30 PER 30 DAYS)

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

Health Partners Medicare Prime and Complete 2023 (List of Covered Drugs)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tasimelteon</i>	5-Specialty	PA, QL (30 PER 30 DAYS)
<i>temazepam (15 mg cap, 30 mg cap)</i>	2-Generic	QL (30 PER 30 DAYS)
<i>zaleplon</i>	2-Generic	PA, QL (30 PER 30 DAYS)
<i>zolpidem tartrate 10 mg tab</i>	2-Generic	PA, QL (30 PER 30 DAYS)
<i>zolpidem tartrate 5 mg tab</i>	2-Generic	QL (30 PER 30 DAYS)
<i>zolpidem tartrate er</i>	2-Generic	PA, QL (30 PER 30 DAYS)

WAKEFULNESS PROMOTING AGENTS

<i>armodafinil</i>	3-Preferred Brands	PA, QL (30 PER 30 DAYS)
<i>modafinil 100 mg tab</i>	4-Non-Preferred Drug	PA, QL (30 PER 30 DAYS)
<i>modafinil 200 mg tab</i>	4-Non-Preferred Drug	PA, QL (60 PER 30 DAYS)
XYREM	5-Specialty	PA, QL (540 PER 30 DAYS)
XYWAV	5-Specialty	PA, QL (540 PER 30 DAYS)

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

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oxaprozin	3	penicillin g sodium	10
oxazepam	48	penicillin v potassium	10
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oxybutynin chloride	78	pentamidine isethionate 300 mg inject soln	36
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phenytoin infatabs	16	pravastatin sodium	62
phenytoin sodium	16	praziquantel	36
phenytoin sodium extended	16	prazosin hcl	56
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PIFELTRO	44	prednisolone acetate	100
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pimtrea	85	prednisone	80
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pioglitazone hcl-glimepiride	51	pregabalin er	66
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polymyxin b-trimethoprim	99	prochlorperazine	21
POMALYST	26	prochlorperazine edisylate	21
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selenium sulfide	70	SPRITAM	14
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sulfadiazine	12	TDVAX	95
sulfamethoxazole-trimethoprim	12	TECENTRIQ	35
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tramadol hcl er (biphasic).....	3	trimipramine maleate.....	20
tramadol-acetaminophen.....	5	TRINTELLIX.....	20
trandolapril.....	57	TRIUMEQ.....	45
trandolapril-verapamil hcl er.....	61	TRIUMEQ PD.....	45
tranexamic acid.....	55	trivora (28).....	86
tranlycypromine sulfate.....	18	TRIZIVIR.....	45
TRAVASOL.....	74	TROGARZO.....	45
travoprost (bak free).....	101	TROPHAMINE.....	74
TRAZIMERA.....	35	tropium chloride.....	78
trazodone hcl.....	20	tropium chloride er.....	78
TREANDA.....	26	TRULICITY.....	51
TRECTOR.....	25	TRUMENBA.....	95
TRELEGY ELLIPTA.....	106	TRUSELTIQ (100MG DAILY DOSE).....	33
TRELSTAR MIXJECT.....	89	TRUSELTIQ (125MG DAILY DOSE).....	33
TRESIBA.....	54	TRUSELTIQ (50MG DAILY DOSE).....	34

TRUSELTIQ (75MG DAILY DOSE)	34	verapamil hcl	59
TRUXIMA	35	verapamil hcl er	59
TUKYSA	34	VERSACLOZ	42
TURALIO	34	VERZENIO	34
TWINRIX	95	vestura	86
TYBOST	45	VIBERZI	76
TYPHIM VI	95	VICTOZA	51
U		vienna	86
unithroid	88	vigabatrin	15
UPTRAVI	105	vigadrone	15
ursodiol	76	VIIBRYD STARTER PACK	20
UZEDY	41	vilazodone hcl	20
V		vinblastine sulfate	30
valacyclovir hcl	47	vincasar pfs	30
VALCHLOR	26	vincristine sulfate	30
valganciclovir hcl	42	vinorelbine tartrate	30
valproate sodium	14	viorele	86
valproic acid	14	VIRACEPT	46
valsartan	56	VIREAD	45
valsartan-hydrochlorothiazide	61	VITRAKVI	34
VALTOCO 10 MG DOSE	15	VIVITROL	5
VALTOCO 15 MG DOSE	15	VIZIMPRO	34
VALTOCO 20 MG DOSE	15	volnea	86
VALTOCO 5 MG DOSE	15	VONJO	34
vanadom	106	voriconazole	23
vancomycin hcl	8	VOTRIENT	34
VAQTA	95	VRAYLAR	41
varenicline tartrate	6	VUMERITY	67
VARIVAX	95	vyfemla	86
VASCEPA	63	vylibra	86
VECTIBIX	35	VYXEOS	30
velivet	86	W	
VELTASSA	75	warfarin sodium	54
VEMLIDY	42	WELIREG	30
VENCLEXTA	34	wera	86
VENCLEXTA STARTING PACK	34	wymzya fe	86
VENLAFAXINE BESYLATE ER	20	X	
venlafaxine hcl	20	XALKORI	34
venlafaxine hcl er	20	XARELTO	54

XARELTO STARTER PACK	54	ZANOSAR	30
XATMEP	92	zarah	86
XCOPRI	14	ZARXIO	55
XCOPRI (250 MG DAILY DOSE)	14	ZEJULA	34
XCOPRI (350 MG DAILY DOSE)	14	ZELBORAF	34
XELJANZ	90	ZEMAIRA	78
XELJANZ XR	90	zenatane	68
XEOMIN	106	zidovudine	45
XERMELO	76	ZIEXTENZO	55
XGEVA	96	ziprasidone hcl	41
XIFAXAN	8	ziprasidone mesylate	41
XIGDUO XR	52	ZIRABEV	35
XIIDRA	98	ZIRGAN	99
XOLAIR	90	zoledronic acid	97
XOSPATA	34	ZOLINZA	30
XPOVIO (100 MG ONCE WEEKLY)	30	zolmitriptan	24
XPOVIO (40 MG ONCE WEEKLY)	30	zolpidem tartrate	107
XPOVIO (40 MG TWICE WEEKLY)	30	zolpidem tartrate er	107
XPOVIO (60 MG ONCE WEEKLY)	30	ZONISADE	16
XPOVIO (60 MG TWICE WEEKLY)	30	zonisamide	16
XPOVIO (80 MG ONCE WEEKLY)	30	ZONTIVITY	54
XPOVIO (80 MG TWICE WEEKLY)	30	zovia 1/35 (28)	86
XTAMPZA ER	3	ZTALMY	14
XTANDI	26	zumandimine	86
xulane	86	ZYDELIG	34
XYREM	107	ZYKADIA	34
XYWAV	107	ZYLET	98
		ZYPREXA RELPREVV	41

Y

YERVOY	35
YF-VAX	95
YONDELIS	26
YONSA	26
YUPELRI	103
yuvafem	86

Z

zafemy	86
zafirlukast	103
zaleplon	107
ZALTRAP	30

This formulary was updated on 9/1/2023. 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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